



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007363

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Joel Charles Buckley
Date of birth:	30 April 1974
Date of death:	20 December 2024
Cause of death:	1a: Metastatic carcinoma of unknown primary
Place of death:	Golf Links Road Rehabilitation Centre 125 Golf Links Road Frankston Victoria 3199
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable death, natural causes

INTRODUCTION

1. On 20 December 2024, Joel Charles Buckley was 50 years old when he died at Golf Links Road Rehabilitation Centre, 125 Golf Links Road, Frankston, Victoria.
2. At the time of his death, Mr Buckley resided at a Specialist Disability Accommodation (SDA) enrolled dwelling under the National Disability Insurance Scheme (NDIS). Mr Buckley received funded daily independent living support from the NDIS due to his disability which was provided at the SDA enrolled dwelling.
3. Mr Buckley had a history of intellectual disability, hypercholesterolemia, depression, and metastatic cancer.

THE CORONIAL INVESTIGATION

4. Mr Buckley's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, being a person residing in Victoria who is an SDA resident residing in an SDA enrolled dwelling.¹ The coroner is required to investigate such deaths, and publish their findings.
5. This finding draws on the totality of the coronial investigation into the death of Joel Charles Buckley 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

6. Since 2004, Mr Buckley had been living in supported accommodation in Frankston. He was the recipient of a disability pension which paid for his accommodation and living costs.
7. On 7 March 2024, Mr Buckley was reviewed by his regular GP with whom he had been a patient since 2007. He presented with back and shoulder pain following a fall. He was sent

¹ This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), Reg. 7(1)(d).

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.

for an X-ray, prescribed pain medication and referred to a physiotherapist and exercise physiologist. The X-ray showed osteoarthritis in the acromioclavicular (AC) joint and degenerative changes in the thoracic spine. Mr Buckley was not noted to be otherwise unwell.

8. In June 2024, one of Mr Buckley's carers noticed that he was unwell and he was taken to Frankston Hospital for review. He was diagnosed with extensive metastatic cancer and admitted to Oncology where medical investigations were conducted. Due to the extensive nature of the metastases, he was not recommended for surgical intervention. A decision was made for palliative care, aimed at pain management and comfort care. He was admitted to the Palliative Care Unit (PCU) at the Golf Links Road Rehabilitation Unit. Mr Buckley wanted to return to his accommodation in Frankston, but his care needs were too high.
9. Mr Buckley was approved as a NDIS recipient and on 15 October 2024, he was discharged to reside at an SDA enrolled dwelling in Seaford, managed by Aruma, where he received Supported Independent Living Services (SIL) and 24-hour care. His condition continued to deteriorate, which was the expected course of his natural disease, and he received routine visits from the PCU team.
10. On 17 December 2024, Mr Buckley was in the final stages of his illness and was readmitted to the PCU at the Golf Links Road Rehabilitation Unit. He passed away at 6:20 am on 20 December 2024.

Identity of the deceased

11. On 19 December 2024, Joel Charles Buckley, born 30 April 1974, was visually identified by Jayne Holmes, a carer at the SDA enrolled dwelling where he resided.
12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted a post-mortem external examination on 20 December 2024 and provided a written report of her findings dated 16 January 2025.
14. The post-mortem examination revealed no remarkable features and no evidence of any injury which caused or contributed to the death. A post-mortem CT scan showed a right

proximal humerus acute pathological fracture, extensive skeletal metastases, lung metastases and left renal mass. Dr Archer opined that the pathological fracture did not contribute to the death and noted that Mr Buckley was “highly prone” to such fractures due to the skeletal metastases.

15. Dr Archer provided an opinion that the medical cause of death was “1(a) metastatic carcinoma of unknown primary”, and that Mr Buckley’s passing was due to natural causes.
16. I accept Dr Archer’s opinion.

FINDINGS AND CONCLUSION

17. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was Joel Charles Buckley, born 30 April 1974;
 - b) the death occurred on 20 December 2024 at Golf Links Road Rehabilitation Centre, 125 Golf Links Road, Frankston, Victoria, from metastatic carcinoma of unknown primary;
and
 - c) the death occurred in the circumstances described above.
18. Having considered all the available evidence, I find that Mr Buckley’s death was from natural causes and was not unexpected. No further investigation is required. 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 Buckley’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:

Nicholas Roberts, Senior Next of Kin

Peninsula Health

Senior Constable Matthew Chrichton, Coronial Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 19 February 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.
