IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005031

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Adrian Colin Phillips
Date of birth:	28 September 1964
Date of death:	9 September 2023
Cause of death:	1a : COMPLICATIONS OF COMMUNITY-ACQUIRED PNEUMONIA, IN A MAN WITH CHRONIC LUNG DISEASE AND INTELLECTUAL DISABILITY
Place of death:	46-48 Royal Avenue Essendon North Victoria 3041
Keywords:	In care death; NDIS participant; natural causes

INTRODUCTION

1. On 9 September 2023, Adrian Colin Phillips was 58 years old when he passed from pneumonia. At the time of his death, Adrian lived in care at 46-48 Royal Avenue Essendon North Victoria 3041.

2. Adrian was the oldest of three children born to and raised by Dorothy and Ronald Phillips. His intellectual disability prevented his development beyond the mental capacity of a 10-year-old, and he had significant additional health issues (neurofibromatosis, high blood pressure, obsessive-compulsive disorder, chronic asthma, and bronchopulmonary aspergillosis, and emphysema). He was never able to work and was reliant on carers to do most things for him.[1]

3. After his parents passed in 2011, Adrian had lived with his brother Michael's family for about a year until his needs became too difficult for them to manage, and he was moved into the Royal Avenue Supported Residential Service (**Royal Avenue**), in Essendon North. Adrian was happy at the facility for close to ten years but in the last year of his life, Michael noted weight loss and Adrian's mounting reluctance to eat. His carers were aware of the issue and confirmed that his diet was being supplemented by Sustagen to increase his weight. [2]

THE CORONIAL INVESTIGATION

4. Adrian'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. Because Adrian was an Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling[3] at the time of his death, his passing was determined to be 'in care' and, as such, is subject to a mandatory inquest, unless the cause of death is a natural one, pursuant to section 52(3A) of the Act, which is indeed the case here. [4]

6. 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

[1] Statement of Michael Phillips, *Coronial Brief.*
[2] Statement of Michael Phillips, *Coronial Brief.*
[3] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

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.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Adrian's death. The Coronial 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.

9. This finding draws on the totality of the coronial investigation into the death of Adrian Colin Phillips 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.[5]

10. In considering the issues associated with this finding, I have been mindful of Adrian'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

11. In the middle of August 2023, Adrian became unwell with what was believed to be a cold, and on the 30th August, was taken to Wellington Street Medical Centre, Flemington where he saw GP Dr Hewa. He was prescribed antibiotics and returned to Royal Avenue.[6] The next day Adrian reported breathing issues to staff, who called an Ambulance, and he was transported to the Royal Melbourne Hospital.[7]

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[5] 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.

[6] Statement of Dr Jay Hewa, *Coronial Brief.*

[7] Statement of Vicky Nguyen, *Coronial Brief.*

12. He was admitted to the hospital with community-acquired pneumonia due to methicillin resistant Staphylococcus aureus (**MRSA**) and Rhinovirus and remained in hospital for seven days.[8]

13. Adrian was discharged on 7 September 2023, returning to Royal Avenue, with oxygen cannisters to assist his breathing. His multidisciplinary treating team indicated an expected 28-day mortality rate of over 38%, citing very severe pneumonia, longstanding structural lung disease and malnutrition. Due to the severity of Adrian's condition, a referral was made to community palliative care. [9]

14. Kolapo Oladipo, an Supported Residential Service (**SRS**) Carer, described Adrian as not looking well on return from hospital and recalls assisting Adrian to attach his oxygen tubes.[10] Adrian was last seen alive by Mr Oladipo at approximately 1 am on 9 September 2023, and was then found deceased on the floor of his room at 6.50 am the next morning.[11]

15. Ambulance and Police attended, and no suspicious circumstances were identified.[12]

Identity of the deceased

16. On 9 September 2023, Adrian Colin Phillips, born 28 September 1964, was visually identified by their carer, Kolapo Oladipo.

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

Medical cause of death

18. Senior Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 11 September 2023 and provided a written report of his findings dated 12 September 2023.

19. The examination revealed no unexpected signs of trauma.

[8] Statement of Prof Daniel Steinfort, *Coronial Brief.*
[9] Statement of Prof Daniel Steinfort, *Coronial Brief.*
[10] Statement of Kolapo Oladipo, *Coronial Brief.*
[11] Statement of Vicky Nguyen, *Coronial Brief.*
[12] Statement of Shaun Jeffs, *Coronial Brief.*

20. A post mortem CT scan showed severe bullous emphysema in the lungs, with relative white-out of the right lung. Pneumonia (lung infection) causes death from respiratory failure, especially in the setting of pre-existing chronic lung disease such as this.

21. The heart showed coronary artery calcification, but was still functioning.

22. Dr Young concluded that this death was due to natural causes.

23. Toxicological analysis of post-mortem samples identified a therapeutic level of a mucolytic agent[13] called Bromhexine, and did not identify the presence of any alcohol or other common drugs or poisons.

24. Dr Young provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF COMMUNITY-ACQUIRED PNEUMONIA, IN A MAN WITH CHRONIC LUNG DISEASE AND INTELLECTUAL DISABILITY, and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Adrian Colin Phillips, born 28 September 1964;

    b) the death occurred on 9 September 2023 at 46-48 Royal Avenue Essendon North Victoria 3041, from 1(a) COMPLICATIONS OF COMMUNITY-ACQUIRED PNEUMONIA, IN A MAN WITH CHRONIC LUNG DISEASE AND INTELLECTUAL DISABILITY; and

    c) the death occurred in the circumstances described above.

26. As Adrian was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[14] I am satisfied by the available evidence that Adrian's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

27. I am further satisfied that his care was reasonable and appropriate.

[13] Colloquially known as a 'cough mixture'.
[14] Section 52(2) of the Act.

I convey my sincere condolences to Adrian'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.

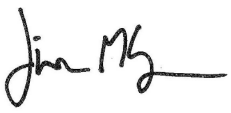
I direct that a copy of this finding be provided to the following:

Michael Phillips, Senior Next of Kin

Adrian Mariadason, Royal Melbourne Hospital

Senior Constable Shaun Jeffs, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 14 May 2025

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.