IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003379

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Paul Christopher George
Date of birth:	28 September 1959
Date of death:	17 June 2024
Cause of death:	1a : Unascertained
Place of death:	329 Diamond Creek Road Diamond Creek Victoria
Keywords:	In care, disability, unascertained, natural causes

INTRODUCTION

1. On 17 June 2024, Paul Christopher George was 64 years old when he died unexpectedly. At the time, Paul lived at Henderson Court, Bundoora Victoria.

2. Paul was born with Borjeson-Forssman-Lehman Syndrome, a rare genetic disorder primarily affecting males and which is characterised by intellectual disability, obesity and distinctive physical features. As a teenager, Paul began living in supported accommodation and in 1997, moved to Henderson Court Specialist Disability Accommodation (**Henderson Court**). From 2019, he received support from Life Without Barriers (**LWB**).

3. Henderson Court staff provided assistance for all of Paul's daily living tasks and facilitated a Mealtime Management Plan (**MMP**) due to his dysphagia.[1] According to the MMP, he was required to have soft, moist, bite-sized foods and mildly thickened liquids, and required full supervision at mealtimes to monitor the timing and quantity of his mouthfuls.

4. Paul enjoyed attending his day placement and participating in sensory activities, watching news programs on the television and community excursions.

THE CORONIAL INVESTIGATION

5. Pauls' death fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**) as she was a *'person placed in custody or care'* within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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 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.

[1] Difficulty chewing or swallowing foods and liquids.

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 Coroner's Investigator for the investigation of Paul'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.

9. This finding draws on the totality of the coronial investigation into the death of Paul Christopher George 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.[2]

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

Circumstances in which the death occurred

10. On 17 June 2024, Paul awoke and *'felt a bit flat'*. A COVID-19 test returned a negative result, his temperature was normal and he otherwise *'felt ok'*. At 11.30am, Paul's support worker, Grant Coulthard (**Grant**), was informed of Paul's complaint when he collected him from Henderson Court. The pair travelled to the Diamond Creek Netball Court, as they had done each week for the past six months.

11. Grant helped Paul do some exercise, including strength training and walking the length of the netball court, which he had done several times in the past and completed without issue. The pair travelled to the Diamond Creek Hotel where Paul had *'a very serious coughing fit'* lasting for 15-45 seconds, which Grant had not witnessed before.

12. Once Paul settled, Grant helped him eat lunch by cutting his meal into small pieces and provided him with thickened water. While eating, Paul had *'another serious coughing fit'*

[2] 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.

which eventually subsided. Paul also drank a thickened coffee and at around 2.40pm, Grant began driving him back to Henderson Court.

13. Shortly after beginning their journey home, Paul started coughing, *'appeared to be in pain'* and said that his throat hurt. A few minutes later, Paul screamed, was *'clearly distraught'* and *'in visible pain and discomfort'*. He began *'flailing'* his arm and striking Grant, before he became *'still and silent, and his head slumped forward'*. Grant attempted to verbally and physically prompt Paul however, he did not respond. As Grant was driving on a narrow street, it was not safe to pull over at that time but was able to do so approximately 500 metres later.

14. Grant noticed that Paul's lips were a purple-blue colour, he could not feel any breath nor a pulse in his neck and so pulled him from the vehicle and commenced cardiopulmonary resuscitation (**CPR**) while contacting emergency services. Bystanders approached and assisted with resuscitation efforts until Ambulance Victoria paramedics arrived around 10 minutes later and took over CPR. Mobile Intensive Care Ambulance (**MICA**) paramedics and firefighters also arrived at the scene and provided assistance.

15. During CPR, fluid came from Paul's mouth which Grant cleared using his fingers.

16. Despite ongoing resuscitation efforts, Paul was unable to be revived and at 3.40pm, paramedics declared him deceased.

Identity of the deceased

17. On 17 June 2024, Paul Christopher George, born 28 September 1959, was visually identified by his carer, Grant Coulthard.

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

Medical cause of death

19. Forensic Pathologist Dr Joanne Ho of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 26 June 2024 and provided a written report of her findings dated 9 September 2024.

20. The post-mortem examination did not reveal any significant natural disease that could have caused or contributed to the death.

21. There were injuries identified consistent with CPR, including bilateral rib fractures, a sternal fracture, soft tissue haemorrhage and likely aspiration of food material. There were no injuries which may have caused or contributed to the death.

22. Dr Ho explained that there are some causes of sudden, unexpected death where there are no anatomical changes identifiable at post-mortem examination. These include cardiac arrythmias, seizure disorders and metabolic and biochemical derangements. An examination of the brain did not reveal any obvious causes for seizure and examination of the heart did not show any valvular or significant coronary artery disease. Dr Ho stated the cardiac channelopathies such as long QT syndrome, catecholaminergic polymorphous ventricular tachycardia and Brugada syndrome have been implicated with some cardiac arrythmias.

23. Routine toxicological analysis of post-mortem samples detected sertraline,[3] chlorpromazine[4] and olanzapine.[5]

24. The c-reactive protein, an inflammatory marker, was mildly elevated (at 108 mg/L). However, the autopsy did not establish any overt infection within the levels of the post-mortem change and procalcitonin, a marker of severe infection or sepsis, was negative. Accordingly, the significance of the elevated c-reactive protein to the cause of death remains unknown.

25. Dr Ho provided an opinion that the medical cause of death was '*1(a) Unascertained'*. Dr Ho noted that the death was due to natural causes.

26. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Paul Christopher George, born 28 September 1959;

    b) the death occurred on 17 June 2024 at 329 Diamond Creek Road Diamond Creek Victoria, from unascertained natural causes; and

    c) the death occurred in the circumstances described above.

[3] An antidepressant.
[4] An antipsychotic.
[5] An antipsychotic.

I convey my sincere condolences to Paul'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:

Frances De Jong, Senior Next of Kin

Life Without Barriers, c/- Barry Nilsson Law

Senior Constable Rachael Dols, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 20 August 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.