



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007480

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	BA
Date of birth:	1979
Date of death:	23 October 2025
Cause of death:	1a : COMPLICATIONS OF MEGACOLON IN A MAN WITH MULTI ORGAN INJURY SUSTAINED IN A REMOTE MOTOR VEHICLE INCIDENT (PALLIATED)
Place of death:	Epworth Richmond 89 Bridge Road Richmond Victoria 3121
Keywords:	In care; Specialist Disability Accommodation; SDA resident; Natural causes

INTRODUCTION

1. On 23 October 2025, BA was 46 years old when he died at Epworth Hospital. At the time of his death, BA lived in Specialist Disability Accommodation (SDA) at Box Hill, Victoria, 3128.
2. BA was raised as the eldest of four children born to parents, BB and BC. BA was unfortunately involved in a motor vehicle accident on 17 March 1982, when he was struck by a car and admitted to the Royal Children's Hospital for six months.¹ BA sustained significant head trauma from the accident and was later diagnosed with an Acquired Brain Injury.²
3. BA had mild to moderate cognitive and physical impairment following the accident and used a wheelchair to mobilise when indoors and was supervised when using his wheelchair outdoors.³
4. BA commenced living at the SDA in Box Hill in August 2025 and was supported by staff to complete most of his daily living needs.⁴ BA was an active person and enjoyed going to cafes and theatres in his spare time and bowling with his carers.

THE CORONIAL INVESTIGATION

5. BA'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.
6. Because BA was a Specialist Disability Accommodation (SDA) resident residing in an SDA enrolled dwelling⁵ at the time of his death, his passing was determined to be 'in care' and, as such, is subject to a mandatory further investigation, pursuant to section 52(3A) of the Act. These findings are the result of that investigation.
7. 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

¹ *Coronial Brief*, Statement of BB.

² *Ibid.*

³ *Coronial Brief*, Statement of Sue Piece.

⁴ *Ibid.*

⁵ See Regulation 7(1)(d) of the Coroners Regulations 2019.

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.

8. 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.
9. Victoria Police assigned Constable Vivienne Dang to be the Coronial Investigator for the investigation of BA'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.
10. This finding draws on the totality of the coronial investigation into the death of BA 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
11. In considering the issues associated with this finding, I have been mindful of BA's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, 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

12. On 22 October 2025, BA was supported by his SDA carers to attend an external venue for his morning routine. BA was observed by SDA carers to be tired and that he felt uncomfortable around his stomach area as he reported not opening his bowels for two weeks.
13. SDA staff checked with the SDA facility and confirmed that records indicated BA had opened his bowels a few days earlier on 19 October 2025. BA continued to feel uncomfortable and had laboured breathing. SDA staff contacted "Nurse on Call" who advised them to send BA

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.

to the hospital for treatment. SDA staff contacted Ambulance services for support to transport BA to Epworth Hospital (Richmond) and accompanied him to the hospital.

14. At Epworth Hospital, BA was provided supplemental oxygen in the Emergency Department but his health deteriorated over the evening and he was transferred to the Critical Care Unit with bag-mask ventilator assistance to maintain his oxygen saturations. BA's condition was discussed with the treating medical team and his family; a shared decision was made to transition him to end of life care.⁷
15. On 23 October 2025 at around 10:36 am, BA was pronounced deceased by medical staff in the Critical Care Unit.⁸

Identity of the deceased

16. On 23 October 2025, BA, born 1979, was visually identified by their father, BC.
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 external examination on 24 October 2025 and provided a written report of his findings dated 2 December 2025.
19. The post-mortem CT scans showed a markedly dilated colon (megacolon) without evidence of acute bowel obstruction, remote brain injury but no acute intracranial pathology, marked kyphoscoliosis with lumbar spinal mental fixation.
20. In view of the reported circumstances and post-mortem CT findings, Dr Bouwer was of the opinion that the death was due to natural causes.
21. Dr Bouwer provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF MEGACOLON IN A MAN WITH MULTI ORGAN INJURY SUSTAINED IN A REMOTE MOTOR VEHICLE INCIDENT (PALLIATED) and I accept his opinion.

⁷ *Coronial Brief*, E-medical deposition records.

⁸ *Ibid.*

FINDINGS AND CONCLUSION

22. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was BA, born 1979;
 - b) the death occurred on 23 October 2025 at Epworth Richmond, 89 Bridge Road, Richmond, Victoria, 3121, from 1(a) COMPLICATIONS OF MEGACOLON IN A MAN WITH MULTI ORGAN INJURY SUSTAINED IN A REMOTE MOTOR VEHICLE INCIDENT (PALLIATED); and
 - c) the death occurred in the circumstances described above.
23. Having considered all of the circumstances, I am satisfied that BA's care was reasonable and appropriate at all material times.
24. As BA was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.⁹ I am satisfied by the available evidence that BA's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

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

⁹ Section 52(2) of the Act.

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

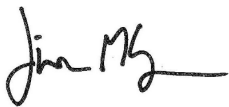
I direct that a copy of this finding be provided to the following:

BB and BC, Senior Next of Kin

Louise Corder, Epworth Hospital (Richmond)

Constable Vivienne Dang, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 22 September 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.
