



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 002969

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Michael Charles Miller
Date of birth:	13 June 1958
Date of death:	26 May 2026
Cause of death:	Multiple sclerosis
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria
Keywords:	In care - natural causes

INTRODUCTION

1. On 26 May 2026, Michael Charles Miller was 67 years old when he passed away at the Austin Hospital in Heidelberg. At the time of his death, Mr Miller lived in supported accommodation in Watsonia managed by MS Plus, where he had been residing since 2012. His medical history included multiple sclerosis, recurrent urosepsis, atrial fibrillation and hypertension. He also had a cognitive impairment.
2. In the months leading to his death, Mr Miller was assessed to have transitioned to end stage multiple sclerosis. He had longstanding oropharyngeal dysphagia and was receiving end of life care through Banksia Palliative Care Service at his accommodation.

THE CORONIAL INVESTIGATION

3. Mr Miller'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. Mr Miller was a person in care at the time of his death as he was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to s52(3A) of the Act as Mr Miller's death was 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. This finding draws on the totality of the coronial investigation into Mr Miller's death, including information obtained from his health records and the National Disability Insurance Agency. 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.¹

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

Circumstances in which the death occurred

7. On 23 May 2026, staff at Mr Miller's accommodation observed that he was experiencing increased agitation with laboured breathing following a significant decline in his condition over the previous month with reduced oral intake. He was refusing water and appeared weak and lethargic. A palliative care nurse attended and administered medication. Mr Miller's symptoms could no longer be managed in the community and an unsuccessful attempt was made to find a bed in a specialist palliative care unit. Emergency services were then called for Mr Miller to be transported to the Austin Hospital emergency department by ambulance.
8. On 24 May 2026, Mr Miller was admitted to the palliative care ward at the Austin Hospital for end-of-life care. Over the following two days, he became unrousable and his condition further deteriorated. He passed away on 27 May 2026.

Identity of the deceased

9. On 27 May 2026, Michael Charles Miller, born 13 June 1958, was visually identified by his sister-in-law, Kathleen Miller.
10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an examination on 29 May 2026 and provided a written report of his findings dated 4 June 2026.
12. Dr Bedford formed the opinion that Mr Miller's death was due to natural causes.
13. Dr Bedford provided an opinion that the medical cause of death was 1(a) *Multiple sclerosis*.

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

14. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Michael Charles Miller, born 13 June 1958;
- b) the death occurred on 26 May 2026 at Austin Hospital, Heidelberg, Victoria from multiple sclerosis; and
- c) the death occurred in the circumstances described above.

16. As noted above, Mr Miller'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 Miller died from natural causes and no further investigation is required. His death was not unexpected. 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 Miller'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:

Peter Miller, Senior Next of Kin

Austin Health

Leading Senior Constable Steven Pitt, Coronial Investigator

Signature:



Coroner David Ryan

Date: 06 October 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.
