IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004043

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Jamie Lee Argent
Date of birth:	1 November 1986
Date of death:	13 July 2025
Cause of death:	1a : Diabetic ketoacidosis 1b : Pyelonephritis in a man with insulin dependent diabetes mellitus
Place of death:	Northern Hospital Epping 185 Cooper Street Epping Victoria 3076
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 13 July 2025, Jamie Lee Argent **(Mr Argent)** was 38 years old when he died at Northern Hospital shortly after being admitted.

2. At the time of his death, Mr Argent resided in Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**) in Beveridge. Since 2020, Mr Argent received funded daily independent living support due to his complex medical history which included partial blindness, gastroparesis, seizures and Type I diabetes mellitus and associated complications of peripheral vascular disease and chronic kidney disease.

3. Mr Argent also had a history of substance use including cannabis and according to his mother, *'harder drugs'*. In 2018, Mr Argent had a brain tumour removed and following the surgery, experienced multiple seizures. His mother, Wendy Argent (**Ms Argent**) recalled that in 2019, he became unresponsive after a seizure and was admitted to the Intensive Care Unit (**ICU**) of Northern Health. During this admission, Mr Argent sustained an Acquired Brain Injury (**ABI**).

THE CORONIAL INVESTIGATION

4. Mr Argent'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.

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

[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).

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 the death of Jamie Lee Argent. 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

8. In June and July 2025, Mr Argent had two previous hospital admissions; the first for a superficial femoral artery stent and angiogram, and the second for an upper gastrointestinal bleeding treated as likely gastritis for which he was awaiting an outpatient gastroscopy.

9. On 12 July 2025, Ms Argent telephoned Mr Argent. He told her that *'he wasn't feeling well and had vomited'*. She visited him to deliver groceries and recalled he *'seemed fine, he was sitting in the garage on his phone smoking a cigarette'*.

10. The next day, on 13 July 2025 at around 10:00am, Mr Argent's carers contacted emergency services. Ambulance Victoria paramedics arrived, and Mr Argent entered cardiac arrest. Following resuscitation efforts, he demonstrated a return of spontaneous circulation and was transported to the Northern Hospital Emergency Department. Mr Argent vomited blood and aspirated during resuscitation.

11. Clinicians spoke with Mr Argent's family, and they decided that he was not for further resuscitation. Mr Argent was declared deceased at 12:45pm.

Identity of the deceased

12. On 17 July 2025, Jamie Lee Argent, born 1 November 1986, was visually identified by his mother, Wendy Argent.

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

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[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.

Medical cause of death

14. Forensic Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 22 July 2025 and provided a written report of his findings dated 1 October 2025.

15. The post-mortem computed tomography (**CT**) scan showed remote left lateral temporal infarct (craniotomy) with no acute changes. The stomach was grossly distended with air-fluid level. The small bowel appeared dilated to the caecum. There were small pleural effusions (fluid in the space between the lung and the chest wall) with possible right lower lobe pneumonia. The heart appeared unremarkable.

16. Toxicological analysis of ante-mortem samples collected at 11:41am on 13 July 2025 detected acetone, methylamphetamine and lamotrigine. There was also a markedly raised blood sugar level of 81.9 mmol/L and urea at 30 mmol/L, the latter of which indicated significant renal (kidney) impairment.

17. According to Dr Burke, the toxicological results indicated the diagnosis of diabetic ketoacidosis. This occurs when there is insufficient insulin resulting in high blood glucose which results in an osmotic diuresis with renal impairment. Furthermore, there are electrolyte shifts with depletion of total body potassium, however, with a raised serum potassium. It is a potentially fatal complication of diabetes.

18. The postmortem examination showed underlying diabetic nephropathy and renal calculi. There was a left pyelonephritis (infected kidney). Microbiology culture of left kidney swab grew *Escherichia coli* and *Nakaseomyces glabratus.* Dr Burke commented that in all likelihood, this was the precipitant of the diabetic ketoacidosis.

19. Dr Burke provided an opinion that the medical cause of death was 1(a) *Diabetic ketoacidosis* secondary to 1(b) *Pyelonephritis in a man with insulin dependent diabetes mellitus*.

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

21. I accept Dr Burke's opinion as to cause of death.

FAMILY CONCERNS

22. During my investigation, Ms Argent expressed her concerns regarding Northern Health's management of Mr Argent, at the time of his death and in 2019 when he was admitted to the ICU and sustained an ABI.

23. I do not wish to undermine the distress that Mr Argent's 2019 hospitalisation and subsequent injury brought to the Argent family. However, my powers of investigation, as enunciated in the Act, are not all encompassing and are limited to the matters which are proximate and causal to the death. In this instance, while Mr Argent's 2019 hospitalisation and ABI speak to his long and complex medical history, they do not fall within the remit of this investigation. I am aware that Ms Argent has referred her concerns to Victorian health oversight organisations, and I note that these entities are best placed to investigate this particular concern.

24. Ms Argent also recalled that at the time of Mr Argent's death, her family was not adequately informed of the coronial process and that *'No permission was given by family for Jamie to be transferred to the Coroner's Office'.*

25. Mr Argent's death was reported to the Court by Northern Health and a member of Coronial Admissions and Enquiries confirmed that it constituted a *'reportable death'* as defined by the Act. On that basis, my powers of investigation were enlivened, and I required that Mr Argent be transferred into the care of the Victorian Institute of Forensic Medicine for the purposes of a post-mortem examination.

26. This is a statutory function and owing to the circumstances of Mr Argent's death, Victorian law required that an investigation be undertaken. While the Argent family's permission is not strictly required, it is unfortunate that they were not comprehensively informed of the coronial process – particularly as it pertains to the transportation of Mr Argent following his death.

27. This has, regrettably, bought significant distress to his family and indeed Ms Argent described that *'[the family] feel strongly that the process lacked transparency, communication, and respect for Jamie and his loved ones'.* I express my condolences that the already difficult experience of Mr Argent's death was made more difficult by a lack of transparency regarding the Court's role.

28. While there are several informative resources available on the Court's website, it is not practical nor reasonable to expect that in the immediate aftermath of a loved one's death that

their families will seek out such information. For that reason, the Court relies on health services (amongst others, such as Victoria Police) to explain to families the role of the Court including the need for and process of post-mortem examination. Indeed, the Court provides hard-copy resources to these organisations with the view that they be provided to families.

29. While it is unclear why the Argent family did not receive this information on this occasion and despite it not being casually related to Mr Argent's death, their experience is a reminder of the need for all organisations – including the Court itself – to ensure that families are well-informed and supported during this already difficult time.

30. I seek to remind Northern Health that the Court has several resources which it can rely on when speaking with families who have lost a lost one in reportable circumstances.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jamie Lee Argent, born 1 November 1986;

    b) the death occurred on 13 July 2025 at Northern Hospital Epping 185 Cooper Street Epping Victoria 3076 from 1(a) *Diabetic ketoacidosis* secondary to 1(b) *Pyelonephritis in a man with insulin dependent diabetes mellitus*; and,

    c) the death occurred in the circumstances described above.

32. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Northern Health that caused or contributed to Mr Argent's death.

33. Having considered all the available evidence, I find that Mr Argent'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 Argent's death in chambers.

I convey my sincere condolences to Mr Argent'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:

Ms Wendy and Mr Tony Argent, Senior Next of Kin

Northern Health

Senior Constable Liam Lewis, Reporting member, Victoria Police

Signature:

Coroner Leveasque Peterson

Date: 08 December 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.