IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 004221

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	John Henry Hamilton
Date of birth:	14 April 1956
Date of death:	2 August 2023
Cause of death:	1(a) Metastatic gastric cancer
Place of death:	Wantirna Health Supportive and Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria
Key words:	In care, metastatic gastric cancer, natural causes, SDA resident

INTRODUCTION

1. On 2 August 2023, John Henry Hamilton was 67 years old when he passed away peacefully in a palliative care unit from natural causes. At the time, Mr Hamilton had resided in an Independence Australia Group Ltd care facility in Croydon for over 20 years.

2. His medical history included cerebral palsy, intellectual disability, epilepsy, asthma, sleep apnoea, anxiety and depression, hearing impairment, age-related memory loss, primary hyper-parathyroidism, parathyroidectomy, pituitary tumour removal in 1999, and insertion of ventriculoperitoneal shunt for hydrocephalus in 2004.

3. Mr Hamilton mobilised with the assistance of a wheelchair. His sister, Magaret Hamilton, noted that while her brother's intellectual disability limited his cognitive ability, he was always able to converse and advocate for himself. He required assistance from his support workers for all aspects of his daily life.

4. Simon McDowell, Head of Quality and Safeguarding at Independence Australia Group Ltd, described Mr Hamilton as a kind, generous, caring, and considerate person with a great sense of humour who liked to have a joke with friends, housemates, and staff. He was a supporter of the Essendon Football Club and enjoyed listening to music and socialising with family, friends, and members of his church.

5. Mr Hamilton's weekly activities included hydrotherapy and gym to maintain his movement. He also participated in activities at Fire and Clay (employment in a supportive environment), attended church, and socialised within the church community.

6. Ms Hamilton described her brother's support workers as *"great"* in caring for her brother, and they always kept in contact with her if there were any issues.

THE CORONIAL INVESTIGATION

7. Mr Hamilton's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act. Regulation 7(1)(d) of the Coroners Regulations

8. 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.

9. 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.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Hamilton's death. The Coroner's 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.

11. This finding draws on the totality of the coronial investigation into Mr Hamilton's death, 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.[2]

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

Identity of the deceased

12. On 2 August 2023, John Henry Hamilton, born 14 April 1956, was visually identified by his sister, Margaret Hamilton, who signed a formal Statement of Identification to this effect.

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

2019 provides that a 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling".* 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling). 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

[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.

Medical cause of death

14. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 3 August 2023 and provided a written report of his findings dated 15 August 2023.

15. The post-mortem examination was consistent with the reported medical history.

16. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Metastatic gastric cancer"*. He was also of the opinion that Mr Hamilton's death was due to natural causes.

17. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

18. In June 2023, Mr Hamilton was diagnosed with metastatic gastric adenocarcinoma with metastases on his liver and lungs. Ms Hamilton stated that her brother made it clear that he did not want to undergo surgery. It was therefore decided that Mr Hamilton would be treated conservatively, and the goals of care would be to keep him as comfortable as possible.

19. On 28 July 2023, Mr Hamilton was assessed by his palliative care team and general practitioner, and it was determined that he would likely require admission to a palliative care unit sooner rather than later.

20. On 31 July 2023, Mr Hamilton was admitted to the Wantirna Health Supportive and Palliative Care Unit for provision of supportive care during the terminal phase of his illness.

21. Mr Hamilton subsequently passed away at 3.21pm on 2 August 2023 with his sister present.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was John Henry Hamilton, born 14 April 1956;

    (b) the death occurred on 2 August 2023 at Wantirna Health Supportive and Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria;

    (c) immediately before death, Mr Hamilton was a "person placed in custody or care" as defined in section 4 of the Act;

(d) the cause of Mr Hamilton's death was metastatic gastric cancer which I consider to be a death from "natural causes" for the purposes of section 52(3A) of the Act; and

(e) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Hamilton'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:

Margaret Hamilton, senior next of kin
Eastern Health
Senior Constable Sean Rickard, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 21 June 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.