IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002953

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	John Conway McKenzie
Date of birth:	29/10/1959
Date of death:	30/05/2025
Cause of death:	1a : ADENOCARCINOMA WITH UNKNOWN PRIMARY
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade Fitzroy Victoria 3065

INTRODUCTION

1. On 30/05/2025, John Conway McKenzie **(Mr McKenzie)** was 65 years old when he died at St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy Victoria 3065 following 1a : ADENOCARCINOMA WITH UNKNOWN PRIMARY

2. At the time of his death, Mr McKenzie was serving a term of imprisonment at Port Phillip Prison. He had been diagnosed with gall bladder cancer and was receiving chemotherapy treatment for his cancer condition.

THE CORONIAL INVESTIGATION

3. Mr McKenzie'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 who was serving a term of imprisonment 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.

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. This finding draws on the totality of the coronial investigation into the death of John Conway McKenzie. Whilst I have reviewed all the material, I will only refer to that which is directly

[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).

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

7. On 11 May 2025 Mr McKenzie was admitted to St Vincent's Hospital as his condition had deteriorated, and he was diagnosed with sepsis. His chemotherapy treatment for his gall bladder cancer was stopped, and he was treated with intravenous antibiotics

8. Over the next 14 days his condition continued to deteriorate and by 28 May 2025 he was transitioned to end of life care and placed in palliative care

9. At 3.20 am on 30 May 2025 Mr McKenzie passed away.

Identity of the deceased

10. On 30 May 2025, John Conway McKenzie, born 29/10/1959, was visually identified by Jason Paul Woelk.

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

Medical cause of death

12. On 2 June 2025 Dr Paul Bedford Specialised Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination and provided a written report of his findings dated 12 June 2025.

13. Dr Bedford provided an opinion that the medical cause of death was 1(a) ADENOCARCINOMA WITH UNKNOWN PRIMARY,

14. Dr Bedford provided an opinion that the cause of death was due to natural causes.

15. I accept Dr Bedford's opinion.

[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.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Conway McKenzie, born 29/10/1959;

    b) the death occurred on 30/05/2025 at St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy Victoria 3065 from 1a : ADENOCARCINOMA WITH UNKNOWN PRIMARY; and

    c) the death occurred in the circumstances described above.

17. Having considered all the available evidence, I find that Mr McKenzie's death was from natural causes and that 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 and to finalise the investigation of Mr McKenzie's death in chambers.

I convey my sincere condolences to Mr McKenzie's family and friends for their loss

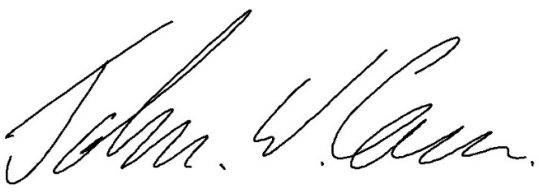
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Pieres O'Shea, Senior Next of Kin

David Milivojac, Coroner's Investigator

Signature:



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Judge John Cain
State Coroner
Date:17 July 2025

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.