IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002592

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Mark Ronald Blyth
Date of birth:	3/04/1958
Date of death:	13/05/2025
Cause of death:	1a : COMPLICATIONS OF CHRONIC BOWEL OBSTRUCTION 1b : MARKED FAECAL LOADING IN A MAN WITH AN INTELLECTUAL DISABILITY
Place of death:	3 Botanic Drive, Kew Victoria 3101
Keywords:	In care, SDA resident, natural causes death, chronic bowel obstruction, intellectual disability

INTRODUCTION

1. On 13/05/2025, Mark Ronald Blyth **(Mark)** was 67 years old when he died at his residence in Kew. He is survived by his brothers, David Blyth and Steve Blyth.

2. Mark was born with severe intellectual disability. He also had a complex medical history that included epilepsy, poor mobility, recurrent aspiration pneumonia, dysphagia, was nonverbal and required full physical support. He also had a history of cerebrovascular accident (stroke) in 2024 and chronic hyponatraemia. He had been under the care of Dr Hiran Edirisinghe since 2009.

3. At the time of his death, Mark was a Supported Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 3 Botanic Drive Kew, Victoria 3101. He received Supported Independent Living Services from Scope, a National Disability Insurance Scheme provider.

4. In October 2024, Mark participated in the National Bowel Cancer Screening Program and there was evidence of blood in his stool sample. On 10 December 2024, he attended an appointment with a Gastroenterologist who recommended that he undergo a colonoscopy and gastroscopy. The procedures were scheduled for 20 December 2024 at Doncaster Private Hospital but did not go ahead as the facilities were inadequate to support Mark. Scope staff followed up with Dr Edirisinghe to explore alternatives.

5. On 3 April 2025, Mark was scheduled to have a CT colonography. Despite completing the bowel preparation, the procedure was cancelled due to insufficient bowel evacuation.

6. On 4 April 2025, Scope staff observed that Mark was lethargic with little appetite. He developed vomiting and had a distended abdomen. He was transported to the Emergency Department at St Vincent's Hospital **(SVH)** and underwent an exploratory laparotomy for a suspected small bowel obstruction, but no obstruction was identified. SVH Nephrologist Dr Veena Roberts noted that Mark's procedure was complicated by aspiration pneumonia and multiple hypoxic episodes. Mark remained at SVH until 15 April 2025 before returning to his supported living facility to recover from pneumonia.

THE CORONIAL INVESTIGATION

7. Mark'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, as a person with disability who received funded daily independent living support and resided in an

SDA enrolled dwelling immediately prior to his death.[1] 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.

8. 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.

9. 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.

10. This finding draws on the totality of the coronial investigation into the death of Mark Ronald Blyth 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

11. On 16 April 2025, Mark was re-admitted to SVH with symptoms of vomiting and abdominal pain. He was discharged on 25 April 2025 with a plan that included management of bowel issues, community nursing for wound care, and a comprehensive medication regime.

12. On 29 April 2025, Scope staff noted that Mark's ability to swallow was impaired and he was also constipated. He was again admitted at SVH.

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

13. On 7 May 2025, a discharge planning meeting was held between Mark's family, Scope staff and the treating hospital team. Given Mark's poor prognosis, a decision was made to transition him to palliative care. Mark was discharged back home on 8 May 2025 with a referral to the Eastern Palliative Care team for palliative support comprising comfort care and symptom management.

14. Mark subsequently died on 13 May at 2pm.

Identity of the deceased

15. On 13 May 2025, Mark Ronald Blyth, born 3/04/1958, was visually identified by his carer, Lisa Wright.

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

Medical cause of death

17. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an autopsy on 19 May 2025 and provided a written report of his findings dated 18 June 2025.

18. The post-mortem examination showed no evidence of any injury which would have contributed to or led to death. The post-mortem CT scan and post-mortem examination showed marked faecal loading from the rectum and up to including the oesophagus. There was no transition point. Dr Burke noted that it appeared reasonable to suggest that Mark's chronic bowel obstruction was secondary to severe faecal loading. Microscopic examination of the bowel showed the presence of ganglion cells. Absence of ganglion cells is a diagnostic marker for Hirschsprung's disease.

19. The toxicological analysis showed a vitreous urea concentration of 19 mmol/L, indicating a mild degree of renal impairment. Renal impairment may occur in individuals with chronic constipation as a result of intravascular depletion.

20. Dr Burke provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF CHRONIC BOWEL OBSTRUCTION, 1(b) MARKED FAECAL LOADING IN A MAN WITH AN INTELLECTUAL DISABILITY.

21. Dr Burke provided an opinion that the cause of death was due to natural causes.

22. I accept Dr Burke's opinion.

SCREENING BY THE CORONERS PREVENTION UNIT

23. Given Mark's medical history and time in hospital, I referred the matter to the Coroners Prevention Unit **(CPU)** for screening. The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

24. The CPU considered the available materials and noted that Mark had a decades long history of constipation despite aperients (which become less effective with time). At SVH, the surgeons looked for the surgical cause of any bowel obstruction but found none. The CPU considered the medical care and management to be reasonable in all the circumstances. No prevention opportunities were identified.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mark Ronald Blyth, born 3/04/1958;

    b) the death occurred on 13/05/2025 at 3 Botanic Drive Kew Victoria 3101 from complications of chronic bowel obstruction in circumstances of marked faecal loading in a man with an intellectual disability; and

    c) the death occurred in the circumstances described above.

26. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Mark died from natural causes, and 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 Mark'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:

David Blyth, Senior Next of Kin

Lisa Evans, Scope Australia

Senior Constable Aaron Hastings, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 06 September 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.