IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005002

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Brian Matthew McDonald
Date of birth:	28 April 1955
Date of death:	24 August 2024
Cause of death:	1a : HAEMOPERICARDIUM 1b : ISCHAEMIC HEART DISEASE
Place of death:	32 Hillingdon Crescent Doncaster Victoria 3108
Keywords:	Death in care; SDA resident; Disability

INTRODUCTION

1. On 24 August 2024, Brian Matthew McDonald was 69 years old when he passed of natural causes whilst living in care at 32 Hillingdon Crescent, Doncaster, Victoria, 3108.

2. Brain had a life long autistic intellectual disability, and was unsteady on his feet.[1] He had lived in care since he was 9 years old, and was moved from the old Kew Cottages facility to the Hillingdon facility about 20 years ago. [2]

3. His other medical conditions included epilepsy, asthma, gastric ulcers and episodic vomiting.[3]

THE CORONIAL INVESTIGATION

4. Brian'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 Brian resided in Specialist Disability Accommodation (**SDA**) at the time of his death, his passing was deemed to be 'in care'[4] and, as such, is subject to a mandatory investigation, pursuant to section 52(3A) of the Act.[5]

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.

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

[1] Report of Dr Shan Li, *Coronial Brief*.
[2] Statement of Michael McDonald, *Coronial Brief*.
[3] Report of Dr Benjamin Katz, *Coronial Brief*.

[5] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

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 Brian'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 Brian Matthew McDonald 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.[6]

10. In considering the issues associated with this finding, I have been mindful of Brian'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. On Wednesday, 24 August 2024, at approximately 2:00 pm, Brian was alone outside in the rear yard of his care facility. There was a concrete path with railing leading down from the back door to a gazebo. Another resident, Mr Lindsey Snell, found Brian lying there on his back and alerted carer, Mr Baljit Singh, who had first aid qualifications.[7]

12. Mr Singh noticed Brian was bleeding from the back of his head, called 000 immediately. Mr Singh followed the 000 call taker's instructions but unfortunately Brian stopped breathing after approximately 3 to 5 minutes of cardiopulmonary resuscitation. Brian could not be revived even when the Fire Rescue team arrived and took over resuscitation efforts. [8]

---

[6] 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.

[7] Statement of Baljit Singh, *Coronial Brief*.

[8] Statement of Baljit Singh, *Coronial Brief*.

13. Brian had no cardiac history[9] and had otherwise been behaving normally during the day's activities.[10]

Identity of the deceased

14. On 26 August 2024, Brian Matthew McDonald, born 28 April 1955, was visually identified by their carer of the last two years, Mr Baljit Singh.

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

Medical cause of death

16. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 26 August 2024 and provided a written report of his findings dated 30 August 2024.

17. The post-mortem CT scan revealed signs of a "hammered heart" indicating that the fatal cardiac event occurred whilst Brian was still alive, and that he likely then fell as a consequence of that event, and not the other way around. The physical examination confirmed a small scalp laceration but otherwise revealed nothing inconsistent with the history given and no other independent causes of death.

18. Toxicological analysis of post-mortem samples identified the presence of Levetiracetam[11] and paracetamol, consistent with his medical history.

19. Dr Beer provided an opinion that the medical cause of death was 1(a) HAEMOPERICARDIUM, 1(b) ISCHAEMIC HEART DISEASE, and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Brian Matthew McDonald, born 28 April 1955;

    b) the death occurred on 24 August 2024 at 32 Hillingdon Crescent, Doncaster, Victoria, 3108, from 1(a) HAEMOPERICARDIUM and 1(b) ISCHAEMIC HEART DISEASE; and

[9] Report of Dr Shan Li, *Coronial Brief*.
[10] Statement of Baljit Singh, *Coronial Brief*.
[11] A drug used to treat epilepsy.

c) the death occurred in the circumstances described above.

21. Having considered all of the evidence, I am satisfied that Brian's care was reasonable and appropriate at all material times.

I convey my sincere condolences to Brian'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 McDonald, Senior Next of Kin

Tony McDonald, Senior Next of Kin

Scott Shelly, Life without Barriers

Senior Constable Darren Snowden, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 06 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.