IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 002813

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Deceased:	James Christopher Diver
Delivered on:	5 November 2026
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	5 November 2026
Findings of:	Coroner Sarah Gebert
Counsel assisting the coroner:	Emily Sandrussi, Coroner's Solicitor
Key words:	*In care, NDIS, MRSA bacteraemia, aspiration pneumonia, rib fractures*

INTRODUCTION

1. On 23 May 2025, James Christopher Diver was 63 years old when he died at Northern Hospital Epping. At the time of his death, James lived in supported living accommodation in Bundoora with other residents.

THE CORONIAL INVESTIGATION

2. James' 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.

3. 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.

4. 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.

5. In the coronial jurisdiction, the standard of proof applicable to findings is the balance of probabilities.[1]

Mandatory inquest

6. An inquest into James' death was mandatory as, immediately before his death, James was a person in care.[2]

[1] 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.
[2] Section 52(2)(b) of the Act.

Sources of evidence

7. As part of the coronial investigation, Coroner's Investigator Senior Constable Charlie Gill prepared a coronial brief comprising statements from witnesses including James' general practitioner, the forensic pathologist who examined James, and representatives from his disability support service and Northern Heath. Other documents on the coronial file include James' medical records, National Disability Insurance Scheme (**NDIS**) support plan, and the e-medical deposition from Northern Health.

8. This finding is based on the entirety of the investigation material. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into James' death. In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

BACKGROUND

9. James lived in supported living accommodation serviced by registered NDIS provider Life Without Barriers. He loved playing with tactile toys and often twiddled string in his hands to calming effect. He enjoyed spending time outside with the other residents, throwing then collecting balls, going to the cinema and going for walks. He previously enjoyed swimming and horse riding until he had to cease these activities due to osteoporosis pain.

10. James' medical history included autism spectrum disorder, syndrome of inappropriate secretion of antidiuretic hormone (SIADH), osteoporosis with neck of femur fracture, dysphasia, arthritis and historical epilepsy. In August 2023, he underwent a left hip replacement due to osteoporosis. James' support workers observed he had generally fragile skin, often suffering skin tears that required dressing.

11. James had limited mobility and sometimes used a wheelchair. He could walk slowly and independently but preferred to crawl on his hands and knees or walk on his knees or toes. As a result, James sustained frequent injuries to his hands, knees and feet. James was non-verbal and communicated using gestures, vocalisations, facial expressions and

pointing. He sometimes displayed aggressive behaviours and self-injurious behaviours (for example, banging his head, ingesting inedible items and inducing vomiting).

12. James had complex support needs and received 24 hour one to one support, including assistance with eating and drinking, personal care, and taking medication. James was at risk of falls and received additional support to manage this risk, including physiotherapy and occupational therapy. His bed was adjusted to make it easier for him to get in and out.

13. James attended regular appointments with his general practitioner and was supported by additional clinicians when required including a podiatrist, psychiatrist, endocrinologist, neurologist, dietician, gastroenterologist, cardiologist, optometrist and dentist.

14. In the months prior to his death, James' health began to decline, and he had several hospital admissions.

15. On 21 November 2024, James was admitted to Northern Hospital Epping with recurrent cellulitis of the left arm. He was found to have methicillin-resistant staphylococcus aureus (**MRSA**) bacteraemia secondary to cellulitis and was treated with oral antibiotics. During this admission, James experienced a suspected seizure in the setting of acute-on-chronic hyponatraemia. He was prescribed as needed medication in case of further seizures. He was later identified as having a possible mild hospital acquired pneumonia and treated with antibiotics.

16. On 23 December 2024, James was transferred to Broadmeadows Health Service for rehabilitation. He continued to receive follow up care from Northern Hospital Epping until 19 February 2025. James was also treated for a stage two sacral pressure ulcer, iron deficiency anaemia, helicobacter pylori infection, ongoing sodium management and recurrent aspiration pneumonia. On 2 April 2025, James was discharged from Broadmeadows Health Service.

17. On 18 April 2025, James was again admitted to the Northern Hospital Epping with swelling and redness of his right foot and calf. He was diagnosed with right lower limb cellulitis and MRSA bacteraemia and treated with antibiotics. On 22 April 2025, James was discharged home.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

18. On 16 May 2025, James' support workers observed he appeared weak and was unable to crawl as was his preference. They noticed he was clammy and sweating and recorded a temperature of 35.4 degrees Celsius. James' support workers called emergency services.

19. Ambulance Victoria responded and transported James to Northern Hospital Epping, where he was admitted with suspected sepsis. His right lower leg was again noted to be swollen and red.

20. On 17 May 2025, James was diagnosed with pneumonia likely caused by aspiration due to food or vomit and cellulitis of the lower limb. He was treated with intravenous antibiotics (ceftriaxone and vancomycin) and subsequently found to have MRSA bacteraemia. James was noted to have significant distress with medical intervention. In light of this, together with concerns about his quality of life and repeated admissions with sepsis, the plan was to continue with the least restrictive approach to care and, if James' clinical condition deteriorated further, to transition to comfort based care.

21. At about 7.10pm, James had an unwitnessed fall. No new injuries were found on review, and a brain computed tomography (**CT**) scan later confirmed no intracranial haemorrhage following the fall.

22. In the days that followed, James' oxygen levels improved slightly with antibiotic therapy. However, he was observed as suffering ongoing distress and pain. He was noted to be cachectic (significant weight and muscle loss), and at times dyspnoeic (laboured breathing). Following discussions with James' brother Simon, the decision was made to cease antibiotic therapy and transition to comfort based care.

23. On 20 May 2025, James was transferred to palliative care. He died in his sleep in the early hours of 23 May 2025.

24. Following their investigation, police found no evidence of any suspicious circumstances relating to James' death.

IDENTITY OF THE DECEASED

25. On 23 May 2025, James Christopher Diver, born 8 February 1962, was visually identified by his brother, Simon Diver.

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

MEDICAL CAUSE OF DEATH

27. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 26 May 2025 and provided a written report of her findings dated 3 June 2025.

28. The findings of the post-mortem examination were consistent with the clinical history.

29. A post-mortem CT scan identified increased lung markings with consolidative changes within the lungs. There were multiple healing and healed rib fractures with callus formation and more recent rib fractures.

30. Dr Ho explained that rib fractures (or 'broken ribs') occur in chest injuries such as trauma to the chest, for example in a fall. Aspiration pneumonia is a type of infection of the lungs that occurs when an individual inhales foreign material (for example, food or liquid) into the lungs. Dr Ho explained rib fractures can increase the risk of aspiration pneumonia due to pain-induced shallow breathing, decreased cough reflex and aspiration of gastric contents.

31. Dr Ho provided an opinion that the medical cause of death was *"1(a) MRSA bacteraemia secondary to aspiration pneumonia in the setting of multiple healing rib fractures"*.

32. I accept Dr Ho's opinion.

FURTHER INVESTIGATION

33. As part of my investigation, I asked the Coroners Prevention Unit (**CPU**) to consider the adequacy of the medical care James received in the lead up to his death.[3]

34. The CPU noted that James' recurrent cellulitis was due to his preference for crawling and his rib fractures were likely due to his unsteady gait and history of falls and osteoporosis.

35. Given his severe underlying autism and James' behavioural challenges, the CPU noted medical staff would be unable to realistically prevent either falls or crawling.

36. The CPU concluded the medical care James received was reasonable.

FINDINGS AND CONCLUSION

37. Having applied the applicable standard of proof to the available evidence, I find that:

    (a) the identity of the deceased was James Christopher Diver, born 8 February 1962;

    (b) the death occurred on 23 May 2025 at Northern Hospital Epping, 185 Cooper Street, Epping, Victoria;

    (c) the medical cause of James' death was MRSA bacteraemia secondary to aspiration pneumonia in the setting of multiple healing rib fractures; and

    (d) the death occurred in the circumstances described above.

38. I convey my sincere condolences to James' family for their loss.

PUBLICATION OF FINDING

39. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[3] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

DISTRIBUTION OF FINDING

40. I direct that a copy of this finding be provided to the following:

Simon Diver, senior next of kin

Life Without Barriers, care of Barry Nilsson Lawyers

Senior Constable Charlie Gill, Victoria Police, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date: 05 November 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 inquest. 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.