IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 008848

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sara Dennis
Deceased:	Hugh Cedric Grant
Date of birth:	16 September 1950
Date of death:	23 December 2025
Cause of death:	1a: Urosepsis on a background of obstructed iliac conduit and metastatic malignancy
Place of death:	Sunshine Hospital 176 Furlong Road St Albans Victoria 3021
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 23 December 2025, Hugh Cedric Grant was 75 years old when he died at Sunshine Hospital.

2. At the time of his death, Hugh resided in a Specialist Disability Accommodation (**SDA**) dwelling in Taylors Lakes. He was a participant of the Disability Support for Older Australians program, and received funded daily independent living support due to his intellectual disability, which was provided by disability service provider, Scope (Aust) Limited (**Scope**).

3. Hugh was verbal and communicated using simple language. He required support for activities of daily living including meal preparation and assistance, personal care, medication administration and continence management.

4. Hugh was a social man who formed friendships easily. He enjoyed outings in the community, going for drives and window shopping. He attended at a day program three days per week, where he participated in group activities and learned new skills. At home, he spent his time watching Western movies, listening to music and speaking with his fellow residents.

5. Hugh's medical history included swallowing difficulties, mental illness (suspected to be bipolar disorder), insomnia and chronic faecal loading. In 2014, he was diagnosed with carcinoma of the bladder requiring a radical cystectomy with ileal conduit in 2016.

6. Scope records indicate that, on several occasions between June and September 2025, Hugh called out for help or screamed loudly during the night, at breakfast time and while being supported with personal care. He said that he was not in pain and did not need assistance, and there were no obvious issues causing this behaviour, which later subsided.

7. In late August 2025, concerned that Hugh's health may be deteriorating, Scope applied to the Victorian Civil and Administrative Tribunal for the appointment of a guardian to make medical treatment decisions. This had not yet been finalised at the time of his death.

THE CORONIAL INVESTIGATION

8. Hugh'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.

9. 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.

10. 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.

11. Coroner Audrey Jamieson (as her Honour then was) originally held carriage of this investigation prior to her retirement in April 2026. I assumed carriage of this investigation on 27 April 2026.

12. This finding draws on the totality of the coronial investigation into the death of Hugh Cedric Grant 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.[2]

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

Circumstances in which the death occurred

13. Hugh presented to Sunshine Hospital on 22 November 2025 with an obstructed ileal conduit. He had an emergency right nephrostomy and was admitted to the intensive care unit (**ICU**).

[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).

[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.

14. It was incidentally identified that Hugh likely had a new metastatic gastro-oesophageal junction malignancy, with multiple spine and liver metastases. This was determined to be for conservative management given his frailty.

15. On 26 November 2025, Hugh was transferred to Footscray Hospital under the urology team. He made slow process and recovered medically. He was transferred to the Geriatric Evaluation and Management ward at Sunshine Hospital on 5 December 2025.

16. Hugh subsequently deteriorated with suspected infection, which was found to be a resistant urinary tract infection. He received intravenous antibiotics and fluids and was transferred to the general medicine ward on 12 December 2025.

17. Hugh's condition did not improve despite treatment. He experienced hypotension and hypoxia, and profound, severe hypoactive delirium. On 20 December, he was placed on end-of-life care.

18. Hugh died peacefully at 10:45am on 23 December 2025.

Identity of the deceased

19. Hugh Grant, born 16 September 1950, was identified by circumstantial evidence. A Determination by Coroner of Identity of Deceased (Form 8) was signed by Coroner Audrey Jamieson on 6 January 2026.

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

Medical cause of death

21. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Hugh Grant on 29 December 2025 and provided a written report of his findings dated 2 February 2026.

22. The findings at external examination were in keeping with the clinical history.

23. Dr Beer provided an opinion that the death was due to natural causes and ascribed the medical cause of death as *1(a) urosepsis on a background of obstructed iliac conduit and metastatic malignancy.*

24. I accept Dr Beer's opinion as to the cause of death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Hugh Cedric Grant, born 16 September 1950;

    b) the death occurred on 23 December 2025 at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria 3021;

    c) the cause of Hugh's death was urosepsis on a background of obstructed iliac conduit metastatic malignancy; and

    d) the death occurred in the circumstances described above.

26. 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 Western Health that caused or contributed to Hugh's death.

27. Having considered all the available evidence, I find that Hugh'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 Hugh's death and to finalise the investigation in chambers.

I convey my sincere condolences to those who knew and cared for Hugh.

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:

Scope (Aust) Limited

Western Health

First Constable Dane Seeley, Coronial Investigator

Signature:





Coroner Sara Dennis

Date: 02 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 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.