IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006610

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Andrew Cameron McDougall
Date of birth:	26 August 1966
Date of death:	28 November 2023
Cause of death:	1a: Bilateral bronchopneumonia in a man with asthma, tetraplegia and multiple other medical co-morbidities
Place of death:	1/23 Hanke Road, Doncaster, Victoria 3108

INTRODUCTION

1. On 28 November 2023, Andrew Cameron McDougall was 57 years old when he was found deceased at his home. At the time of his death, Andrew lived in Supported Disability Accommodation (SDA) in Doncaster.

2. In 2022, Andrew moved to the Doncaster residence and utilised NDIS services in a limited capacity. Closer to his death he required full assistance with personal care.

3. Andrew had a complex medical history including ischaemic heart disease, presumed heart failure, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus with multiple complications, depression, hypertension, Fournier's gangrene and tetraplegia.

4. Andrew had several admissions to hospital in the year preceding his death. He was last admitted to Box Hill Hospital on 15 October 2023 for acute infective exacerbation of COPD and was treated with intravenous (IV) antibiotics before discharging himself against medical advice the following day. He was re-admitted the same day after being slumped over and hypoxic in the hospital lobby and was again treated with IV antibiotics before being discharged on 19 October 2023.

5. Andrew last saw his general practitioner on 23 November 2023 for repeat scripts, a medication chart update and blood test requests to monitor his kidney function. He showed no signs or symptoms of an ongoing or recurrent chest infection.

THE CORONIAL INVESTIGATION

6. Andrew's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Specifically, Andrew was immediately before his death 'a person placed in custody or care', as he was an SDA resident residing in an SDA enrolled dwelling.[1] The death of a person in care must be reported to the Coroner, even if the death appears to have been from natural causes.

7. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or

[1] Regulation 7(d) of the *Coroners Regulations 2019* (Vic).

care. However, as Andrew's death was due to natural causes, I am not required to hold an Inquest.[2]

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Andrew'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.

11. This finding draws on the totality of the coronial investigation into the death of Andrew Cameron McDougall 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

12. On the evening of 27 November 2023, support worker Daisy commenced a sleepover shift providing care for Andrew. She checked on him at around 3am on 28 November 2023, and he appeared well.

[2] Section 52(3A) of the *Coroners Act 2008* (Vic).

[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.

13. At around 6am, Daisy heard noises from Andrew's room and located him lying in bed with foam in his mouth. She repositioned him to drain the fluid and called both Triple Zero and her manager.

14. Daisy and her manager commenced CPR at the direction of the call-taker, until paramedics arrived. Andrew was unable to be revived and was declared deceased at 7:30am.

Identity of the deceased

15. On 28 November 2023, Andrew Cameron McDougall, born 26 August 1966, was visually identified by his sister, Susan Goldrick, who completed a Statement of Identification.

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

Medical cause of death

17. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Andrew McDougall on 29 November 2023. Dr Fronczek considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and scene photographs and provided a written report of her findings dated 4 December 2023.

18. The findings at external examination were consistent with the history. The post mortem CT scan showed the following findings:

    a) Bilateral lung consolidation with air bronchograms

    b) Coronary artery calcifications

    c) Mitral valve calcifications

    d) Bilateral pleural effusions

    e) Ascites

    f) Subcutaneous oedema

    g) Anterolateral rib fractures in keeping with CPR

19. Toxicological analysis of post mortem samples identified the presence of oxycodone (~ 0.01 mg/L), mirtazapine (~ 0.08 mg/L) and bisoprolol (~ 0.1 mg/L).

20. Dr Fronczek provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) BILATERAL BRONCHOPNEUMONIA IN A MAN WITH ASTHMA, TETRAPLEGIA AND MULTIPLE OTHER MEDICAL CO-MORBIDITIES.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Andrew Cameron McDougall, born 26 August 1966;

    b) the death occurred on 28 November 2023 at 1/23 Hanke Road, Doncaster, Victoria 3108;

    c) I accept and adopt the medical cause of death ascribed by Dr Judith Fronczek and I find that Andrew Cameron McDougall, a man with multiple medical comorbidities including asthma and tetraplegia, died from bilateral bronchopneumonia;

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Andrew Cameron McDougall's death was due to natural causes;

3. AND FURTHER, I find that there is no evidence of a relationship or causal connection between the death of Andrew Cameron McDougall and the fact that immediately before his death, he was as a person placed in custody or care.

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

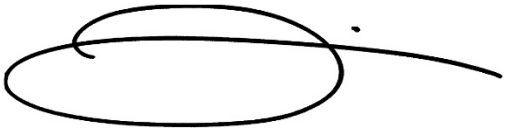
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Codey Ramrakha, Senior Next of Kin

First Constable Rachel Whitehead, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 1 April 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.