IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4204

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	**Coroner Kate Despot**
Deceased:	**Andrew James McNeil**
Date of birth:	**26 September 1982**
Date of death:	**9 August 2019**
Cause of death:	**1(a) Metastatic non-seminomatous germ cell tumour**
Place of death:	**Eastern Health, Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria, 3152**

INTRODUCTION

1. On 9 August 2019[1], Andrew James McNeil was 36 years old when he passed away at the Wantirna Hospital Palliative Care Unit. At the time of his death, Andrew lived at 8 Polaris Drive Doncaster East which is a supported accommodation facility. Andrew had resided at this facility for approximately 24 years. In the period proximate to his passing, Andrew was provided disability services and support by Life Without Barriers[2].

2. Andrew had a medical history which included cerebral palsy, moderate intellectual disability, a congenital hip dislocation and testicular cancer diagnosed in 2015.

THE CORONIAL INVESTIGATION

3. Andrew's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Andrew's death. The Coroner's Investigator, Acting Sergeant Cameron Nugent, conducted inquiries and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Andrew James McNeil including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

[1] Date of Death taken from E-Medical Deposition Form, Eastern Health, Wantirna Health, dated 9 August 2019.
[2] Life Without Barriers is a National Disability Insurance Scheme provider.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

7. On 8 July 2019 Andrew was transported from his Doncaster East home to Box Hill Hospital with a suspected chest infection however subsequent scans diagnosed Andrew with metastatic non-seminomatous testicular cancer and extensive lung metastases[4].

8. Andrew was treated with antibiotics and remained at Box Hill Hospital until 12 July 2019 after which time he was discharged to his group home with a referral to Eastern Palliative Care.

9. On 30 July 2019 Andrew was at home where he was observed to be coughing loudly and having difficulty breathing. Onsite staff called an ambulance which transported Andrew to Box Hill Hospital Emergency Department. "*A chest x-ray and CT scan showed a large pleural effusion and a large burden of bulky tumours throughout both his lungs*"[5]. A discussion subsequently took place between Andrew's family and clinicians where it was decided the focus for Andrew would be on symptom management[6].

10. On 31 July 2019 Andrew was transferred to the Wantirna Health Palliative Care Unit where he remained until his passing in the early hours of 9 August 2019.

Identity of the deceased

11. Andrew James McNeil, born 26 September 1982, was visually identified by his mother Pauline McNeil.

12. Identity is not in dispute and requires no further investigation.

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[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[4] Statement of Dr Grace Walpole, Palliative Medicine Specialist, Eastern Health, dated 7 February 2020.

[5] Statement of Dr Grace Walpole, Palliative Medicine Specialist, Eastern Health, dated 7 February 2020.

[6] Statement of Dr Grace Walpole, Palliative Medicine Specialist, Eastern Health, dated 7 February 2020.

Medical cause of death

13. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine performed an external examination on 12 August 2019 and provided a typed report dated 15 August 2019.

14. Dr Glengarry commented as follows:

> "*The external examination of the body does not show evidence of an injury of a type likely to have caused or contributed to death*."
>
> "*On the basis of the information available to me at this time, I am of the opinion that this death is due to natural causes*."

15. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) Metastatic non-seminomatous germ cell tumour.

16. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

17. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Andrew James McNeil, born 26 September 1982;

    b) the death occurred on 9 August 2019 at Eastern Health, Wantirna Hospital, 251 Mountain Highway Wantirna from Metastatic non- seminomatous germ cell tumour; and

    c) the death occurred in the circumstances described above.

18. Having considered all of the circumstances I am satisfied that Andrew's death resulted from natural causes.

I convey my sincere condolences to Andrew's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

- Mrs Pauline McNeil and Mr John McNeil, Senior Next of Kin;

- Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health;
- Disability Services Commissioner; and
- Acting Sergeant Nugent, Coroner's Investigator, Victoria Police.

Signature:

Coroner Kate Despot

Date : 24 January 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.