



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2026 000870**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

|                 |                                                                          |
|-----------------|--------------------------------------------------------------------------|
| Findings of:    | Coroner Sarah Gebert                                                     |
| Deceased:       | WK                                                                       |
| Date of birth:  | 1988                                                                     |
| Date of death:  | 12 February 2026                                                         |
| Cause of death: | 1(a) Unascertained (natural causes)                                      |
| Place of death: | Northeast Health Wangaratta<br>35/47 Green Street<br>Wangaratta Victoria |
| Keywords:       | <i>In care; Natural causes; Specialist Disability<br/>Accommodation</i>  |

## INTRODUCTION

1. On 12 February 2026, WK was 37 years old when he died at Northeast Health Wangaratta (**Northeast Health**).
2. At the time of his death, WK resided in Specialist Disability Accommodation (**SDA**) in Wangaratta managed by disability service provider, Scope (Aust) Limited (**Scope**). He is survived by his parents, siblings, and extended family.

## THE CORONIAL INVESTIGATION

3. WK's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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 Belinda McErvale to be the Coroner's Investigator for the investigation of WK'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. In addition, I asked the Coroners Prevention Unit (**CPU**)<sup>1</sup> to advise whether WK should have been seen by a haematologist sooner to assess whether he had a malignancy.

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<sup>1</sup> The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas

8. This finding draws on the totality of the coronial investigation into WK'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.<sup>2</sup>

## **Background**

9. WK had a complex medical history. He was born with spina bifida, hydrocephalus, cleft palate and lip, and autism. He also suffered from an intellectual disability, muscle weakness, a large abdominal hernia, and bilateral hearing impairment for which he used hearing aids and sign language to support his communication. Over the course of his life, he had a number of different operations.
10. WK attended Nepean School and then Dandenong Valley Special Developmental School. Between the ages of 18 and 26, he was supported by Outlook in Pakenham. At 26 years old, he moved into an SDA in Glen Huntly managed by Scope.
11. In March 2024, WK went to live with his mother and stepfather in Glenrowan.
12. On 22 October 2024, WK was unwell with a fever and a chest x-ray showed he had pneumonia. His breathing had deteriorated and he was intubated in the intensive care unit (ICU) at Northeast Health. WK was airlifted from Northeast Health to the Royal Melbourne Hospital the following day where he had a prolonged admission requiring sedation with intubation and ventilation complicated by significant tongue swelling of unclear cause likely inducing oropharyngeal dysphagia for which he was commenced on nasogastric feeding for part of his admission. He also required several blood transfusions, completed a course of antibiotics to treat his pneumonia, and lost weight due to reduced oral intake.
13. On 6 December 2024, WK was transported from the Royal Melbourne Hospital back to Northeast Health where he remained until his mother was able to secure a new SDA facility for him in Wangaratta in April 2025. This SDA was enrolled under the National Disability Insurance Scheme (NDIS), and the facility was managed by Scope.

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including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

<sup>2</sup> 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. Due to WK's medical conditions, he received Supported Independent Living (**SIL**) services for daily tasks including personal care, meal preparation, medication administration, and mobility. He also received care from his general practitioner (**GP**) Dr Bruce White, behaviour support practitioners, a urologist, nephrologist, speech pathologist and dietician. WK's mother also remained actively involved in his care and management.
15. WK had end stage renal failure and was receiving haemodialysis treatment three times a week at Northeast Health. He received one-on-one support from North East Care Connect (**Care Connect**) to attend his dialysis appointments. Furthermore, a district nurse and Scope staff supported him with bowel irrigation treatment which he also received three times a week.
16. Throughout the second half of 2025, WK's health started to deteriorate again. He had episodes including breathing issues, vomiting, stomach pain and bleeding from his Mitrofanoff channel, and had to be taken to hospital on a number of occasions.
17. Prior to his death, WK had become increasingly distressed during dialysis and discussions were had with his treating nephrologist regarding the burden of ongoing dialysis on WK and whether ceasing dialysis needed to be considered. During a hospital admission in June 2025, it was noted that WK's intolerance of and behaviour towards dialysis was becoming unmanageable and that it had become a safety issue for both him and staff. WK had also become agitated and resistant during his bowl irrigation treatment.

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

### **Circumstances in which the death occurred**

18. On 9 February 2026, WK's carers noted that his urine output was less than usual. He vomited after consuming some of his breakfast and was experiencing stomach pain. He was also pale in colour and could not stand up straight. WK's carer and Care Connect support worker transported him to the emergency department (**ED**) at Northeast Health where they met his mother. WK was given a nausea tablet, and it was planned that he would have a blood test and provide a urine sample the following day during his dialysis appointment. The doctor advised that WK was likely feeling unwell due to antibiotics he was taking for stomach bacteria. He was discharged to his SDA later that day.
19. At 8.00am the following day, being 10 February 2026, WK attended Northeast Health for his usual dialysis appointment. Whilst dialysing, he started to feel faint and dizzy and developed

significant bradycardia and ventricular ectopy, with subsequent episodes of non-sustained ventricular tachycardia. Due to these cardiac abnormalities, he was admitted for further monitoring and treatment. He was transferred to the ICU presumed to have sepsis of unknown origin causing multi-organ failure.

20. During his admission, investigations identified several significant medical issues. A computed tomography (CT) scan showed possible inflammatory or infectious colitis, increasing ascites, a left-sided pleural effusion and mediastinal lymphadenopathy. There was concern that the lymphadenopathy may have represented an underlying malignancy in circumstances where he had been awaiting a haematology review. WK was commenced on heart medication and antibiotics to treat the sepsis infection and colitis.
21. Despite treatment with intravenous antibiotics and supportive care, WK continued to deteriorate and was suffering from progressive multi-organ failure involving the renal, respiratory, cardiovascular and hepatic systems. He developed respiratory failure requiring high-flow nasal oxygen and remained dialysis dependent with evidence of worsening liver dysfunction with ascites and impaired synthetic function.
22. Following discussions between the family and the medical team, a decision was made to focus on end-of-life care and comfort measures considering WK's comorbidities, recent decline and likely new malignancy. WK passed away in hospital on 12 February 2026.

### **Identity of the deceased**

23. On 12 February 2026, WK, born 1988, was visually identified by his mother.
24. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

25. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination on 13 February 2026 and provided a written report of her findings dated 7 April 2026.
26. The post-mortem CT scan revealed an enlarged heart, possible bilateral pneumonia, bilateral pleural effusions, minimal renal tissue and large abdominal wall hernia.
27. Routine toxicological analysis was not indicated and was therefore not performed.

28. Dr Baber provided an opinion that the medical cause of death was “*1(a) Unascertained (natural causes)*”.
29. I accept Dr Baber’s opinion.

#### **CORONERS PREVENTION UNIT REVIEW**

30. In November 2025, Dr White referred WK to a haematologist as investigations showed enlargement of his lymph nodes and low haemoglobin, but he was put on a four-month waiting list with an appointment booked for 17 February 2026. Despite a follow-up letter from Dr White in January 2026 informing the oncology clinic that the referral was urgent as WK had persistent severe anaemia despite blood transfusions, and that there was significant concern for an underlying haematological malignancy including lymphoma, without any clear underlying cause yet identified, WK was not considered urgent by the clinic and was not offered an earlier appointment.
31. The CPU Health and Medical Investigations Team (**HMIT**) reviewed WK’s case to assess whether he should have been seen by a haematologist more urgently to determine if he had cancer and required treatment.
32. HMIT advised that WK was struggling to tolerate dialysis in recent times and that his nephrologist had raised the possibility of ceasing dialysis—a course that would have caused death within days. Although dialysis was not stopped, HMIT indicated that the consideration of this option reflected just how poor WK’s quality of life and physiologic reserve was at the time.
33. WK would have likely required biopsies of the affected lymph nodes and bone marrow to establish a diagnosis, and these procedures would have been difficult to perform on WK without sedation. Given that investigating for cancer and cancer treatments can be invasive and possibly more distressing than dialysis, HMIT considered that it seemed unlikely that a timely oncology review would have recommended any investigations or treatments. Additionally, they noted that Dr Baber’s external examination did not identify any treatable cancer. Following their review, HMIT did not identify any issues with WK not being assessed by a haematologist in the months before his death.
34. I accept the advice of HMIT on this matter.

## FINDINGS AND CONCLUSION

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

- (a) the identity of the deceased was WK, born 1988;
- (b) the death occurred on 12 February 2026 at Northeast Health Wangaratta, 35/47 Green Street, Wangaratta, Victoria, from *unascertained causes (natural causes)*; and
- (c) the death occurred in the circumstances described above.

36. Having considered all of the available evidence, I am satisfied that WK's death was due to natural causes, and an inquest is therefore not required pursuant to section 52(3A) of the Act.

I convey my sincere condolences to WK'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:

WK's mother, senior next of kin

Scope (Aust) Limited

Senior Constable Belinda McErvale, Victoria Police, Coroner's Investigator

Signature:



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Coroner Sarah Gebert

Date: 13 October 2026

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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.

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