IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004455

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Brian Kevin Scurrah
Date of birth:	15 July 1946
Date of death:	22 August 2021
Cause of death:	1(a) Complications of multiple myeloma (palliated)
Place of death:	28 Pratt Street, Ringwood, Victoria, 3134
Key Words:	Home@Scope, Supported Residential Service, SRS, palliative care, multiple myeloma

INTRODUCTION

1. On 22 August 2021, Brian Kevin Scurrah was 75 years old when he died. At the time of his death, Brian lived at 28 Pratt Street, Ringwood, Victoria at a supported residential service (**SRS**) facility administered by Home@Scope.[1]

2. Brian's medical history included chronic venous stasis of his legs, an intellectual disability, paraproteinanaemia, benign biclonal gammopathy, atrial fibrillation, osteopaenia, multiple myeloma, renal impairment, and pneumonia. [2]

3. At the time of his death, Brian was prescribed amiodarone, hyoscine, calcium, betamethasone, fentanyl, mometasone, oxycodone, hydromorphone, hydrocortisone, metoclopramide, midazolam, meloxicam, olanzapine, ondansetron, clonazepam, and rivaroxaban.[3]

4. When Brian turned five, he was placed into state care due to his intellectual disability against the wishes of his mother. He initially lived at Kew Cottages before moving to Janefield, and then finally moved to the SRS at Pratt Street in approximately 2001.[4]

5. Brian remained close with his family throughout his life, with his mother visiting him every week, and his family continuing to visit him after she passed away. He would also visit his niece's house every Christmas.[5]

THE CORONIAL INVESTIGATION

6. Brian'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.

7. Whilst Brian's death occurred whilst in care, I determined that a mandatory inquest was not required as his death was the result of natural causes, pursuant to section 52 (3A) of the Act.

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[1] Home@Scope is an approved Commonwealth Home Support Program provider and registered National Disability Insurance Scheme provider. The SRS was initially administered by the Department of Families, Fairness, and Housing (formerly the Department of Health and Human Services) before transitioning to Home@Scope in 2019.
[2] Medical records dated 23 August 2021, pages 1-3.
[3] Medical records dated 23 August 2021, pages 1-3.
[4] Coronial brief, statement of Karen Scurrah dated 24 January 2022, page 1; statement of Leanne Webster (undated), page 4.
[5] Coronial brief, statement of Karen Scurrah dated 24 January 2022, page 1.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brian'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.

11. This finding draws on the totality of the coronial investigation into the death of Brian Kevin Scurrah 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.[6]

12. In considering the issues associated with this finding, I have been mindful of Brian's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

13. In June 2021, Brian attended Maroondah Hospital with suspected compaction of his bowel. Scans taken during this admission revealed cancerous lesions on his spine and rib which led to a diagnosis of multiple myeloma.[7]

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[6] 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.

[7] Coronial brief, statement of Leanne Webster (undated), page 4.

14. Following discussions between Brian's family and cancer specialists at Box Hill Hospital in which clinicians highlighted the risk of paralysis and likelihood of a poor quality of life should surgery be conducted, as well as the effects of extended and invasive chemotherapy, a decision was made by Brian's family to transition him to palliative care which would be administered at his SRS by Eastern Palliative Care.[8]

15. As Brian's condition deteriorated, he began eating less and resisting taking his medications, however his family remained by his side until he passed away at approximately 11.00am on 22 August 2021.

Identity of the deceased

16. On 24 August 2021, Brian Kevin Scurrah, born 15 July 1946, was visually identified by his niece, Cheryl Scurrah.

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

Medical cause of death

18. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 25 August 2021 and provided a written report of his findings dated 26 August 2021.

19. The post-mortem examination revealed chronic venous stasis changes about the legs. The post-mortem computed tomography scan showed evidence of advanced multiple myeloma with multiple lytic skull lesions, multiple vertebral body lesions with destruction of the mid thoracic spine vertebral column and adjacent cord compression, lung consolidation and pseudo large bowel obstruction.

20. Toxicological analysis was not indicated and, accordingly, was not performed.

21. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) *complications of multiple myeloma (palliated)*.

22. Dr Bouwer opined that Brian's death was due to natural causes.

23. I accept Dr Bouwer's opinion.

[8] Coronial brief, statement of Karen Scurrah dated 24 January 2022, pages 1-2; statement of Leanne Webster (undated), page 4

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Brian Kevin Scurrah, born 15 July 1946;

    b) the death occurred on 22 August 2021 at 28 Pratt Street, Ringwood, Victoria, 3134, from *complications of multiple myeloma (palliated)*; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Brian's family for their loss.

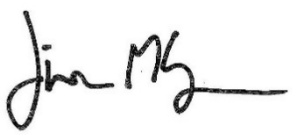
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Cheryl Scurrah, Senior Next of Kin

Leading Senior Constable Mark Deacon, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 20 July 2022

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.