IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003222

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

(Amended pursuant to section 76A of the Coroners Act 2008)[1]

Findings of:	Coroner David Ryan
Deceased:	Mr B
Date of birth:	25 September 1964
Date of death:	8 June 2025
Cause of death:	End stage multiple system atrophy
Place of death:	Box Hill Hospital 8 Arnold Street Box Hill, Victoria
Keywords:	In care - natural causes

[1] This document is an amended version of the Finding into the death of Mr B dated 14 July 2025. The Finding has been amended pursuant to section 76A of the *Coroners Act 2008* to include the circumstances of Mr B's death.

INTRODUCTION

1. On 8 June 2025, Mr B was 60 years old when he passed away at Box Hill Hospital. At the time of his death, Mr B resided in supported residential care in Doncaster. His medical history included multiple system atrophy. Mr B had a successful career as a teacher in Queensland, but the rapid onset of his disease required him to move to Melbourne in 2021 to be closer to family and to reside in a supported residential environment. He continued to be actively engaged in tertiary study.

THE CORONIAL INVESTIGATION

2. Mr B's 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.

3. On 14 July 2025, having commenced an investigation into Mr B's death, I determined to discontinue my investigation under section 17 of the Act.

4. Since concluding the investigation, it has come to my attention that Mr B's death satisfied the definition of a reportable death in section 4(2)(c) of the Act as Mr B was, immediately before his death, a person placed in care or custody by virtue of his status as a Specialist Disability Accommodation (**SDA**) resident residing within an SDA enrolled dwelling. In those circumstances, I am required by the Act to make findings with respect to the circumstances of Mr B's death and have done so accordingly within this amended finding.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into Mr B's death. While 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

8. On 5 June 2025, in the context of a progressive decline in his condition, Mr B was admitted to Box Hill Hospital after he was observed to experience increased respiratory distress in the setting of a recent upper respiratory tract infection and dysphagia. Mr B's symptoms were managed by hospital staff including with the administration of intravenous antibiotics.

9. Mr B's condition deteriorated in hospital and, in consultation with family, he was transitioned to comfort care. He passed away on 8 June 2025 at 4.25am.

Identity of the deceased

10. On 13 June 2025, Mr B, born 25 September 1964, was visually identified by his brother.

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

Medical cause of death

12. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an examination on 16 June 2025 and provided a written report of his findings dated 17 June 2025.

13. Dr Burke provided an opinion that the medical cause of death was *1(a) End stage multiple system atrophy*. Dr Burke expressed the opinion Mr B's death was due to natural causes.

14. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

[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.

a) the identity of the deceased was Mr B, born 25 September 1964;

b) the death occurred on 8 June 2025 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria from end stage multiple system atrophy; and

c) the death occurred in the circumstances described above.

16. As noted above, Mr B's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr B died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr B's family 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:

Senior Next of Kin

Eastern Health

National Disability Insurance Agency

Senior Constable David Serong, Coronial Investigator

Signature:

Coroner David Ryan

Date: 06 August 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.