IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007104

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Deceased:	Kenneth James Anderson
Delivered on:	28 October 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	28 October 2025
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Ms Olivia Collings, Solicitor
Key words:	In care, Disability Support for Older Australians, cholecystectomy, gallbladder removal, iatrogenic injury

INTRODUCTION

1. On 22 December 2023, Kenneth James Anderson was 85 years old when he died following abdominal surgery. At the time of his death, Mr Anderson lived in Chadstone, Victoria.

2. Mr Anderson was born to Alma and Robert Anderson (**Mr Robert Anderson**). Due to complications during childbirth, Mr Anderson experienced an episode of asphyxia which resulted in permanent brain damage and an intellectual disability. As an adult, he had further diagnoses of Type II diabetes mellitus, Meniere's disease, pancreatitis, gallstones, gastro-oesophageal reflux disease (**GORD**), high blood pressure and Paget's disease. As a consequence, he experienced episodes of increased vertigo, nausea, disorientation and vomiting.

3. Mr Anderson first experienced gall bladder pain in April 2021. An ultrasound revealed a single gallstone, but no cholecystitis.[1] His symptoms resolved with a low-fat diet.

4. Throughout Mr Anderson's adulthood, his father cared for him. When Mr Robert Anderson died, Mr Anderson moved to live with his aunt and uncle. In the 1990s, Mr Anderson began living at a facility managed by OC Connections Limited (**OC Connections**) where he received full time care and assistance with daily tasks. During the week, he attended Wavlink day service operated by the City of Monash

5. Mr Anderson's nephew, Robert Janes (**Mr Janes**) was his guardian and assisted in his medical care. Mr Anderson liked going to Church on Sundays, enjoyed gardening, visiting nurseries to look at and buy plants, and visiting local farmers and makers markets.

INVESTIGATION AND SOURCES OF EVIDENCE

6. This finding draws on the totality of the coronial investigation into the death of Mr Anderson including evidence contained in the coronial file comprising her medical records; the e-Medical Deposition Form completed by Monash Medical Centre, and the inspection report from the Victorian Institute of Forensic Medicine (**VIFM**).

[1] Inflammation of the gallbladder, often caused by gallstones blocking the bile duct.

7. All of this material, together with the inquest transcript, will remain on the coronial file.[2] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

8. The purpose of a coronial investigation of a '*reportable death*'[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

9. The '*cause*' of death refers to the '*medical*' cause of death, incorporating where possible the '*mode*' or '*mechanism*' of death. For coronial purposes, the '*circumstances*' in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[5]

10. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the '*prevention*' role.[6]

11. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations

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[2] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[3] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[4] Section 67(1).

[5] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[6] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[7] These are effectively the vehicles by which the coroner's prevention role can be advanced.[8]

12. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[9]

MR ANDERSON'S *'IN CARE'* FOR THE PURPOSES OF THE ACT

13. An important threshold issue was whether Mr Anderson was an individual placed *'in custody or care'* for the purposes of the Act. If he was such an individual then his death would be reportable by virtue of section 4(2)(c) of the Act and pursuant to section 52(2)(b) of the Act, I would be required to hold an inquest into his death ('a mandatory inquest').

14. At the time of Mr Anderson's death, in late 2023, the definition of a Supported Disability Accommodation (SDA) resident included a person who (a) is an SDA recipient, or (b) a person who is a supported accommodation client under the Continuity of Support Program (**CoS Program**). The CoS Program was a Commonwealth operated program to provide funding for older Australians who had aged out of the National Disability Insurance Scheme (**NDIS**).[10]

15. On 1 July 2021, the CoS Program was replaced by the Disability Support for Older Australians Program (**DSOA Program**). The Federal Government for Disability and Ageing (as it then was) stated that the DSOA Program was a direct replacement of the CoS Program and individuals would only be eligible for the DSOA Program if they were a recipient under the CoS Program.

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[7] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.
[8] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[9] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).
[10] Eligibility for the NDIS ceases at age 65 or 50 for Aboriginal and/or Torres Strait Islander persons.

16. However, despite the CoS Program ceasing to exist, the legislative definition of a 'SDA resident' was not updated to reflect this change until 1 July 2024.[11] As a result, individuals who were receiving support under the DSOA Program (and who met the other criteria for being a person *'in custody or care'*) fell into a legislative gap and would not have, on a strict and literal interpretation, been considered a person *'in custody or care'* for the purpose of the Act. Mr Anderson fell into this gap.

17. Even though Mr Anderson did not meet the legislative requirements as they existed at the time of the death, had he died a year later once the definition of an 'SDA resident' been repealed and re-drafted, he would have been considered a person *'in care or custody'* for the purposes of the Act.

18. The underlying policy consideration requiring that Coroners investigate and hold an inquest into the deaths of persons *'in custody or care'* recognises that these individuals form a vulnerable cohort in our community. Due to this vulnerability, organisations (private or public) that oversee and provide life-sustaining care to these individuals exercise considerable power and it is important, to ensure that these individuals receive appropriate care, that the actions of these organisations are subject to independent scrutiny by the Court.

19. In furtherance of this objective, I considered it appropriate to exercise the discretion to hold an inquest under section 52(1) of the Act.

IDENTITY OF THE DECEASED

20. On 22 December 2023, Kenneth James Anderson, born 6 June 1938, was visually identified by his niece, Meredith Graham, who signed a formal Statement of Identification to this effect.

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

[11] At which time the definition was repealed and the new definition is considerably more broad to include 'a person with a disability who receives or is eligible to receive funded daily independent living support and who is residing or proposed to reside in an SDA enrolled dwelling under an SDA residency agreement or residential rental agreement', pursuant to section 3 of the *Residential Tenancies Act 1997* (Vic).

MEDICAL CAUSE OF DEATH

22. Forensic Pathologist, Dr Hans de Boer, of the VIFM, conducted an inspection on 27 December 2023 and provided a written report of his findings dated 2 January 2024.

23. The post-mortem examination showed signs of medical intervention consistent with the reported history.

24. The post-mortem computed tomography (**CT**) demonstrated coronary artery calcifications, bilateral pleural fluids and increased lung markings, atrophic kidneys and peripheral oedema.

25. Dr de Boer provided an opinion that the medical cause of death was *"1(a) liver ischaemia and portal vein thrombosis complicating emergency cholecystectomy"* secondary to *'1(b) acute cholecystitis'*.

26. I accept Dr de Boer's opinion as to cause of death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

27. On 1 December 2023, Mr Anderson complained of right upper quadrant abdominal pain. OC Connections staff told him to alert them if he experienced increased discomfort. On 4 December 2023, Mr Anderson visited his general medical practitioner (GP), who ordered an ultrasound and blood tests. The results of the latter showed a raised c-reactive protein (**CRP**) and reduced kidney function. According to the GP, *'there were no features of hepatic disorder or biliary inflammation or infection'*. The GP concluded that Mr Anderson had a lower respiratory infection and prescribed antibiotics.

28. On 5 December 2023, Mr Anderson is recorded in the OC Connections journal as feeling better and that he had been having *'extra healthy food options for dinner'*.

29. During a review on 9 December 2023, the ultrasound returned *'inconclusive'* results and Mr Anderson's symptoms were found to be *'improving'*. Repeat blood tests demonstrated a lower CRP, improved kidney function and *'liver function was again satisfactory'*. Mr Anderson was continued on the antibiotics.

30. On 13 and 14 December 2023, Mr Anderson *'started to feel nauseated and had decreased appetite'*. Staff continued to monitor him and on 15 December 2023, Mr Anderson's symptoms continued but he told staff, *'He was ok, just tired'.* A clinician attended the OC Connections residence at 9.55 pm and attributed Mr Anderson's symptoms to his recent course of antibiotics.

31. On 19 December 2023, Mr Anderson re-visited his GP with *'slightly slurred speech and subtle dysarthria'*.[12] The GP ordered a computed tomography (**CT**) and on reviewing the result the following day, identified cholecystitis. According to the GP, blood tests *'showed, for the first time, severely abnormal liver function tests of a cholestatic and hepatic mixed picture'*. The CRP had risen but kidney function improved. The GP referred Mr Anderson to the Monash Medical Centre Emergency Department (**ED**).

32. When Mr Anderson arrived in the ED, he had a tender right upper abdomen, tachycardia and a fever. Clinicians commenced intravenous antibiotics, and an ultrasound confirmed the presence of an acute gallbladder infection with gallstones. Given the *'high likelihood of the gallbladder being gangrenous which could lead to septicaemia'*, clinicians decided surgery was indicated. They spoke with Mr Janes, explained the *'risks of bile duct injury, bleeding and infection',* and obtained verbal consent to the surgery.

33. The following day, 21 December 2023, clinicians commenced the surgery laparoscopically.[13] Operative findings of *'gallbladder gangrene with pus in the gallbladder were confirmed'*. During the procedure, clinicians confirmed that Mr Anderson had Mirizzi's syndrome – a rare complication of gallstones where a stone gets stuck in the neck of the gallbladder or cystic duct, leading to compression of the common hepatic duct.

34. The dissection of anatomical structures was *'difficult due to acute and chronic inflammation'* around the gallbladder and liver. The operating registrar requested assistance from a specialist hepatopancreaticobiliary surgeon, Mithra Sritharan (**Mr Sritharan**). Mr Sritharan entered the theatre to provide *'verbal advice and support'* given the *'operation was not proceeding as planned and was turning out to be difficult'*. Mr

[12] Speech disorder which occurs when the speech muscles are weak or are difficult to control.
[13] *'Keyhole'* surgery.

Sritharan suggested the registrar perform a subtotal cholecystectomy, as a *'safe and performable procedure'*.

35. Mr Sritharan left the theatre but was soon *'asked to urgently return'* to attend to Mr Anderson. At this time, the surgery was complicated by *'bleeding from aberrant, unrecognisable vascular anatomy'.* Mr Sritharan recalled *'it was clear that there had been some major bleeding as a massive transfusion protocol had been activated and Mr Anderson appeared unstable'.* By this time, the surgery had been converted from a laparoscopic to an open procedure.

36. Cholangiograms[14] performed confirmed that *'a major bile duct injury had occurred'* as well as a vascular injury. Dr Sritharan determined *'the safest thing to do was to pack the abdomen'*, to transfer Mr Anderson to the Intensive Care Unit (**ICU**) and awaiting imaging of his injuries.

37. A CT demonstrated that Mr Anderson *'had a completely transected biliary hilum with the right anterior, right posterior and left main ducts all disconnected from an iatrogenic injury. The right hepatic artery had been transected and the right portal vein had been completely occluded in an attempt to repair it'.* Mr Sritharan stated, these were *'all iatrogenic injuries'.* Also identified was *'a clear occlusion of the right portal vein and right hepatic artery and ischaemia of the right side of the liver. The portal vein clot extended through to the main portal vein as well as to the start of the superior mesenteric vein'*.

38. At 9.00 am the following morning, 22 December 2023, Mr Sritharan returned Mr Anderson to theatre and discovered that the right side of his liver was *'dead and not functioning'.* In consultation with another senior liver surgeon, Mr Sritharan decided the right side of the liver needed to be removed. This was done with minimal blood loss. They also performed a portal vein thrombectomy and a large clot was retrieved from the portal vein. On an ultrasound of the vein, the surgeons were not able to locate a blood flow in the portal vein as it had *'re-thrombosed'*.[15]

[14] Medical imaging procedure used to visualise the bile ducts.
[15] Refers to the recurrence of a blood clot in a vein.

39. Given Mr Anderson's critical state, it was not safe to proceed with a reconstruction of the bile ducts injured in the previous surgery. Clinicians applied a surgical dressing and returned him to the ICU.

40. After his return, Mr Anderson's condition deteriorated, and he required increasing support to maintain his blood pressure and blood pH. According to Mr Sritharan, *'these were all signs suggesting that his situation was unrecoverable'.* Clinicians spoke with Mr Janes and informed them of his poor prognosis.

41. Mr Anderson continued to deteriorate, and he died at 7.00 pm that evening.

INTERNAL REVIEW BY OC CONNECTIONS

42. Following Mr Anderson's death, OC Connections conducted an internal investigation regarding the circumstances leading up to the same and provided a copy of its report dated 28 December 2023.

43. OC Connections identified that Mr Anderson's illness, manifesting as abdominal pain, *'could have been escalated earlier'*. However, noted that he did not complain of worsening symptoms which would have prompted staff to organise earlier or more urgent GP appointments.

44. Nonetheless, OC Connections identified a quality improvement opportunity for *'staff to ensure any ongoing symptoms or discomfort are monitored closely and medical appointment made early'.*

45. OC Connections concluded that *'staff responded appropriately to Mr Anderson's complaints of pain, by seeking medical advice and following trough with urgent requests for scans, ultrasounds, blood tests and hospital admission'.*

CORONERS PREVENTION UNIT

46. Given that Mr Anderson's death appeared related to an iatrogenic injury sustained during surgery on 21 December 2023, I sought the assistance of the Coroners Prevention Unit (**CPU**) to aid my understanding of the care provided by Monash Medical Centre.

47. The CPU considered materials including statements contained in the coronial brief, medical records and the VIFM inspection report and a supplementary statement from Niyaz Naqash (**Mr Naqash**), consultant general surgeon who was present during Mr Anderson's procedure on 21 December 2023.

48. Mr Naqash spoke to the preoperative consent process – the surgical registrar explained to Mr Janes that there was a risk of infection, bleeding and bile duct injury. They also explained the risks and benefits to Mr Anderson.

49. When asked whether there was any indication that Mr Anderson's surgery was going to be challenging, Mr Naqash stated that *'a cholecystectomy procedure is always technically challenging when there is existing disease of the pancreas, as Mr Anderson had previous necrotising pancreatitis. This is particularly in the setting of sepsis and acute on chronic presentation as was the case with Mr Anderson'.*

50. Mr Naqash further explained that despite imaging prior to surgery, comprising ultrasound and CT, it was only during the surgery that the extent of his pathology was confirmed. Specifically, Mr Anderson's Mirizzi's syndrome was only identified and diagnosed during the procedure.

51. Mr Naqash stated that *'even with hindsight',* he *'would not have approached the procedure any differently'.* When reflecting on surgeons' actions, Mr Naqash stated, *'everything was done to appropriately manage the complications that arose'.*

52. The CPU concluded that the consent procedure was appropriate and that Mr Anderson and his nephew were appropriately advised of the risks of the surgery, including of a bile duct injury and bleeding. The CPU was of the view that Mr Anderson needed the surgery and would have died of sepsis without it.

53. Regarding the technical nature of the surgery, the CPU agreed with Mr Naqash, that a cholecystectomy is always technically challenging when there is existing disease of the pancreas. All preoperative investigations were carried out - ultrasound and CT - however, these scans have limited utility when delineating complex pathology which can only be found in theatre when the organs are exposed, such as Mr Anderson's Mirizzi's syndrome.

54. Mr Anderson's death was reviewed at the Monash Health Mortality and Morbidity Meeting and no issues were identified. The case was also referred to the Victorian Audit of Surgical Mortality, of the Royal Australian College of Surgeons, and no areas of consideration or concern were identified.

55. The CPU provided its opinion that Mr Anderson underwent a procedure for gallstones in the setting of septic shock with multiple co-morbidities. Complications arising from the procedure were not unexpected given Mr Anderson's clinical presentation and subsequent intra-operative findings.

56. The CPU did not identify any issues associated with Mr Anderson's death.

FINDINGS AND CONCLUSION

57. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [16]

58. Having applied the applicable standard of proof to the available evidence, I find that:

    (a) the identity of the deceased was Kenneth James Anderson, born 6 June 1938;

    (b) the death occurred on 22 December 2023 at Monash Medical Centre, 246 Clayton Road, Victoria;

    (c) the medical cause of Mr Anderson's death was liver ischaemia and portal vein thrombosis complicating emergency cholecystectomy secondary to acute cholecystitis; and

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

[16] *Briginshaw* v *Briginshaw* (1938) 60 C.L.R. 336 especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

59. The available evidence supports a finding that Mr Anderson's death occurred as a known and not unexpected complication of a cholecystectomy.

60. I accept and adopt the opinion of the CPU and find that surgeons could not have known the extent of Mr Anderson's disease until the time of the procedure and that they responded appropriately to complications which subsequently arose.

61. The available evidence does not support a finding that there was any want of care on the part of OC Connections staff or want of clinical management and care on the part of the clinical staff of Monash Health that caused or contributed Mr Anderson's death.

62. I convey my sincere condolences to Mr Anderson's family for their loss.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Meredith Graham, senior next of kin
Monash Health
Constable Kyle Sellers, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 06 November 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 inquest. 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.