IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001880

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Mukesh Jayantilal Sanghavi
Date of birth:	2 April 1955
Date of death:	2 April 2024
Cause of death:	1(a) complications post trauma related acquired brain injury
Place of death:	Calvary Health Care Bethlehem Aged Care 476 Kooyong Road Caulfield South Victoria 3162
Date of hearing:	3 December 2024
Counsel Assisting the Coroner:	Dr Declan McGavin, Coroner's Solicitor
Key Words:	Homicide, acquired brain injury

INTRODUCTION

1. Mukesh Jayantilal Sanghavi was 69 years old when he died in a residential aged care facility on 2 April 2024. Mukesh moved into the facility because of his persisting care requirements from injuries sustained in an unprovoked violent assault by a stranger in December 2021. These injuries included brain bleed with acquired brain injury and left sided paralysis and facial and hip fractures.

2. Prior to the assault, Mukesh worked as a software engineer. Mukesh was born in Mumbai on 2 April 1955 and migrated to Australia in 1984 for business with his then partner and later wife. His wife sadly died in 2015.

3. Mukesh was known as a highly disciplined, spiritual, and kind natured person. He was born Jain and was later a devotee of Sathya Sai Baba – he followed Sathya Sai's slogan "love all, serve all". Mukesh had strong connections to many religious groups in Melbourne including Hare Krishna, Jain, many churches, Sikh Gurudwaras and Sathya Sai Centres.

THE CORONIAL INVESTIGATION

4. Mukesh'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.

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. The Act recognises that it is in the public interest to hold a public hearing when a person causes the death of another. It is mandatory for a coroner to hold an inquest if the death occurred in Victoria and the coroner suspects the death was the result of homicide.

7. The forensic pathologist formulated the medical cause of death as *complications post trauma related acquired brain injury*. This is sufficient to draw a causal connection between the unprovoked violent assault and the death. As such, I suspect that the death was the result of homicide and therefore an inquest must be held.

8. However, a coroner is not required hold an inquest in such circumstances where a person has been charged with an indictable offence in respect of the death being investigated.[1] Victoria Police laid charges in respect of the assault, and the accused, Daniel Darbyshire, pleaded guilty to Recklessly Causing Serious Injury in Circumstances of Gross Violence on 14 September 2022. Dr Darbyshire died prior to sentencing.

9. This all occurred prior to Mukesh's death. As such, I did not consider it appropriate to exercise my discretion not to hold an inquest into the death. In other words, I elected to proceed with holding an inquest. No witnesses were called at inquest as I was satisfied that I could make the required findings on the available materials. Nonetheless, I considered it in the public interest to hold a public hearing to deliver these findings.

10. The Act prohibits a coroner to include in a finding or comment any statement that a person is, or may be, guilty of an offence.[2] This does not preclude a coroner from making findings that a person contributed or caused the death of another so long as such a finding does not express any judgment or evaluation of the legal effect of that finding.[3]

11. This finding draws on the totality of the coronial investigation into the death of Mukesh Jayantilal Sanghavi. 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.[4]

BACKGROUND

12. Following the assault on 17 December 2021, Mukesh was admitted to The Alfred in a critical condition with threatened airway, bleeding behind the eye, a large right basal ganglia intraparenchymal haemorrhage and a small right temporal sulcal traumatic subarachnoid haemorrhage, numerous facial fractures and a left neck of femur fracture. He also had spinal ligament tears and aspiration pneumonitis. He was intubated and transferred to the intensive care unit.

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[1] Section 52(3)(b) of the Act.
[2] Section 69 of the Act.
[3] As Callaway JA observed in *Keown v Khan and ANOR* [1999] 1 VR 69: *"[a] coroner…will ordinarily set out the relevant facts in the course of finding how death occurred and the cause of death. The facts will then speak for themselves, leaving readers of the record of investigation to make up their own minds"*
[4] 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. Following a lengthy admission at The Alfred, Mukesh was transferred to Caulfield Hospital and, as result of his ongoing dense left hemiplegia and high care needs, was moved to residential aged care.

14. Mukesh did not regain the ability to walk and was wheelchair bound. He required assistance with many daily living activities including being assisted by two staff members with the use of a sling hoist for transfers.

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

Circumstances in which the death occurred

15. On 1 April 2024, Mukesh tested positive for COVID-19 with fever being his only symptom. A locum doctor reviewed Mukesh and prescribed antiviral medications.

16. At about 6pm on 2 April 2024, Mukesh suddenly became more unwell and called for assistance. Staff called for a nurse to review Mukesh as he also looked unwell. When the nurse reviewed Mukesh, he became unresponsive, and a Code Blue was called. Staff performed CPR and called Triple Zero.

17. Paramedics from Ambulance Victoria attended soon after but unfortunately, Mukesh was deceased and could not be revived.

Identity of the deceased

18. On 18 April 2024, Mukesh Jayantilal Sanghavi, born 2 April 1955, was visually identified by a friend, who completed a statement of identification.

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

Medical cause of death

20. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 5 April 2024 and provided a written report of the findings.

21. The examination showed evidence of the existing head injuries from the assault with no new changes.

22. Dr Bedford noted the history of COVID-19. However, Dr Bedford explained that it was not entirely clear if the death was directly owing to this infection. Dr Bedford commented that the deceased had been adversely affected by the brain injury which would predispose to an infection and early death.

23. Dr Bedford provided an opinion that the medical cause of death was *1(a) complications post trauma related acquired brain injury.*

24. I accept Dr Bedford's opinion.

FAMILY CONCERNS

25. Mukesh's family reported that he was very fit prior to the assault and believed that the assault caused him to be physically vulnerable to medical conditions such as COVID-19. The family believed that the assault shortened Mukesh's life significantly.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mukesh Jayantilal Sanghavi, born 2 April 1955;

    b) the death occurred on 2 April 2024 at Calvary Health Care Bethlehem Aged Care 476 Kooyong Road, Caulfield South from *complications post trauma related acquired brain injury*; and

    c) the death occurred in the circumstances described above.

I find that the assault on Mukesh in December 2021 significantly contributed to his death.

I convey my sincere condolences to Mukesh's family and friends for their loss.

Pursuant to section 73(1) of the Act, this finding is to be published on the Court's website in accordance with the rules.

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

Praveen Voda, Senior Next of Kin

Signature:

Coroner Dimitra Dubrow

Date : 05 December 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.