IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006619

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	William Anthony Daniel
Date of birth:	23 April 1952
Date of death:	09 November 2024
Cause of death:	1a : COMPLICATIONS OF A GASTRODUODENAL PERFORATION (PALLIATED) IN THE SETTING OF MULTIPLE MEDICAL COMORBIDITIES
Place of death:	Box Hill Hospital 8 Arnold Street, Box Hill Victoria 3128
Keywords:	In care, natural causes death, SDA resident

INTRODUCTION

1. On 09 November 2024, William Anthony Daniel **(William)** was 72 years old when he died at Box Hill Hospital. William is survived by his sister, Ms Marian Brennan **(Marian)** and nephew, Mr Justin Brennan.

2. William's medical history included intellectual impairment, glaucoma, hypertension and osteoporosis. He was independent with most daily activities and used a four-wheel frame to mobilise.

3. At the time of his death, William was a Specialist Disability Accommodation **(SDA)** resident residing in an SDA enrolled dwelling at 4 Woodcrest Road Vermont, 3133. William received funding under the Disability Support for Older Australians program.

4. On 29 October 2024, William presented to the Box Hill Hospital's Emergency Department following an unconscious collapse in the setting of nausea, vomiting and deceased oral intake. His symptoms resolved on 30 October, and a CT abdomen was conducted with no abnormalities detected. William was discharged and returned to his supported accommodation.

5. William re-presented to Box Hill Hospital on 31 October 2024 with postural dizziness and deceased oral intake. His carers reported that he had one vomit but had not complained of abdominal pain. William was treated with intravenous fluids, and his symptoms improved the following day. He was again returned to his supported accommodation.

THE CORONIAL INVESTIGATION

6. William'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. The death of a person in care or custody[1] is a mandatory report to the coroner, even if the death appears to have been from natural causes. William was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as he was *"a prescribed person or a person belonging to a prescribed class of person"* due to her status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

[1] See the definition of 'reportable death' in section 4 of Act, especially section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) of the Act.

[2] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of William's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of William Anthony Daniel 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

11. On 7 November 2024, William presented to Box Hill Hospital with postural hypotension, nausea, vomiting and abdominal pain. He underwent a CT scan of the brain which did not indicate any acute intracranial haemorrhage, territorial infarction or any space occupying lesion. He remained in hospital for further observation due to suspicion of gastrointestinal bleeding.

12. On 8 November 2024, an abdominal CT scan revealed that William had a possible gastroduodenal perforation with free fluid and pneumoperitoneum. The General Surgical Unit **(GSU)** discussed these findings with Marian. A diagnostic laparoscopy was discussed;

[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.

however, it was decided that it would not improve William's quality of life and surgery had the potential to decondition him further. William would be offered a short trial of medical management, intravenous antibiotics and serial examination, with a view to palliation if his condition deteriorated or no improvements were seen.

13. At 7.15pm that evening, a Medical Emergency Team call was required as William had an increased respiratory rate. He also reported 10/10 pain in his abdomen. William was commenced on subcutaneous morphine and intravenous fluids. He was then reviewed by the Hospital Medical Officer at 10.30pm where his blood pressure was 100/68 with a rigid abdomen. The agreed plan with the on-call Consultant was that if William were to deteriorate before the morning, he would be for a transition to end of life care.

14. At 7am on 9 November 2024, William was reviewed by the GSU, and the impression was that he was critically deteriorating and unlikely to survive this episode. William subsequently died at 9.07am.

Identity of the deceased

15. On 14 November 2024, William Anthony Daniel, born 23 April 1952, was visually identified by his nephew, Justin Brennan.

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

Medical cause of death

17. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an external examination on 15 November 2024 and provided a written report of her findings dated 11 December 2024.

18. The post-mortem examination showed changes in keeping with the clinical history. There were no signs of injury. The CT scan revealed cerebral oedema, bilateral pleural effusions, hyperinflated lungs and focal coronary artery calcifications.

19. Dr Francis provided an opinion that the medical cause of death was 1*(a) Complications of a gastroduodenal perforation (palliated) in the setting of multiple medical comorbidities*. Dr Francis considered that the death was due to natural causes.

20. I accept Dr Francis's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was William Anthony Daniel, born 23 April 1952;

    b) the death occurred on 09 November 2024 at Box Hill Hospital, 8 Arnold Street Box Hill Victoria 3128, from natural causes, namely, complications of a gastroduodenal perforation (palliated) in the setting of multiple medical comorbidities the death occurred in the circumstances described above.

22. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that William died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to William'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:

Marian Brennan, Senior Next of Kin

Yvette Kozielski, Eastern Health

First Constable Cameron Churchill, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 29 January 2026

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.