IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000664

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of David James Dorling

Delivered On:	10 February 2026
Delivered At:	Southbank, Victoria
Hearing Dates:	10 February 2026
Findings of:	Coroner Paul Lawrie
Representation:	Ms Stephanie Clifton for the Chief Commissioner of Police Mr Peter Ryan For Monash Health
Counsel Assisting the Coroner:	Ms Laura McDonough
Keywords	Death in custody, remand, suicide, paracetamol toxicity

INTRODUCTION

1. David James Dorling was 59 years old when he died at the Dandenong Hospital on 4 February 2024.

2. On 2 February 2024, Mr Dorling attended the Latrobe Valley County Court in Morwell where he pleaded guilty to serious criminal charges. The day before this scheduled court appearance, he had consumed a large quantity of paracetamol tablets.

3. He was remanded into custody pending a further plea and sentencing hearing scheduled for 1 May 2024. It was after having been remanded and whilst in police custody on 2 February 2024 that Mr Dorling became overtly unwell. He was transferred to the Dandenong Hospital where he continued to deteriorate from the effects of paracetamol toxicity.

4. Even though Mr Dorling was transferred to hospital, his legal status as a person in custody remained unchanged until his death on 4 February 2024.

The Coronial investigation

5. Mr Dorling'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, no matter what the apparent cause.[1]

6. 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 or apportion blame, or determine criminal or civil liability.

7. 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.

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[1] Section 4 of the Act.

8. Detective Acting Sergeant Kate Lynch of the Victoria Police Homicide Squad acted as the Coroner's Investigator for the investigation of Mr Dorling's death. The Coroner's Investigator conducted inquiries on my behalf and compiled a coronial brief of evidence. The court also obtained records, statements, policy documents, and other material from Dandenong Hospital (Monash Health) and the Austin Hospital (Austin Health).

The Inquest

9. I have concluded as a preliminary matter that Mr Dorling was a person in custody immediately before his death[2], and that his death was not due to natural causes. Accordingly, an inquest into Mr Dorling's death is mandatory.[3]

10. On 10 February 2026 the inquest proceeded in a manner which has become known as a "summary inquest". That is, in a manner not requiring *viva voce* evidence but where the court receives the evidence in a summary form and from the coronial brief. This approach is adopted in appropriate circumstances where the evidence is complete (or will not be further illuminated by oral evidence) and uncontentious.

11. This finding draws on the totality of the material obtained in the coronial investigation of David Dorling's death: the coronial brief prepared by Detective Acting Sergeant Kate Lynch and additional materials obtained by the Court. Whilst I have considered 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.[4]

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

Identity of the deceased

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2 Section 3 of the Act.

3 Section 52(2)(b) of the Act.

4 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.

12. On 8 February 2024, Coroner Gebert determined the identity of David James Dorling based upon fingerprint comparison and circumstantial evidence. Mr Dorling's identity was not in dispute and required no further investigation.

Cause of death

13. On 5 February 2024, Dr Matthew Lynch, Specialist Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination of Mr Dorling.

14. Dr Lynch reviewed a postmortem CT scan which revealed coronary calcification and fatty liver but was otherwise unremarkable. There was no observable drug residue in the stomach.

15. Toxicological analysis of antemortem specimens collected at the Dandenong Hospital 2.14am on 3 February 2024 indicated paracetamol at 11 mg/L and salicylic acid at 6.3 mg/L.

16. Dr Lynch also reviewed the police report of death[5], and the medical records and the medical deposition from Dandenong Hospital. He concluded the cause of death to be "1(a) MULTIORGAN FAILURE COMPLICATING PARACETAMOL TOXICITY".

17. I accept Dr Lynch's opinion.

Background

18. Mr Dorling was born on 10 July 1964 in Koo Wee Rup, Victoria. He grew up in the South Gippsland region, residing on various farming properties managed by his father. He attended Leongatha Technical School and worked in a variety of jobs including factory roles and grape picking.

19. In 1999, Mr Dorling was diagnosed with multiple sclerosis and ceased paid employment, although he continued with volunteer work. He also suffered ischaemic heart disease, angina, Type II diabetes[6] and haemochromatosis.

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5 Victoria Police Form 83

6 Mr Dorling's Type II diabetes was controlled through diet and exercise.

20. As of 2024, Mr Dorling resided alone at a rental property in Boolarra, Victoria.

Circumstances in which the death occurred

Prelude

21. On 21 November 2022, police investigators executed a search warrant at Mr Dorling's premises. He was arrested and charged with serious criminal offences and then bailed.

22. On 19 May 2023, Mr Dorling attended a committal mention hearing at the Latrobe Valley Magistrates' Court in Morwell where he entered a plea of guilty to several of the offences originally charged. The case was adjourned to 20 September 2023, and then further adjourned (administratively) to 2 February 2024 for a plea hearing. The nature of the charges was such that Mr Dorling would reasonably expect to be sentenced to a substantial period of imprisonment.

23. On 5 January and 19 January 2024, Mr Dorling purchased paracetamol tablets from a supermarket in Morwell. On each occasion he purchased 2 packets of 20 tablets.

24. At approximately 10.00pm on 1 February 2024, whilst at home alone, Mr Dorling consumed between 90 and 100 paracetamol tablets with vodka. (He subsequently told police investigators that he was hoping not to wake up the next day.)

Appearance at court on 2 February 2024 and remand into custody

When Mr Dorling woke up on the morning of 2 February 2024, he concluded that the paracetamol had not worked as he had intended, and he decided to attend court as scheduled.

25. Mr Dorling attended at the County Court at Morwell and his case commenced shortly after 10.00am with a barrister appearing on his behalf. The plea hearing proceeded for approximately one hour but was then adjourned to a later date for further plea and sentence. At 11.30am Mr Dorling was remanded and taken into custody.

26. There is no evidence to suggest that Mr Dorling indicated to anyone whilst he was at the County Court that he had ingested the paracetamol tablets.

27. Mr Dorling was handcuffed and escorted from the court by two Police Custody Officers (**PCOs**) (McMillan and Tosin) to the Morwell Police Station via a secure tunnel.

28. PCO Tosin noticed that Mr Dorling appeared frail and wore a glove on one hand, which Mr Dorling said was to manage the symptoms of multiple sclerosis.

29. At 11.39am Mr Dorling was presented at the charge counter of Morwell Police Station and subsequently placed in a holding cell alone. Mr Dorling was searched and provided with a mattress, blanket and slippers, black coffee and biscuits.

30. PCO Tosin then completed the Detainee Risk Assessment which included questions relating to medication and risk of suicide or self-harm. Mr Dorling advised that he took 'Nitro'[7] for chest pain (a medication spray he had previously provided to the PCO) and responded 'no' to questions about suicide and self-harm. He did not reveal that he had consumed the paracetamol tablets.

31. At 12.35pm Mr Dorling's blood sugar was checked and recorded as 15.3 mmol/L. Senior PCO Ramanthan reported this to the Victoria Police Custodial Health Advice Line (**CHAL**) who advised not to give Mr Dorling anything sweet. After further discussions with a nurse at CHAL relating to Mr Dorling's known medical conditions (angina, diabetes and multiple sclerosis), it was determined that he be moved from Morwell Police Station (where a nurse visited once a week) to Dandenong Police Station (where a nurse visited daily).

32. At 12.47pm Mr Dorling was given a hot meal.

Transfer to Dandenong Police Station

[7] Glyceral trinitrate, a sublingual medication for treatment of angina.

33. At 3.53pm on 2 February 2024, Mr Dorling was taken from his cell to the prisoner transfer van operated by staff from G4S[8], where he was given a safety briefing. The prisoner transfer van comprises separate secure compartments for prisoners and a crew cabin. Mr Dorling was one of three prisoners being transported.

34. At 3.57pm the prisoner transfer van departed Morwell Police Station for Dandenong Police Station, a journey of approximately one and a quarter hours.

35. At 4.18pm Mr Dorling activated the intercom in his compartment and told G4S staff in the crew cabin that he had vomited. The vehicle pulled over two minutes later and Prisoner Transport Officer Cameron Knights opened the handcuff hatch to Mr Dorling's compartment to speak with him. Mr Knights saw that Mr Dorling had vomited and that there was still some vomitus around his lips. Mr Knights provided Mr Dorling with tissues and sick bags. He also asked why he had been sick, to which Mr Dorling replied that he had not eaten.

36. Mr Knight explained that he had no food he could give Mr Dorling but offered him water and asked if he was alright to continue for the remaining 40 minutes of the journey. Mr Dorling declined the offer of water and said that he was okay to continue.

37. Mr Knights monitored Mr Dorling for the remainder of the journey, and he was seen to vomit "a little more".

38. At 5.47pm Mr Dorling exited the prisoner transfer van at Dandenong Police Station. He was able to do so unaided, and he deposited the sick bags in a bin. When Police Custody Officer (**PCO**) Sary asked if he was okay, Mr Dorling advised that he had been sick from travelling backwards in the vehicle.

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8 A private organization providing custodial services to Corrections Victoria.

39. Mr Dorling was taken to a room to be searched. PCO Sary and PCO Singh then saw him place his hand on a cupboard and lean forward. Mr Dorling stated that he felt dizzy. He was told to sit if he needed to. He turned around and slid down with his back against a cupboard to a seated position on the floor.

40. Mr Dorling was then asked a series of health related questions, including if he had taken any medication or consumed drugs, to which he replied 'no'. At some stage while in this room Mr Dorling vomited again. His blood sugar was tested with a result of 15.5 mmol/L. CHAL were notified and they advised to provide Mr Dorling with water and dry biscuits.

41. At 6.01pm Mr Dorling stood up and walked unassisted to a holding cell.

42. Between 6.00pm and 7.00pm Mr Dorling was given a meal, and he ate a small amount. When his plate was collected, he advised PCO Westwood that he was feeling better.

43. At 8.58pm Mr Dorling was given dry biscuits and tea.

44. At 9.38pm a further blood sugar test was performed with a result of 14.5 mmol/L. This was reported to CHAL who advised to check again before Mr Dorling had breakfast.

45. At 10.56pm, as part of the shift handover, PCO Nation conducted a welfare check. He opened the flap on Mr Dorling's cell door and spoke to him. Mr Dorling indicated that everything was okay.

3 February 2024

46. At 11.58pm (2 February) and 12.00am (3 February) Mr Dorling pressed the duress button in his cell. At 12.00am he told PCO Bumpstead that he had chest pain, and he was seen to be holding the middle of his chest. Mr Dorling told PCO Bumpstead that he had a history of angina and had a nitro-glycerine spray in his property. Just as PCO Bumpstead was

moving away to call CHAL, Mr Dorling then revealed that he had taken 100 Panadol tablets prior to coming into custody and that he had not disclosed this previously.

47. PCO Bumpstead called CHAL and was advised to call 000 Emergency, which he did at 12.07am. The 000 operator and PCO Bumpstead agreed that the call taker would call Bumpstead back on his personal mobile phone so that he could remain with Mr Dorling during the phone call to allow for better communication.

48. At 12.10am the 000 operator called PCO Bumpstead's mobile phone which he answered whilst at Mr Dorling's cell. The 000 operator asked Mr Dorling a series of questions and, in response, he (and PCO Bumpstead) advised that he had consumed 100 paracetamol tablets. An ambulance was then dispatched to the police station while the 000 operator remained on the line with PCO Bumpstead.

49. At 12.13am Advanced Life Support Paramedic Nicholas Johnson arrived and assessed Mr Dorling. Mr Dorling disclosed to Mr Johnson that he had taken the paracetamol tablets.

50. At 12.25am Mr Johnson radioed for another ambulance to attend to transport Mr Dorling to hospital. At 12.30am the second ambulance arrived, and at 12.45am Mr Dorling was placed onto a stretcher and transported to the Dandenong Hospital. He was accompanied by police due to his status as a remand prisoner.

Admission to Dandenong Hospital

Medical Treatment

51. Mr Dorling arrived at the Dandenong Hospital Emergency Department (**ED**) at 1.00am. A blood sample was taken at 2.14am but it was clotted so the sample was taken again. The second blood sample was taken at 5.16am and analysed. It revealed a paracetamol level of

200 µmol/L. Mr Dorling was jaundiced with bilirubin at 100 µmol/L[9]. He had acute liver failure with an alanine aminotransferase[10] level of 4,286 U/L[11], coagulopathy (indicated by an INR[12] of 2.6), acute kidney injury (indicated by a Glomerular filtration rate of 66 ml/min), and a lactate level of 7.3 mmol/L.[13]

52. At approximately 6.15am standard infusion protocol intravenous fluids commenced with N-acetylcysteine[14] and acid suppression, intravenous fluid and thiamine. Between 6.00am and 7.00am Mr Dorling's serial troponins[15], CT brain scan and chest x-ray results were normal.

53. Emergency Department doctors formed the initial impression of an upper gastrointestinal bleed, massive paracetamol overdose and a fall with head strike (as reported by Mr Dorling[16]) but no neurological abnormality.

54. At 7.36am the toxicology team recommended referrals for internal gastroenterology and transfer to the intensive care unit (**ICU**). They also recommended a discussion with the Austin Health Liver Transplant Service.

55. At 8.00am the Dandenong ED Registrar called the Austin Health Liver Transplant Service who advised that Mr Dorling did not yet meet the criteria for a liver transplant, and to admit him to the ICU at Dandenong Hospital.

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9 Normal total bilirubin range in adults is 5.1 to 17 µmol/L.

10 An enzyme which serves as a key marker for hepatocellular injury.

11 An alanine aminotransferase level above 100 U/L is considered to be significantly elevated.

12 International Normalised Ratio – based on the Prothrombin Test time for how long it takes blood to clot.

13 A level above 4 mmol/L is indicative of severe metabolic disease.

14 A widely used antidote for paracetamol poisoning. Its efficacy comes from its ability to stimulate glutathione synthesis, which is essential for the metabolism of the toxic paracetamol metabolite NAPQI (N-acetyl-p-benzoqiunone imine). NAPQI is produced in large amounts when the normal metabolic pathway is saturated by paracetamol overdose. Prognosis is usually good in overdose cases when administered within 8 hours of paracetamol ingestion.

15 A protein biomarker for heart muscle damage.

16 On admission to the emergency department, Mr Dorling reported having suffered a fall on the preceding Wednesday (31 January 2024) with no loss of consciousness: CB 29-128

56. At 8.39am Mr Dorling was transferred to the Dandenong ICU and at 8.47am he was admitted under the treatment of the Gastroenterology Team.

57. At 10.00am further blood tests revealed severe coagulopathy (INR 12) and worsening hepatitis with an alanine aminotransferase of 5,594 U/L, in association with severe thrombocytopaenia[17] (platelets 35,000/μL), and elevated ammonia levels at 179 μmol/L consistent with advanced liver failure. Mr Dorling became progressively acidotic, with a serum pH of 7.14[18] at 11.00am.

58. At 11.00am a second call was made to the Austin Liver Transplant Service who advised that Mr Dorling could now be accepted into their ICU, and that they would confirm availability of a bed within the ICU. Dandenong Hospital agreed to arrange the transfer logistics with Adult Retrieval Victoria (**ARV**) once a bed was confirmed at the Austin ICU. ARV is a branch of Ambulance Victoria and is responsible for coordinating the inter-hospital transfer of critically ill or injured adult patients across Victoria.

59. At 4.47pm the Dandenong Hospital ICU was notified that a bed had become available at the Austin ICU.

60. At 5.06pm a discussion took place between the Dandenong Hospital ICU Registrar and the ARV Clinical Director concerning the potential for Mr Dorling's transfer that evening. Immediate transfer was not possible due to limited ARV resourcing.

61. At 7.01pm, an ARV retrieval crew was briefed and tasked to Mr Dorling's case, which was deemed to be a Priority Code 2, an interhospital transfer with police escort. The retrieval crew was dispatched at 7.48pm.

62. At 7.52pm an elective intubation was performed at the Dandenong ICU to support Mr Dorling for the planned transfer.

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17 Low platelet count. Normal adult range is 150,000 to 450,000/μL – below 51,000/μL is classified as severe.

18 Normal human physiological pH is 7.35 to 7.45. A pH below 7.2 indicates severe acidosis.

63. A short time later ARV received an update from Dandenong Hospital ICU that Mr Dorling was stable for transport post intubation.

64. At 8.30pm the ARV retrieval team arrived at Dandenong ICU and, at this time, Mr Dorling became progressively unstable with tachycardia (at 150 BPM), increasing vasopressor requirements, and progressive lactate rise despite blood filtration.

65. From 9.30pm a four-way telephone conference took place with the ARV Retrieval Registrar, the ARV Clinical Co-ordinator, the Registrar of the Dandenong Hospital ICU, and the Registrar of the Austin Liver Transplant Unit. It was considered that Mr Dorling's clinical condition had deteriorated significantly with the likelihood of secondary to progressive multi-organ failure. It was also considered that he would not survive transfer to the Austin Hospital.

66. During the four-way conference the Austin Liver Transplant Unit advised that there was no liver available at that time for transplant, and it was determined that Mr Dorling remain at Dandenong ICU to continue with general intensive care therapy, with the understanding that his prognosis was grave. At 10.17pm the ARV retrieval crew was cleared from the case.

67. Despite maximal supports at the Dandenong ICU, Mr Dorling continued to deteriorate. A transthoracic echocardiogram demonstrated profound global cardiac dysfunction, suggesting heart failure. At 1.35am on 4 February he developed ventricular tachycardia despite maximal inotrope support.

68. Mr Dorling died at 1.45am on 4 February 2024.

<u>Police interaction with Mr Dorling at Dandenong Hospital</u>

69. At 12.00pm on 3 February 2024 Detective Senior Constable Lynch of the Victoria Police Homicide Squad was notified by Detective Sergeant Gallagher of Professional Standards Command that Mr Dorling was in a critical condition at Dandenong Hospital.

70. Between 2.08pm and 2.30pm Constable Lewis (who was performing hospital guard duties) advised DSC Lynch that Mr Dorling had further deteriorated but was conscious and willing to speak to DSC Lynch.

71. At 4.00pm, DSC Lynch attended Dandenong Hospital and spoke with Mr Dorling. Their conversation was recorded on body worn camera. Mr Dorling told DSC Lynch that he had not disclosed to custody staff that he had ingested the paracetamol until after he had pressed the intercom at Dandenong Police Station when he was experiencing chest pain.

72. DSC Lynch asked Mr Dorling what his intention was when he took the paracetamol and he replied, "So I wouldn't wake up the next morning, but I did". When asked if he wished to relay anything regarding "police involvement" he stated that the police "did nothing wrong by me".

73. Mr Dorling remained under police guard until he died the following morning.

Mr Dorling's intention

74. Having regard to all of the available evidence, I find that Mr Dorling deliberately ingested a large quantity of paracetamol on the evening of 1 February 2024 with the intention of ending his own life.

Treatment of Mr Dorling in police custody, including transportation by G4S

75. The members of Victoria Police having contact with Mr Dorling responded promptly and appropriately as the situation emerged. I am satisfied that it was only after Mr Dorling pressed the duress button in his cell at 12.00am on 3 February at Dandenong Police Station

that anyone knew he had ingested paracetamol before going into custody. Before this time, there was nothing to indicate that he had poisoned himself. Moreover, there is nothing to suggest any failure of process or inquiry by any member of Victoria Police or staff of G4S that might have led to an earlier revelation of the poisoning. Once police became aware of what Mr Dorling had done, they acted swiftly and appropriately by calling CHAL and following their advice to call 000 Emergency.

76. I am satisfied that G4S staff responded appropriately when Mr Dorling became unwell during his transfer from Morwell to Dandenong. It is notable that Mr Dorling attributed his symptoms to a lack of food and said that he was okay to complete the remaining 40 minutes of the journey. In this circumstances, it was a sensible decision to continue to Dandenong as they did. I also note that, upon arrival at Dandenong Police Station, Mr Dorling attributed his symptoms to "travelling backwards".

Assessment of management of proposed transfer to Austin Hospital

77. Once the Austin Liver Transplant Unit had accepted Mr Dorling for transfer, it actively worked together with Austin Hospital ICU, Dandenong Hospital ICU and ARV to try to affect the transfer as soon as practicable.

78. The first call from the Dandenong Hospital ICU to the Austin Hospital regarding a potential liver transplant was at approximately 8.00am on 3 February 2024. At approximately 11.00am, during a subsequent call, the Austin Liver Transplant Unit advised that Mr Dorling had been accepted for potential transplant.

79. Austin Health does not have any records detailing the rationale for initially declining and later approving Mr Dorling for inter-hospital transfer for potential liver transplant. The Court obtained two statements from Professor Adam Testro, Director of Liver and Intestinal Transplant Medicine at Austin Health. Professor Testro stated that the following principles are in place at the Austin Hospital for consultants to accept or decline a hospital transfer:

(a) *Is the patient someone who may need to be assessed for liver transplantation during this admission and do they have any contraindication? If no contraindication and patient is unlikely to be well enough for outpatient assessment, transfer is accepted.*

(b) *If the patient has an absolute contraindication they would not usually be accepted.*

(c) *For patients with acute liver failure, most will not need transplantation, and acceptance will be based on fulfilling Kings College Criteria for urgent transplantation as defined by* TSANZ [Transplantation Society of Australia & New Zealand] *guidelines.*

80. Professor Testro stated that these principles are not formalised in a policy or procedure at the Austin Hospital but that this is the approach adopted in practice, and it is consistent with the TSANZ guidelines.

81. The available records indicate that there was no donor liver available for transplant at the Austin Hospital between the time Mr Dorling became overtly seriously ill, and his death.

Record keeping regarding inter-hospital transfers

82. Austin Health provided the Court with various statewide and internal policies and procedures relating to inter hospital transfers. It also provided recent data indicating that there were 272 telephone referrals for potential liver transplant between 2 February 2025 and 24 September 2025. Of these, only 21 were accepted for inpatient transfer to the Austin Liver Transplant Unit.

83. Professor Testro stated that Austin Health had no formal records concerning Mr Dorling's case, save for the personal notes of the doctors involved in the phone calls with Dandenong Hospital ICU. He also stated that it is a sector wide and well accepted convention that it is

the referring clinicians who record the outcomes of discussions in the patient medical records.[19]

84. The Transplantation Society of Australia and New Zealand also provided a statement to the court in which it advised that record keeping requirements relating to inter-hospital transfers for urgent organ transplant assessment are out of scope for TSANZ guidelines, and there are no mandated TSANZ record keeping recommendations. It further noted that documentation obligations fell to the transferring and receiving hospitals in accordance with local health service policy and jurisdictional requirements, and record keeping requirements regarding eligibility of a patient for organ transplantation are governed by local hospital policies.

85. Monash Hospital records include the outcome of the initial discussion regarding Mr Dorling's inter-hospital transfer having been declined due to him not meeting the criteria for liver transplant. The records do not however include the precise information that was provided to Austin Liver Transplant Unit to form the basis for this assessment or the reason(s) for ineligibility at that time.

86. Peter Ryan, Chief legal officer at Monash Health, stated that, while Monash Health does not take issue with Professor Testro's evidence regarding record keeping, the issue needs to be considered in context, including that:

(a) when patients are critically unwell it is not always possible for documentation to be contemporaneous because the priority is delivering care to the patient, and

(b) it is standard practice for interhospital transfer discussions to occur by telephone.

87. Mr Ryan also stated that, had Mr Dorling been transported to the Austin Hospital, a transfer discharge summary would have been completed by Monash Hospital and would have accompanied him. In Mr Dorling's case, a transfer summary had already been drafted.

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[19] CB 34-2

88. I accept these matters to be the case.

89. Having considered all the circumstances I conclude that, even if Mr Dorling had been transferred to the Austin Hospital on 3 February, the lack of availability of a donor liver, leads one inexorably to the conclusion that he would not have been saved. By the afternoon and evening of 3 February, Mr Dorling's condition was grave and unstable. There is nothing to suggest that the decision to provide ongoing intensive care at Dandenong Hospital was not the best (and only viable) decision in the circumstances.

CONCLUSION

90. Mr Dorling's death was not preventable. On the evening of 1 February 2024, he ingested a lethal quantity of paracetamol with the intention of taking his own life and did not expect to wake up the following morning.

91. On 2 February 2024 he appeared at the Latrobe Valley Court in Morwell and was remanded in custody. Throughout the rest of the day whilst he was in custody, he hid the fact that he had consumed 90 to 100 Panadol tablets. When he vomited whilst being transported from Morwell Police Station to Dandenong Police Station, he ascribed his symptoms to benign causes. When he felt unwell upon arrival at Dandenong Police Station he did the same. It was not until midnight, when his symptoms worsened, that he revealed what he had done. Without this declaration, there is no feasible way that police members or G4S staff could have known that he was already on a dire course.

92. After Mr Dorling's disclosure at midnight on 2 February 2024, the police members dealing with him acted promptly and effectively. Their consultation with CHAL was appropriate and Mr Dorling was soon transported from the police station to the Dandenong Hospital.

93. There is nothing to suggest that the care he received at Dandenong Hospital was anything other than appropriate.

94. I am also satisfied that the liaison between clinicians at Dandenong Hospital and the Austin Liver Transplant Unit on 3 February 2024 was appropriate, as were the efforts to have Mr Dorling transferred for a potential liver transplant.

STATUTORY FINDINGS

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

(a) The identity of the deceased was David James Dorling, born 10 July 1964.

(b) The death occurred on 4 February 2024 at the Dandenong Hospital, 135 David Street, Dandenong, Victoria, from MULTIORGAN FAILURE COMPLICATING PARACETAMOL TOXICITY.

(c) The death occurred in the circumstances described above.

COMMENTS

I make the following comments connected with the death pursuant to section 67(3) of the Act:

96. In this case, a precise understanding of the reasons for the initial decision concerning Mr Dorling's suitability for potential liver transplant was made more difficult by the absence of contemporaneous records concerning this point in his care. I accept that strictly contemporaneous record keeping is difficult when clinicians must focus on the immediate needs of an acutely unwell patient. Nonetheless, there remains a need to record matters in such a way that clinical decision making processes may be readily understood, in detail, upon review.

97. The circumstances of this case reveal the potential for improved record sharing systems between hospitals. Peter Ryan of Monash Health submitted that this case demonstrates the value of there being a single, shared, statewide electronic medical record system that

could record patients journeys from one hospital or health service to another. This would be one of the many significant benefits that would flow from a universal electronic patient records system, capable of being shared between different health services in Victoria.

ACKNOWLEDGEMENTS

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

DIRECTIONS

Pursuant to section 73(1) 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:

Susan Chesterfield, Senior Next of Kin

Monash Health

Austin Health

Chief Commissioner, Victoria Police

G4S

Ambulance Victoria

Secretary of the Department of Health, Victoria

Sergeant Kate Lynch, Coroner's Investigator

Signature:

CORONER PAUL LAWRIE

10 February 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 inquest. 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.