



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002423

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Cameron James Stewart
Date of birth:	22 February 1993
Date of death:	30 April 2024
Cause of death:	1a: Aspiration pneumonia in a man with intellectual disability and epilepsy (palliated)
Place of death:	Maroondah Hospital, 1/15 Davey Drive Ringwood East, Victoria, 3135
Keywords:	Death in care, natural causes, aspiration pneumonia

INTRODUCTION

1. On 30 April 2024, Cameron James Stewart was 31 years old when he passed away at Maroondah Hospital. At the time of his death, Mr Stewart lived in specialist disability accommodation (SDA) in Mooroolbark, Victoria, and received supported independent living services from Melba Support Services.
2. Mr Stewart was born with severe cerebral palsy, which caused dystonic spastic quadriparesis, dysuria and epilepsy. His complex medical presentation also included autism spectrum disorder, intellectual disability, scoliosis, gastro-oesophageal reflux disease, sialorrhea, dysphagia and dystonia. He was non-verbal and used a wheelchair for mobility. He required support for all daily living activities and at the time of his passing received all his nutrition and medication via a percutaneous endoscopic gastrostomy (PEG).
3. Mr Stewart had lived at the Mooroolbark residence since January 2020 and, according to his mother, was well taken care of and enjoyed his time there. Despite his significant health challenges, he was mostly a happy man who took great joy in life. He enjoyed the ongoing support of his parents and built strong relationships with his support workers and housemates.

THE CORONIAL INVESTIGATION

4. Mr Stewart's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*.¹ The sole reason for the report was that Mr Stewart was a "person placed in custody or care" pursuant to the definition in section 4 of the Act, as he was a "prescribed person or a person belonging to a prescribed class of person" due to his status as an "SDA resident residing in an SDA enrolled dwelling".²
5. 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.

¹ Section 4(1), (2)(c) of the Act.

² Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5. I have received information that Mr Stewart resided at an address where the residents meet these criteria.

6. 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.
7. Victoria Police assigned an officer to be the coronial investigator for the investigation of Mr Stewart's death. The coronial investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.
8. This finding draws on the totality of the coronial investigation into the death of Cameron James Stewart 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.³

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

Circumstances in which the death occurred

9. In December 2023, Mr Stewart suffered from a COVID-19 infection and thereafter had recurrent hospital admissions for aspiration pneumonia and upper respiratory tract infections (URTI).
10. On 19 April 2024, Mr Stewart was observed vomiting due to coughing at his residential care home and was reviewed by his general practitioner, Dr Sudanthi Amarasekera for a suspected URTI. Dr Amarasekera ordered a chest x-ray and noted that Mr Stewart was not fevered, his airways were normal and there were no signs of respiratory distress.
11. On 23 April 2024, Dr Amarasekera reviewed the chest x-ray results and noted that Mr Stewart's chest was clear and the infection levels were low. Mr Stewart was prescribed cold and flu tablets with advice provided to continue the course of antibiotics he was already taking as a precaution. That afternoon, Mr Stewart vomited twice due to coughing.

³ 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. During a telehealth consultation the following day, Dr Amarasekera was advised that Mr Stewart had vomited again and experienced a recurrence of dystonia.⁴ He advised Melba staff to continue the antibiotics and to take Mr Stewart to hospital if the vomiting persisted over the next 48 hours.
13. On 25 April 2024, Mr Stewart vomited overnight but then recovered.
14. On 28 April 2024, Melba staff called 000 after observing Mr Stewart with a low oxygen saturation level of 91% and continuous vomiting. He was reviewed by Ambulance Victoria (AV) paramedics, who determined that he was in a stable enough condition that he did not require AV transportation to the hospital. He was subsequently transported to Maroondah Hospital (MH) by Melba staff and his mother.
15. Initial investigations at the MH Emergency Department (ED) showed mild pneumonia. At this time, Mr Stewart was also experiencing an intense episode of dystonia and was given diazepam to manage his symptoms. He suffered from this throughout the night and struggled to sleep.
16. On the morning of 29 April 2024, while still in the ED, Mr Stewart became unresponsive, tachycardic and hypotensive, resulting in a MET call. During the MET call, a decision was made to admit Mr Stewart to the Intensive Care Unit for blood pressure support and ongoing management for presumed aspiration. He was commenced on high-flow oxygen and stabilised.
17. By the early hours of 30 April 2024, Mr Stewart's condition had further deteriorated. His family were contacted at around 2:00 am and advised to attend the hospital. Medical staff held a meeting with his family and advised that there had been minimal response to medication and Mr Stewart's condition would continue to deteriorate. Following the meeting, his family agreed to transition him into end-of-life care.
18. Mr Stewart's family, one of his friends, and a Melba support worker remained with him until he passed away on 30 April 2024 at 6:12 pm.

⁴ Dystonia is a condition where a person has uncontrollable muscle movements in some part of their body.

Identity of the deceased

19. On 1 May 2024, Cameron James Stewart, born 22 February 1993, was visually identified by his father, Michael Andrew Stewart.
20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine conducted an external examination of Mr Stewart's body on 2 May 2024 and provided a written report of his findings dated 15 May 2024.
22. The external examination revealed findings consistent with the reported circumstances.
23. A post-mortem CT scan showed kyphoscoliosis with internal spinal brace, a compromised thoracic cavity, bilateral lung consolidation, probable small pleural effusions and a fatty liver.
24. Dr Bouwer provided an opinion that the medical cause of death was "1(a) Aspiration pneumonia in a man with intellectual disability and epilepsy (palliated)" and that the death was due to natural causes.
25. I accept Dr Bouwer's opinion.

FINDINGS AND CONCLUSION

26. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Cameron James Stewart, born 22 February 1993;
 - b) the death occurred on 30 April 2024 at Maroondah Hospital, 1/15 Davey Drive, Ringwood East Victoria 3135, from aspiration pneumonia in a man with intellectual disability and epilepsy (palliated); and
 - c) the death occurred in the circumstances described above.
27. Having considered all the available evidence, I find that Mr Stewart's death was from natural causes and was not unexpected. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death.

28. I convey my sincere condolences to Mr Stewart's family for their loss. I also wish to acknowledge the high level of care provided to Mr Stewart by the Melba support workers and Dr Sudanthi Amarasekera.

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:

Carolyn & Michael Stewart, Senior Next of Kin

Eastern Health

Sergeant Amy Ritchie, Coronial Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 02 March 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.
