IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003855

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Bradley Kenneth Albert Craig
Date of birth:	15 December 1989
Date of death:	6 July 2024
Cause of death:	1(a) Complications of oesophageal cancer
Place of death:	St John of God Frankston Rehabilitation Hospital, 255-265 Cranbourne Road, Frankston, Victoria, 3199
Keywords:	Death in care; disability; natural causes

INTRODUCTION

1. On 6 July 2024, Bradley Craig was 34 years old when he died at St John of God Frankston Rehabilitation Hospital ('**SJGFRH**'). At the time of his death, Bradley lived in Supported Disability Accommodation ('**SDA**') in Langwarrin.

2. Bradley was born with Cri Du Chat syndrome and was non-verbal and non-communicative since birth. He required full-time care for his physical and intellectual disability which was provided by his parents Wendy and Roger Craig for the majority of his life.

3. In 2018, Bradley was diagnosed with Barrett's oesophagus and in 2020, he was placed into Supported Disability Accommodation after the passing of his mother Wendy.

4. In June 2022, Bradly was diagnosed with oesophageal cancer and was not a candidate for treatment. He was treated in the community though Visiting Medical Officers at STGFRH.

5. In March 2024, Bradley underwent a gastroscopy which indicated that there was a progression of his oesophageal cancer. During this time, Bradley continued to decline and his father, the Peninsula Home Hospice Palliative Care team and carers of his accommodation collectively decided to develop a Palliative Care Plan to maintain his comfort. Bradley was cared for by staff at his disability accommodation before being transferred to SJGFRH on 13 June 2024.

6. Bradley was much-loved by his family and stayed at his father's home every second weekend to spend time with his sister and nieces. He enjoyed being around people and attended the MiLife-Victoria program five days per week where he would participate in the group activities, learn new skills and make meaningful connections.

THE CORONIAL INVESTIGATION

7. Bradley'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, Bradley 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 or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

8. 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.*

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

9. 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.

10. 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.

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

12. This finding draws on the totality of the coronial investigation into the death of Bradley Craig 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

13. Between 13 June 2024 and 6 July 2024, Bradley was admitted to SJGFRH palliative care with the aim of supporting his quality of life and managing his symptoms. His symptoms included swallowing difficulties, vomiting and weight loss due to reduced intake.

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

[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.

14. He initially tolerated a pureed diet and moderate thickened fluids and was continuously monitored by SGFRGH's dietetics and speech pathology team with safe swallowing strategies implemented.

15. Between 23 June and 30 June 2024, Bradley began to have several aspiration episodes when given thickened liquid, likely due to his tumour obstructing his oesophagus. In the last week of his life, Bradley continued to deteriorate and received comfort care. Bradley died at 8.30am on 6 July 2024 in the presence of his sister.

Identity of the deceased

16. On 16 July 2024, Bradley Kenneth Albert Craig, born 15 December 1989, was visually identified by his father, Roger Craig, who completed a Statement of Identification.

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

Medical cause of death

18. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Bradley Craig on 15 July 2024. Dr Burke considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and E-Medical Deposition provided by SJGFRH and provided a written report of his findings dated 20 August 2024.

19. The findings of post mortem CT scan included thickened, irregular oesophageal wall and multiple metastases in lungs and head (with no acute changes).

20. The findings at external examination were consistent with the reported circumstances.

21. Toxicological analysis of post-mortem toxicology samples was not indicated and was therefore not performed.

22. Dr Burke provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF OESOPHAGEAL CANCER.

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 Bradley Kenneth Albert Craig, born 15 December 1989;

b) the death occurred on 6 July 2024 at St John of God Frankston Rehabilitation Hospital, 255-265 Cranbourne Road, Frankston, Victoria, 3199;

c) I accept and adopt the medical cause of death ascribed by Dr Burke and I find that Bradley Kenneth Albert Craig, a man with Cri Du Chat syndrome, died from complications of oesophageal cancer.

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Bradley Kennth Albert Craig's death was due to natural causes, and I find there is no relationship or causal connection between his death and his status as a person placed in custody or care immediately before his death.

I convey my sincere condolences to Bradley'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:

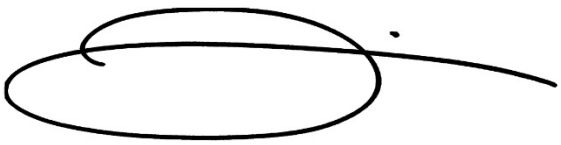
Roger Craig, Senior Next of Kin

Kelly Livings, St John of God Health Care

Naomi Baquing, Scope Australia

Senior Constable David Martin, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 22 May 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.