IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004820

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Michael King
Date of birth:	9 November 1963
Date of death:	24 November 2022
Cause of death:	1(a) Aspiration pneumonia 1(b) Recurrent anal squamous cell carcinoma with surgery
Place of death:	Peter MacCallum Cancer Centre 305 Grattan Street Melbourne Victoria 3000
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 24 November 2022, Michael King was 59 years old when he passed away at the Peter MacCallum Cancer Centre (**PMCC**).

2. At the time of his death, Mr King was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Mr King was receiving these supports due to an acquired brain injury (**ABI**) sustained in a motor vehicle accident in the 1980s, with associated left hemiplegia, epilepsy and cognitive deficits. He was diagnosed with colorectal cancer in early-2020 and received treatment from the PMCC. In December 2021, he underwent a total pelvic exenteration and anterolateral thigh (**ALT**) flap reconstruction for his recurrent squamous cell carcinoma (**SCC**).

3. Mr King is survived by his brothers Paul and James, and sister Cecily, as well as his mother. He enjoyed visiting his mother, who lives in Bendigo, and was well-supported by his siblings. He usually went out most days with a support worker to attend the gym or to watch a movie. He loved cricket, the Rolling Stones, photography, 10-pin bowling, travel and vintage items.

THE CORONIAL INVESTIGATION

4. Mr King's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) he was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr King's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

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.

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. This finding draws on the totality of the coronial investigation into the death of Michael King including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Peter MacCallum Cancer Centre. 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.[2]

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

Circumstances in which the death occurred

8. On 9 November 2022, Mr King was transported to the emergency department (**ED**) of Dandenong Hospital after experiencing vomiting, decreased urine output and lethargy. Clinicians formed the view that he was likely suffering from a urinary tract infection, aspiration pneumonia and a likely small bowel obstruction (**SBO**) on a background of anal cancer. He was intubated and admitted to the intensive care unit (**ICU**) as his condition required significant support.

9. Mr King's condition improved, and he was able to be extubated on 11 November 2022, and was moved to a ward on 14 November 2022. He required re-admission to the ICU for

[2] 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.

increasing oxygen requirements. His acute kidney injury was resolved, and his SBO was decompressed using a nasogastric tube.

10. On 20 November 2022, Mr King was transferred to PMCC for ongoing management of his SBO. He was initially alert and verbal and received intravenous antibiotics. However, he deteriorated with multiple medical emergency team (**MET**) calls for tachypnoea and respiratory distress. He underwent a CT pulmonary angiogram and experienced persistent left moderate ureteric obstruction, a new severe right ureteric obstruction and a new finding of right upper lobe pulmonary embolism. Clinicians offered a nephrostomy insertion, however Mr King's family declined, given his trajectory.

11. Mr King was admitted to palliative care at PMCC and was commenced on a syringe driver. His family were able to visit Mr King whilst he was receiving palliative care, and he passed away peacefully on the morning of 24 November 2022.

Identity of the deceased

12. On 24 November 2022, Michael King, born 9 November 1963, was identified by medical practitioner Dr Ellie Phillips via review of medical records.

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

Medical cause of death

14. On 24 November 2022, medical practitioner Dr Ellie Phillips reviewed Mr King's complete medical history, consulted with another medical practitioner who examined the body, and completed a MCCD. Dr Phillips provided an opinion that the medical cause of death was *aspiration pneumonia*, with other significant contributing conditions of *recurrent anal squamous cell carcinoma and an acquired brain injury following motor vehicle accident.*

15. On 30 September 2024, Forensic Pathologist Dr Paul Bedford at the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the MCCD and the medical records at my direction. Dr Bedford opined that the death did not appear to be related to the ABI from the 1986 motor vehicle accident, however appeared to be causally related to the total pelvic exenteration that occurred in December 2021. Dr Bedford noted that the total pelvic exenteration was not a salvage procedure, and therefore the death was considered reportable, pursuant to the Act, regardless of the deceased's status living in an SDA enrolled dwelling.

16. Dr Bedford provided an opinion that the medical cause of death was *aspiration pneumonia* secondary to *recurrent anal squamous cell carcinoma with surgery.*

    I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Michael King, born 9 November 1963;

    b) the death occurred on 24 November 2022 at Peter MacCallum Cancer Centre, 305 Grattan Street, Melbourne Victoria 3000, from *aspiration pneumonia* secondary to *recurrent anal squamous cell carcinoma with surgery*; and

    c) the death occurred in the circumstances described above.

18. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Dandenong Hospital and Peter MacCallum Cancer Centre, that caused or contributed to Mr King's death.

19. Having considered all the available evidence and taking into account my finding that there is no want of clinical management or care and as, I can see no public interest in holding an inquest (public hearing) into his death I have determined that I will finalise the investigation of Mr King's death in chambers.

I convey my sincere condolences to Mr King's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Mr King's death.

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.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) ASPIRATION PNEUMONIA; 1(b) RECURRENT ANAL SQUAMOUS CELL CARCINOMA WITH SURGERY".

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

Paul King, Senior Next of Kin

Monash Health

PeterMacCallum Cancer Centre

Super Community Care Pty Ltd

Signature:

Date: 29 November 2024

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.