



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 07304

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Brad Adrian Phillipson
Date of birth:	3/12/1970
Date of death:	17/12/2024
Cause of death:	1a: Complications of severe cerebral palsy
Place of death:	Lilydale Victoria 3140
Keywords:	In care, cerebral palsy, epilepsy, natural causes

INTRODUCTION

1. On 17 December 2024, Brad Adrian Phillipson was 54 years old when he died at home. At the time of his death, Mr Phillipson lived in specialist disability accommodation (SDA) in Lilydale, Victoria run by Araluen.
2. Mr Phillipson was placed in state care at 18 months old due to a complex medical history including cerebral palsy, scoliosis, and Melkersson-Rosenthal syndrome. Mr Phillipson also had a severe developmental and epileptic encephalopathy due to MECP2-duplication, for which he had an epilepsy plan. Mr Phillipson was nonverbal, required the use of a wheelchair, and required 24-hour care.

THE CORONIAL INVESTIGATION

3. Mr Phillipson's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).¹ The sole reason for the report was that Mr Phillipson 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".²
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 Coronial Investigator for the investigation of Mr Phillipson's death. The Coronial Investigator conducted inquiries and submitted a coronial brief of evidence.

¹ Section 4(1), (2)(c) of the Act.

² Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5. I have received information that Mr Phillipson resided at an address where the residents meet these criteria.

7. This finding draws on the totality of the coronial investigation into the death of Brad Adrian Phillipson 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.³

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

Circumstances in which the death occurred

8. In October 2024, Mr Phillipson was admitted as an inpatient to Maroondah Hospital with likely aspiration pneumonia, sepsis, and COVID-19. Mr Phillipson recovered and was discharged home with a guarded prognosis. Mr Phillipson's parents discussed his ongoing care with his care provider and stated that they did not wish for him to return to hospital, preferring palliative care at home.
9. Mr Phillipson's SDA residence is a supported independent living facility that houses five residents and provides 24-hour care. Active night shifts are covered by a single carer who is primarily responsible for hourly checks on the residents and attending to their needs.
10. On 16 December 2024, the night shift carer started their shift at 10:30pm, conducted handover, and commenced their first hourly checks on the residents at 11:30pm. Hourly checks were conducted at 12:30am, 1:30am, 2:30am, and 3:30am with no significant events.
11. During the 4:30am check, the carer heard Mr Phillipson coughing and vocalising. They saw that the blanket had fallen off the bed, and a pillow was raised above his head. Mr Phillipson was repositioned and he went back to sleep. Suspecting that Mr Phillipson may have had a seizure, the carer consulted Mr Phillipson's epilepsy plan and sat in his room for twenty minutes, observing him to be breathing normally.
12. At approximately 5:30am during the next hourly check, the carer observed Mr Phillipson in the same position as they had previously left him in, however his eyes were now open. They checked for a pulse, placed their ear to Mr Phillipson's nose, and attempted to rouse him. After they received no response, the carer called their practice leader and 000.

³ 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.

13. The 000 call taker instructed the carer to lay Mr Phillipson on the floor and commence CPR. Ambulance Victoria attended at approximately 6:00am, however Mr Phillipson could not be resuscitated and was confirmed deceased.

Identity of the deceased

14. On 17 December 2024, Brad Adrian Phillipson, born 3 December 1970, was visually identified by his carer, Kathleen Hamilton.
15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (VIFM) conducted a post-mortem examination on 18 December 2024 and provided a written report of his findings dated 3 January 2025.
17. The post-mortem examination and post-mortem CT scan revealed findings consistent with the reported circumstances, with no evidence of substantial injury and no structural cause of death demonstrated.
18. Toxicological analysis of post-mortem samples was conducted and revealed findings consistent with Mr Phillipson's medication regime.
19. Dr de Boer provided an opinion that the medical cause of death was 1(a) Complications of severe cerebral palsy, and that the death was due to natural causes.
20. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was Brad Adrian Phillipson, born 3 March 1970.
 - b) The death occurred on 17 December 2024 at Lilydale, Victoria, 3140 from 1a: Complications of severe cerebral palsy.
 - c) the death occurred in the circumstances described above.

22. Having considered all the available evidence, I find that Mr Phillipson's death was from natural causes and that no further investigation is required. The death was not unexpected and there was no deficiency in the disability support or medical care provided. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr Phillipson's family, friends, and carers 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:

Trevor And Janice Marlene Phillipson, Senior Next of Kin

Scope (Aust) Ltd

Araluen

Leading Senior Constable Jeffrey Disken, Coronial Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 01 October 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 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.
