IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004557

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Timothy John Hacking
Date of birth:	27 January 1970
Date of death:	6 August 2024
Cause of death:	1a : CARDIOMYOPATHY (NOS)
Place of death:	11/64-68 Anderson Street, Lilydale Victoria 3140
Keywords:	'In care' death, natural causes

INTRODUCTION

1. On 6 August 2024, Timothy John Hacking (**Timothy**) was 54 years old when he passed away at his residence. At the time of his death, Timothy lived in an independent supported living facility run by Melba Support Services (**Melba**) at 11/64-68 Anderson Street Lilydale.

2. Timothy was adopted at birth by parents, Frank and Judith Hacking. He grew up alongside two siblings, Jason Hacking and Nyree Hunter, in Vermont.

3. Timothy's medical history included intellectual disability (2022), right temporal lobectomy (2000). epilepsy, schizoaffective disorder, hypertension, depression, gout and morbid obesity.[1] He was prescribed several medications for his conditions and self-administered them.

4. Timothy previously resided at home with his mother and received in-home disability support from Melba under his National Disability Insurance Scheme (**NDIS**) plan. In 2023, arrangements were made for Timothy to move out of his home as he expressed a desire to be independent.

5. Timothy's move was expedited after his mother's passing in September 2023 and after sustaining two unwitnessed falls between March and April 2024. In June 2024, Timothy was allocated an independent unit in the Anderson Street residence. While living there, Timothy received daily living support, including personal care and household tasks during the day,

THE CORONIAL INVESTIGATION

6. Timothy'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. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspect that the death

[1] Court File (**CF**), Maroondah Hospital Medical Records.

was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

8. Immediately before his death, Timothy was a person placed in care within the meaning of section 4 of the Act, as he was a prescribed class of person[2] due to his status as an "*SDA*[3] *resident residing in an SDA enrolled dwelling*".

9. However, section 52(3A) of the Act provides an exception to the requirement under section 52(2) that the coroner is not required to hold an inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3a) of the Act, I determined not to hold an inquest into Timothy's death.

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Timothy's death. The Coronial 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.

13. This finding draws on the totality of the coronial investigation into the death of Timothy John Hacking, 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.[4]

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[2] Section 4(2)(j)(i), *Coroners Act 2008 (Vic).*
[3] Specialist Disability Accommodation.
[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

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

Circumstances in which the death occurred

14. On 6 August 2024, at approximately 2.30pm, a support worker attended Timothy's unit to administer eye drops due to eye conjunctivitis. He required eye drop administration three times a day. The support worker did not observe anything out of the ordinary. She recalled that Timothy "*seemed well…and there were no signs of being unwell*".[5]

15. At approximately 6.00pm, another support worker attended Timothy's unit to check on him. Upon entering, she found him lying face down on the floor, unresponsive. She immediately alerted her co-workers, who called emergency services and commenced cardiopulmonary resuscitation on Timothy.

16. Ambulance Victoria paramedics responded shortly after and assessed Timothy. Resuscitation efforts were not initiated as they considered he was clearly deceased, and Timothy was verified deceased at 6.37pm.

Identity of the deceased

17. On 6 August 2024, Timothy John Hacking, born 27 January 1970, was visually identified by his carer, Emina Sejmen.

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

Medical cause of death

19. Forensic Pathologist Adjunct Associate Professor Sarah Parsons (**Adjunct Asst. Prof. Parsons**) from the Victorian Institute of Forensic Medicine conducted an autopsy on 13 August 2024 and provided a written report of her findings dated 9 October 2024.

20. The autopsy revealed evidence of moderate coronary artery disease, cardiac hypertrophy, fibro-fatty infiltration within the myocardium, cirrhosis, benign nephrosclerosis and gallstones. Adjunct Asst. Prof. Parsons also noted a body mass index of 49.3kg/m, which is indicative of WHO class III obesity.

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

[5] Coronial Brief (**CB**), Statement of Fiona Bak.

21. Adjunct Asst. Prof. Parsons commented that the pattern of changes within the myocardium is suggestive but not diagnostic of arrhythmogenic cardiomyopathy. While these changes were abnormal, they cannot be definitely explained based only on the findings of moderate coronary artery disease with/without hypertension.

22. Adjunct Asst. Prof. Parsons further commented that it is possible that the cause(s) of cardiomyopathy are genetic.

23. Toxicological analysis of post-mortem samples identified the presence of telmisartan[6], aripiprazole[7], venlafaxine[8], desmethylvenlafaxine, phenytoin[9] and topiramate[10].

24. Adjunct Asst. Prof. Parsons provided an opinion that the medical cause of death was 1(a) CARDIOMYOPATHY (NOS[11]).

25. Adjunct Asst. Prof. Parsons further opined that Timothy's death was due to natural causes

26. I accept Adjunct Asst. Prof. Parsons' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Timothy John Hacking, born 27 January 1970;

    b) the death occurred on 6 August 2024 at 11/64-68 Anderson Street, Lilydale, Victoria 3140, from *cardiomyopathy (NOS)*; and

    c) the death occurred in the circumstances described above.

28. Having considered the factual matrix within which the death occurred, I am satisfied that the weight of the available evidence does not support a conclusion that a causal nexus existed between the fact that Timothy was 'in care' at the time of his death and the medical cause of his death. Consequently, on the evidence available to me, I am unable to find that Timothy's

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[6] Telmisartan is a synthetic type-1 angiotensin receptor blocker indicated for hypertension and chronic heart failure.
[7] Aripiprazole is a third-generation antipsychotic drug.
[8] Venlafaxine is indicated for the treatment of depression.
[9] Phenytoin is an anti-convulsant often used in the treatment of epilepsy and convulsions.
[10] Topiramate is an anticonvulsant used in the treatment of epilepsy and for preventing headaches.
[11] Not otherwise specified (**NOS**). NOS is a subcategory in systems of disease/disorder, generally used to note the presence of an illness where the symptoms presented were sufficient to make a general diagnosis, but a specific diagnosis was not made.

status as a person who was 'in care' at the time of his death is connected with or contributed to the medical cause of his death. Further, I find that Timothy died by natural causes.

I convey my sincere condolences to Timothy'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:

Jason Hacking, Senior Next of Kin

Eastern Health

Senior Constable Nicole Finter, Coronial Investigator

Signature:

Coroner John Olle

Date: 12 May 2025

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.