IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006260

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Christopher William Hanson
Date of birth:	10 June 1963
Date of death:	31 October 2022
Cause of death:	1(a) Complications of multiple sclerosis
Place of death:	MS Residential Services, 59 Power Street, Williamstown, Victoria, 3016
Keywords:	Multiple sclerosis, in care, natural causes, MS Residential Services.

INTRODUCTION

1. On 31 October 2022, Christopher William Hanson (**Christopher**) was 59 years old when he passed away at MS Residential Services (**MSRS**) in Williamstown. At the time of his death, Christopher had lived at MSRS, for approximately 20 years.[1]

2. Christopher was born in Adelaide but moved to Portland in the 1980s where he worked for the local council. He was diagnosed with multiple sclerosis (**MS**) and then moved to MSRS.[2]

3. Christopher required care for most activities of daily living and suffered from several conditions including anaemia, depression, epilepsy, hypertension, impaired skin integrity, progressive MS, and recurrent urinary tract infections.[3]

THE CORONIAL INVESTIGATION

4. Christopher'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.

5. 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.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] Coronial brief, MSRS care plan dated 8 March 2022, page 22.
[2] Coronial brief, Summary, page 7.
[3] Coronial brief, Western Health discharge summary dated 28 February 2022, page 27.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Christopher's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Christopher William Hanson 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 narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

9. In considering the issues associated with this finding, I have been mindful of Christopher's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On 17 January 2022, Christopher was admitted to Sunshine Hospital (**Sunshine**) with cold sepsis. He was transferred to the palliative care unit however his condition stabilised and he was discharged to MSRS on 21 February 2022.[5]

11. Throughout the remainder of 2022, Christopher's health and mobility began to decline, and he was transferred to a palliative care pathway.[6]

12. On 30 October 2022, Christopher was observed by MSRS carers to be unresponsive throughout the day. His palliative team attended MSRS several times and, at 12.13pm, Christopher was found to have passed away.[7]

[4] 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.
[5] Coronial brief, statement of Rhonda Cooper dated 16 January 2023, page 12.
[6] Coronial brief, Wound Wise report dated 28 October 2022, page 24; Form 83 dated 31 October 2022.
[7] Form 83 dated 31 October 2022.

Identity of the deceased

13. On 2 November 2022, Christopher William Hanson, born 10 June 1963, was visually identified by his carer, Rhonda Cooper.

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

Medical cause of death

15. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 4 November 2022 and provided a written report of his findings dated 13 November 2022.

16. The post-mortem examination revealed findings in keeping with the history given.

17. The post-mortem computed tomography scan indicated the presence of bilateral tibial rod fixation, coronary artery calcification, bilateral basal lung markings, bilateral dilated pelvicalyceal systems and ureters, and a urinary catheter.

18. Toxicological analysis was not indicated and was not performed.

19. Dr Beer provided an opinion that the medical cause of death was front 1 (a) complications of multiple sclerosis and was due to natural causes.

20. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Christopher William Hanson, born 10 June 1963;

    b) the death occurred on 31 October 2022 at MS Residential Services, 59 Power Street, Williamstown, Victoria, 3016, from *complications of multiple sclerosis*; and

    c) the death occurred in the circumstances described above.

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

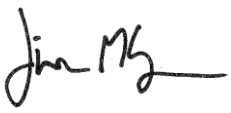
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Craig Hanson, Senior Next of Kin

First Constable Mitchell Carlyon, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 28 March 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.