IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 008060

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Adam Donald Baker
Date of birth:	10 August 1975
Date of death:	19 November 2025
Cause of death:	1(a) Cerebral haemorrhage (cause unknown)
Place of death:	4 Dunlop Street, Wangaratta, Victoria
Key words:	Christianson Syndrome, in care, SDA, epilepsy, cerebral haemorrhage

INTRODUCTION

1. On 19 November 2025, Adam Donald Baker was 50 years old when he was found deceased in bed.

2. At the time of his death, Adam resided in Supported Disability Accommodation in Wangaratta.

THE CORONIAL INVESTIGATION

3. Adam'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. 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.

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. Victoria Police assigned Senior Constable Jerome De Mink to be the Coroner's Investigator for the investigation of Adam's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into Adam's death, 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.[1]

[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

Background

8. Adam and his two brothers were all born with Christianson Syndrome, which is a genetic disorder that causes intellectual disability and seizures. Adam was non-verbal and later required the use of a wheelchair.

9. Adam and his brothers lived on a regional farm property in Rutherglen during their childhood. Later, they moved to supported disability accommodation, and their parents visited them regularly.

10. In June 2019, Adam moved to supported disability accommodation at 4 Dunlop Street, Wangaratta, where Scope (Aust) Limited (**Scope**) provided supported independent living services. Adam's mother, Beverley, said that Adam's carers did a wonderful job of looking after Adam and providing him with outings and activities. Adam enjoyed being involved in various programs which assisted him to participate in group activities and to access the community.

11. Scope provided support for daily living activities including meal preparation, personal care, medication administration, and continence control. Adam was able to stand when being transferred and required 2:1 staff assistance for all transfers into his wheelchair for mobility support. Due to the unpredictable nature of his epilepsy and the associated high falls risk, he used a customised tilt-in-space attendant propelled wheelchair for seating and was fully reliant on support staff for all indoor and outdoor mobility activities. His wheelchair was also used for vehicle transport to medical appointments and outings. Adam slept in a hi-lo bed that was lowered to the floor overnight and used a shower chair supported by one staff member for personal care.

12. In addition to Christianson Syndrome, Adam's medical history included epilepsy, dysphagia, allergies to pollen, grass, and penicillin, sialorrhoea, hypercholesterolaemia, constipation, and eczema. His medical care was managed by Dr Christian Jhoan Rodriguesz Cubillos at Wangaratta Medical Centre, who last reviewed Adam on 30 October 2025 at which time it was noted that Adam appeared stable and there had not been any recent significant decline in Adam's health. He noted that Adam's epilepsy was managed with levetiracetam, sodium valproate, and carbamazepine, and his hypercholesterolaemia was treated with rosuvastatin.

provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

13. Adam was identified as a falls risk due to his condition and limited insight of his need for assistance when mobilising. Scope implemented an overnight alarm in his room to alert staff if he attempted to get out of bed. Despite this measure, Adam experienced a fall in May 2025. At the time, he was assessed in hospital with no injury identified apart from some minor swelling to his frontal lobe.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

14. Adam's parents last visited him in early November 2025. His mother stated that he appeared content and happy.

15. In the weeks preceding his passing, Adam began getting out of bed overnight more often than usual. When the alarm alerted staff of his movements, they redirected him back to bed. He did not experience any falls during this time.

16. On 12 November 2025, staff observed Adam experienced a small tremor in his right hand which lasted about 10 seconds.

17. That day, Adam was reviewed by his neurologist, Dr Lauren Ross, in relation to his epilepsy and recent tremors. Adam was administered botox to his cheeks (to assist the sialorrhoea), his medication was adjusted,[2] and a further review was planned for four to six months. Dr Ross was advised of the previous day's hand tremor, which she attributed to medication side effects or seizure.

18. On 16 November 2025, Adam was noted to be tired during his morning routine, requiring a further 30-minute rest in bed prior to continuing. An appointment was made with Dr Cubillos for 19 November to discuss Adam's recent increased fatigue.

19. At 7.58am on 18 November 2025, Adam experienced a seizure which was noted to last three seconds with *"Arms & legs outstretched. No vocalisation"*.

20. That evening, Adam was assisted to bed by staff. Staff conducted basic observations on Adam at 8.30pm and 9.45pm, due to noted redness in his left eye, and difficulty standing while supported. These observations were normal.

[2] Cross-titration of carbamazepine to lacosamide. Staff were advised to administer 100mg carbamazepine for two weeks then cease, and to administer 50mg lacosamide for two weeks then increase to 100mg bd (twice per day).

21. At approximately 6.10am the next morning, 19 November 2025, staff found Adam unresponsive in his bed. Emergency services were contacted and advised staff to administer cardiopulmonary resuscitation (**CPR**) until paramedics arrived. After paramedics arrived, they continued CPR efforts, but Adam was unable to be resuscitated. They formally verified Adam's death at 6.29am.

Identity of the deceased

22. On 19 November 2025, Adam Donald Baker, born 10 August 1975, was visually identified by his support worker, Richard Kendall.

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

Medical cause of death

24. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 20 November 2025 and provided a written report of his findings dated 2 December 2025.

25. The post-mortem examination was consistent with the reported circumstances. The post-mortem CT (computed tomography) scan showed a left cerebral lobe haemorrhage.

26. An autopsy was recommended to determine the nature of the brain lesion and haemorrhage, however Adam's family expressed a preference for no autopsy.

27. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Cerebral haemorrhage (cause unknown)",* which he noted was due to natural causes.

28. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATION

Coroners Prevention Unit review

29. As part of my investigation, I obtained advice from the Coroners Prevention Unit[3] (**CPU**) to ascertain whether recent changes to Adam's medication regime may have contributed to his death.

[3] The Coroners Prevention Unit (**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

30. The CPU confirmed that the bleed was not related to either seizure activity or any medications prescribed/treatments performed by any medical practitioner. The CPU also agreed that the death was due to natural causes.

31. I accept the CPU's advice on these matters.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Adam Donald Baker, born 10 August 1975;

(b) the death occurred on 19 November 2025 at 4 Dunlop Street, Wangaratta, Victoria, from cerebral haemorrhage (cause unknown);

(c) immediately before death, Adam was a *"person placed in custody or care"* as defined in section 4 of the Act;

(d) I consider Adam's death to be from natural causes for the purposes of section 52(3A) of the Act; and

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

CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

I convey my sincere condolences to Adam'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:

Beverley and Kenneth Baker, senior next of kin

Scope (Aust) Ltd

Senior Constable Jerome De Mink, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 23 July 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.