



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006997

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Amended pursuant to Section 76 of the Coroners Act 2008

On 15 June 2026¹

Inquest into the Death of Darren Russell Collyer

Hearing Date:	23 April 2026
Delivered At:	65 Kavanagh Street Southbank 3006
Findings of:	Coroner Kate Despot
Counsel assisting the coroner:	Ms Melinda Dine, Coroner's Solicitor
Keywords	Specialist Disability Accommodation (SDA); death in care, SDA death

¹ This document is an amended version of the Inquest Finding into the death of Darren Russell Collyer's death dated 1 June 2026. The correction is to the date of death appearing at paragraph 59(b) of the finding.

INTRODUCTION

1. On 18 December 2023, Mr Darren Russell Collyer (**Darren**) was 48 years old when he died at The Royal Melbourne Hospital (**RMH**).
2. At the time of his death, Darren required full time care and was a Specialist Disability Accommodation (**SDA**) resident in an SDA enrolled dwelling at 39 Henry Street Melton Victoria.

THE CORONIAL INVESTIGATION

3. Darren'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. In this instance, Darren was a "person placed in custody or care" pursuant to the definition in section 4 of the Act, as he was "a prescribed person or a person belonging to a prescribed class of person" due to his status as an "SDA resident residing in an SDA enrolled dwelling."
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. 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.
6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Darren's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Darren Russell Collyer 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.

BACKGROUND²

8. Darren was born on 24 of May 1975 at East Melbourne to Ms Heather Collyer (**Heather**).
9. Darren was Heather's only child. Heather had sole parental responsibility for Darren as his father was not actively involved in his life. Darren grew up with Heather in Sunshine.
10. Darren's doctors determined that he had an intellectual disability which was diagnosed early in his life. At approximately 7 years of age Darren was diagnosed with Sotos syndrome.
11. Darren attended the Sunshine Special Development School until he was 18 years of age.
12. Darren was also known to have what Heather describes as 'tantrums', from a young age. These episodes of agitated behaviour continued to get worse as Darren got older.
13. Heather noted that when Darren was agitated, he would intentionally hit his own head either on a surface or with his own fist. Darren was also observed to at times, hit other people if they were near him whilst he was in an agitated state.
14. Heather was concerned about Darren hurting himself or other people whilst in this state. As he got older, Darren got physically stronger and Heather found it difficult to assist him and to keep him and others safe whilst agitated. Heather found it difficult to care for Darren as, in addition to him being difficult to control when agitated, she had sole parental responsibility and was in full time work.

² Unless otherwise noted the background is derived from the Coronial Brief (**CB**), Statement of Heather Collyer dated 6 February 2024.

15. At 17 years of age Darren was placed into full time care in supported accommodation outside of the family home. Until the time of his death, he visited Heather and extended family members one day a week in the family home.
16. The specialist disability accommodation (**SDA**) where Darren lived is situated in Melton and organised by Possability Disability Services. There were other people living at the SDA who required full time care. Darren's carers noted that at any given time there would be two or three other people living in the SDA along with Darren.³
17. The residents of the SDA were supported by 24 hour carers. One of Darren's carers, Helen Morton (**Helen**), had been caring for Darren for eight or nine years at the home at the time of his death. Helen noted that it was not uncommon for there to be new carers in the facility due to short term and casual staffing arrangements within the facility.⁴
18. Darren attended a day program which provided supported group activities during weekdays. Carers would take him to his day program and return to collect him at the end of the day.⁵
19. Records indicate that on weekends and outside the day program Darren enjoyed taking part in cooking, outings to the park, dining out and movies. Darren enjoyed music and dancing as well as attending concerts.
20. Whilst residing in the SDA Darren was further diagnosed with epilepsy and anxiety. On the evidence, it is unknown when these diagnoses were made but Darren received medication in treatment for the conditions.⁶
21. Darren's carers reported to Heather that over the years he continued to have episodes where he would become agitated and would hit his own head. Heather noted that Darren

³ CB, Statement of Helen Morton dated 26 March 2024, [4] – [5].

⁴ Ibid, [21].

⁵ Ibid [17].

⁶ CB, 'Attachment 5'.

would have outbursts about two or three times a week and that he would hit his head against the wall at least once a week.⁷

22. Darren would get particularly agitated when meeting new people. Helen remarked that if Darren did not know a worker it would “set him off” and he would respond by swearing, throwing things and waving his fists. Darren would also hit his head against the wall.⁸
23. Records from Possability indicate that to manage the risk of Darren hurting himself when he was agitated or showing quote ‘self-injurious’ behaviour was the provision of a soft helmet and medication to calm him down, as needed.⁹
24. Darren was also monitored by carers after an outburst to ascertain if he required further medical care as a result of any of his self-injurious behaviour. Helen commented that it was very rare that Darren required further medical care in relation to his self-injurious behaviour.¹⁰

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

25. On 14 December 2023 at approximately 4.00pm, Darren had been at a day placement and was picked up by his carers and taken back to his SDA home in Melton.¹¹
26. A new staff carer had started work for the first time at the SDA that day. The new carer was at the SDA awaiting the residents return from their day placement.¹²
27. Darren had never met the new carer prior to 14 December 2023 and when Darren arrived at home, he became agitated when he realised there was a new person there.¹³
28. Darren was observed to swear and wave his fists around. He was agitated and chased staff and other residents along the hallway in a threatening manner. In order to attempt to disarm

⁷ CB, Statement of Helen Morton dated 26 March 2024, [14].

⁸ Ibid, [13].

⁹ CB, ‘Attachment 4’ CB, ‘Attachment 5’.

¹⁰ CB, Statement of Helen Morton dated 26 March 2024, [16].

¹¹ CB, Statement of Helen Morton dated 26 March 2024, [17] – [18].

¹² CB, Statement of Chigbogu Ezewudo dated 5 April 2024, [4]-[5].

¹³ CB, Statement of Chigbogu Ezewudo dated 5 April 2024, [10] – [12]; CB, Statement of Helen Morton dated 26 March 2024. [18] – [27].

the situation the new carer retreated to the office where he locked the door to separate himself from Darren.¹⁴

29. Darren was observed by Helen to pace up and down the hallway and hit the wall with his fist. He was also observed to hit his head with his fist and on the wall and on a cupboard door in the hallway approximately two or three times.¹⁵
30. Due to the manner in which Darren presented, staff were unable to put Darren's soft helmet on him or provide him with medication to assist him in calming him down. Instead, they attempted to calm Darren down verbally whilst keeping themselves and other residents a safe distance from him.¹⁶
31. Darren entered his bedroom and after about 15 minutes, he was observed to have calmed down. He went to the lounge room and watched television for a few hours. Darren's carers observed him throughout this time. They noted that he appeared calm throughout this time.¹⁷
32. At approximately 6.00pm Helen gave Darren his evening meal and his medication. Helen observed that Darren seemed fine at this point in time.¹⁸
33. Carers observed that Darren started to "play with his food" and whilst he was doing this some of it fell on the floor. Helen asked Darren what he was doing. Helen noted that Darren had a "glazed look" on his face.¹⁹
34. At approximately 6.45pm, the new carer went over to Darren to clean the food from the floor and noticed that he was sweating and that it looked like he wanted to throw up or was about to be sick. He observed that Darren's eyes were "drooping".
35. Helen observed that Darren slumped forward' in his chair.²⁰

¹⁴ Ibid.

¹⁵ Ibid; CB, 'Attachment 4'.

¹⁶ CB, 'Attachment 4'; CB, 'Attachment 5'.

¹⁷ CB, Statement of Helen Morton dated 26 March 2024, [27] – [28].

¹⁸ Ibid, [29].

¹⁹ Ibid, [31].

²⁰ Ibid, [31].

36. Worried about Darren, the new carer put his hand on Darren's face to check his temperature and check his pulse.²¹
37. Helen called emergency services whilst the new carer continued to provide medical assistance to Darren.
38. At 6.59pm Paramedics from Ambulance Victoria arrived and assessed Darren. Notes reflect that Darren had a glasgow coma score of 7, was self-ventilating but with an audible snore and increased abdominal sucking. Darren was noted to be in an altered conscious state and sweating. They determined that Darren was acutely unwell and required the assistance of the mobile intensive care ambulance or MICA paramedics.²²
39. The MICA team arrived and noted that Darren was tachycardic, afebrile and had sluggish eyes that were slightly reactive. They intubated Darren and stabilised him before transporting him to the Royal Melbourne Hospital.²³ The new carer went to the hospital with him in the ambulance.²⁴
40. Helen called Heather to inform her that Darren had hit his head and required treatment and that he was being transported to the Royal Melbourne Hospital.²⁵
41. At approximately 8.30pm, Darren arrived at the Royal Melbourne Hospital. He was assessed and given a computed tomography (CT) scan. The scan revealed that Darren had a large acute left frontal lobe intraparenchymal haemorrhage with intra-ventricular extension and hydrocephalus. Notes reflect that Darren did not have any acute skull or facial bone fractures or cervical spine fractures. A chest x-ray revealed a right lower zone consolidation consistent with aspiration.²⁶
42. Doctors inserted an external ventricular drain.²⁷

²¹ CB, Statement of Chigbogu Ezewudo dated 5 April 2024, [19].

²² Ambulance Victoria, patient summary.

²³ Ibid.

²⁴ CB, Statement of Chigbogu Ezewudo dated 5 April 2024, [26].

²⁵ CB, Statement of Helen Morton dated 26 March 2024, [38].

²⁶ Medical Records, Royal Melbourne Hospital, Discharge Summary.

²⁷ Ibid.

43. Darren was admitted to the intensive care unit at the Royal Melbourne Hospital where treatment continued.²⁸
44. On 17 December 2023 Darren clinically deteriorated with a “sudden deterioration in oxygen saturation”. After consultation with doctors regarding Darren’s health, Heather determined that she did not want further medical intervention for Darren. It was determined that Darren was to be transferred to end-of-life care.²⁹
45. At 8.47 am on 18 December 2023 Darren sadly passed away.

Identity of the deceased

46. On 18 December 2023, Darren Russell Collyer, born 24 May 1975, was visually identified by his mother, Heather Collyer.
47. Identity is not in dispute and requires no further investigation.

Medical cause of death

48. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination on 20 December 2023 and provided a written report of his findings dated 21 December 2023.
49. The post-mortem CT scan revealed an unusual facial skeleton (no fractures), left frontal haemorrhage with intra-ventricular extension, and marked increase in lung markings on the right. The external examination was otherwise unremarkable. Dr Burke noted that pneumonia may have been the cause of respiratory distress. He further noted that the left frontal haematoma is unusual from direct trauma, but clinical contrast imaging studies showed no underlying pathological lesion.

²⁸ Ibid.

²⁹ Ibid.

50. Toxicological analysis of post-mortem samples identified the presence of sertraline. Also present were midazolam, ondansetron and ketamine which were administered in a hospital setting.
51. Dr Burke provided an opinion that the medical cause of death was 1 (a) Complications of an intra-cranial haemorrhage.
52. I accept Dr Burke's opinion.

COMMENTS

I make the following comment(s) connected with the death under section 67(3) of the *Coroners Act 2008 (Vic)*:

53. In my jurisdiction I am enjoined to contribute to a reduction in the number of preventable deaths. Coroners achieve this by making apposite comments and recommendations.
54. Darren was a person with advanced care needs as evidenced by his participation in the NDIS and further, evidenced by his status as an SDA resident living in an SDA enrolled dwelling at the time of his death. As such, Darren formed part of the cohort of vulnerable persons whose deaths, while 'in care', required closer scrutiny.
55. Consequently, given that Darren did not die by natural causes, I focused my investigation on his care and the medical management of his health concerns. I note that Ms Collyer did not have any concerns in respect of the care provided to her son, nor the circumstances surrounding his death.
56. Having reviewed all the evidence, my coronial investigation has not identified any concerns regarding the care provided to Darren at the Melton home. Darren's care plan was well considered to include measures to manage the risk that Darren may hurt himself whilst agitated, and despite these not being able to be put in place owing to his behaviour I submit that Darren's care staff responded appropriately in the circumstances.
57. Similarly, the medical management of Darren's health concerns at the Royal Melbourne Hospital appears to have been reasonable and appropriate in the circumstances.

58. Accordingly, given that my review of the evidence did not identify any opportunities for prevention, I did not direct any further investigation. I was therefore satisfied that the available evidence enabled me to discharge my statutory obligations.

FINDINGS AND CONCLUSION

59. Having considered the evidence before me and having held an inquest, I find that:

- a) The identity of the deceased is Darren Russell Collyer born 24 May 1975;
- b) His death occurred on 18 December 2023, at Royal Melbourne Hospital, 300 Grattan St, Parkville, Victoria 3052 from 1 (a) Complications of an intra-cranial haemorrhage.
- c) His death occurred in the circumstances described above.

I convey my sincere condolences to Heather, Darren's friends and his carers for their loss.

I order that as per section 73(1) of the Coroners Act 2008 (Vic) that this finding be published on the Internet in accordance with the rules

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

Heather Collyer, Senior Next of Kin

Royal Melbourne Hospital

National Disability Insurance Agency

Senior Constable Andrew Sprakel, Coroner's Investigator

Signature:



Coroner Kate Despot

Date: 28 June 2026

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 inquest. 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.
