IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000301

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	KM[1]
Date of birth:	On a date known to the Court
Date of death:	15 January 2025 (date of discovery)
Cause of death:	1(a) Unascertained
Place of death:	At an address known to the Court
Keywords:	Unascertained Causes; Recent decline in health

[1] The name of the deceased has been replaced with a randomly generated pseudonym. Other identifying details have been withheld for the purposes of publication; a copy of the original finding will remain on the Court File.

INTRODUCTION

1. On 15 January 2025, KM was found deceased in his home.

2. KM had a difficult and unstable childhood as his father left the family and was incarcerated when he was four years old. His mother battled long-term alcoholism which severely impacted KM's growth and development. KM's education was interrupted and he attended approximately ten different schools over his seven years of primary education.

3. During their teenage, KM lived with and was cared for by his siter, PM, who was living in Western Australia at the time after having previously moved away from their mother. During these years, KM was a cheerful, friendly teenager who enjoyed football and was always respectful and well behaved. PM had two small daughters, and KM was an immense support for her. He adored his nieces and they, in turn, adored him.

4. KM and PM shared a close and loving connection particularly during their younger years which was strengthened by the common hardships they had endured growing up, and it is evident in PM's compassionate statement that the love they shared never wavered despite the distance life created between them.

5. Sometime after 1994, KM returned to Perth where his mother was residing to try and build a relationship with her, but this was a difficult challenge because of her alcohol addiction. When KM later found out in early 2002 that his mother had passed the year before, he experienced a terrible sadness which affected him deeply.

6. KM met his partner DT around 2000 whilst serving time in prison. DT had a young daughter, and KM happily took on the role of being her father. KM and DT welcomed three children together.

7. From approximately 2014, KM was the sole carer for his three children following his separation from DT. However, sometime in 2021, KM's children were permanently removed from his care. Following the loss of his children, KM experienced a decline but had told a neighbour that he was going to get well again and get his children back.

8. KM was described by his neighbours as a polite man who loved his children. It is clear he was a loving and caring father who cherished his children and wanted to do his best for them.

9. PM reported that KM suffered many mental health challenges during his life. He had diagnoses of anxiety, depression, opiate dependence, hepatitis C and had previous fractures

of the radius and facial bones. He also used drugs and alcohol, predominately heroin and methylamphetamine.

10. On 20 December 2024, KM presented to the emergency department at the Alfred Hospital for cellulitis in both his lower legs and small crusted lesions. He was given intravenous antibiotics and then discharged home with a prescription for oral antibiotics and strict hygiene measures. He was advised to see his general practitioner to follow up the results of a swab test and to see how his legs were healing.

11. KM represented to the Alfred Hospital emergency department on 26 December 2024 due to progressive cellulitis in his legs. He reported that he had not filled the prescription for antibiotics because he could not afford it. Prior to discharge, he was given a dose of antibiotics and advised to take his antibiotic prescription to a Chemist Warehouse or the hospital pharmacy.

THE CORONIAL INVESTIGATION

12. KM's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

13. 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.

14. 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.

15. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of KM's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

16. In July 2025, I assumed carriage of the investigation into KM's death after the retirement of then Coroner John Olle for the purpose of finalising the investigation and making findings.

17. This finding draws on the totality of the coronial investigation into the death of KM. 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

18. In the afternoon on 25 December 2024, KM and a friend visited KM's neighbour. The three of them spent the afternoon relaxing and smoking cannabis. The neighbour reported they had an enjoyable time, but that KM looked unwell and had lost weight. He also believed that KM had recently relapsed heavily into substance abuse. Two of KM's other neighbours also saw him in December 2024 and reported that he looked unwell and had lost weight.

19. On 4 January 2025, another of KM's neighbours saw him at a nearby Coles. She stated that KM looked extremely unwell and fatigued.

20. Based on the evidence obtained by the Coronial Investigator, KM was not seen or heard from by anyone who knew him after 4 January 2025.

21. On 15 January 2025, a welfare check was conducted on KM following a request from a tradesperson who was working nearby to KM's unit due to a strong smell emanating from the unit.

22. When Victoria Police members attended at KM's unit, the front door was locked but they were able to gain access around 1.00pm using a key provided by the Department of Families, Fairness and Housing (**DFFH**). KM was located inside the unit deceased, partially covered by a blanket and in a state of advanced decomposition.

23. Drug paraphernalia including a syringe, a spoon and a bong were found in the unit.

[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.

24. Victoria Police commenced an investigation and did not identify any suspicious circumstances surrounding KM's death. There were no signs of disturbance or forced entry into the unit.

Identity of the deceased

25. On 22 January 2025, KM, born on a date known to the Court, was identified via fingerprint identification.

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

Medical cause of death

27. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 20 January 2025 and provided a written report of her findings dated 11 February 2025.

28. The post-mortem examination revealed no skeletal trauma but there were significant decomposition changes and Dr Glengarry commented that no significant natural disease was able to be identified.

29. There was also no evidence of violence or injury contributing to death.

30. Toxicological analysis of a post-mortem liver sample did not identify the presence of any common drugs or poisons.

31. Dr Glengarry provided an opinion that the medical cause of death was *'1(a) Unascertained'*.

32. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was KM, born on a date known to the Court,

    b) the death occurred between 4 January 2025 and 15 January 2025 at an address known to the Court, from unascertained causes; and

    c) the death occurred in the circumstances described above.

34. Although the cause of KM's death has not been definitively determined, I have considered the surrounding circumstances and exhaustive post-mortem examination, and I am satisfied that there were no suspicious circumstances or third-party involvement in the death.

35. Unfortunately, due to the factors identified by Dr Glengarry in her autopsy report, I am also unable to ascertain an exact date of death but on the evidence available, the death occurred between 4 January 2025 and 15 January 2025.

I convey my sincere condolences to KM's family and friends for their loss and I acknowledge the distressing circumstances in which his death occurred.

Pursuant to section 73(1A) 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:

KM's father, Senior Next of Kin

PM

Alfred Health

Sergeant Matthew Malone, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 31 July 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.