IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 002575

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*
*Section 67 of the **Coroners Act 2008***

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| Findings of: | Sarah Gebert, Coroner |
| Deceased: | PDR |
| Date of birth: | 1946 |
| Date of death: | 12 May 2025 |
| Cause of death: | 1(a) Acute pancreatitis |
| Place of death: | Austin Hospital, 145 Studley Road, Heidelberg, Victoria |
| Key words: | In custody, natural causes death |

## INTRODUCTION

1. On 12 May 2025, PDR was 78 years old when he died at the Austin Hospital.

2. At the time of his death, PDR was in custody at Thomas Embling Hospital (**Thomas Embling**).

## THE CORONIAL INVESTIGATION

3. PDR'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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

4. 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.

5. 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.

6. Victoria Police assigned Senior Constable Sarah Beagley to be the Coroner's Investigator for the investigation of PDR's death. The Coroner's 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.

7. This finding draws on the totality of the coronial investigation into PDR's death, 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.[1]

[1] 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.

**Background**

8. PDR was born in Germany and moved to Australia with his family when he was approximately two years old.

9. When PDR was 16 years of age, he joined the military.

10. PDR met a woman whom he went on to marry. His wife already had a daughter, and the couple welcomed two sons together. The family briefly lived in New Guinea while PDR was stationed there. In around 1983, PDR and his wife divorced. His wife and the children then moved back to Victoria.

11. PDR was deployed to the Vietnam War. His son, EVH, recalled that PDR was not well when he returned from Vietnam.

12. In 1998, one of PDR's sons died in a motor vehicle accident.

13. PDR's mental health history included diagnoses of post-traumatic stress disorder, schizophrenia, anxiety, depression, and a history of self-harm and seclusion.

14. In 2001, PDR attended the Broadmeadows Police Station and stabbed a Victoria Police Officer who was performing reception duties at the front desk. In 2002, the Supreme Court of Victoria determined that PDR was not guilty by reason of mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) for the charges of attempted murder, intentionally cause serious injury, and recklessly cause serious injury. PDR was committed to the custody of the Victorian Institute of Forensic Mental Health under a Custodial Supervision Order (**CSO**). He was placed in the custody of the Thomas Embling, which is operated by Forensicare.

15. PDR's medication regime fluctuated during his time at Thomas Embling, but from 2017, PDR's mental health was managed with olanzapine, amisulpride, risperidone, and venlafaxine.

16. PDR's physical health history included ischaemic heart disease with sinus bradycardia, shortness of breath, gait disturbance, chronic kidney disease, type II diabetes, hearing impairment, cervical osteoarthritis, subclinical hypothyroidism, angina, hypertension, alcohol use disorder, smoking cigarettes, pain, sleep difficulty and Hashimoto's disease.

17. PDR was also prescribed metformin, vitamin C, levothyroxine, hydrochlorothiazide, enalapril, melatonin, salbutamol, and maltofer, for his physical health needs.

18. In April 2022, following a Major Review Hearing, it was determined that PDR would not be released from the CSO. PDR's delusions intensified, and his risperidone dose was increased to alleviate these symptoms. He also showed increased levels of confusion, poor mobility, reduced engagement in activities, and a slowed heart rate.

19. On 22 January 2025, PDR agreed to be referred for discharge to the Berengarra Psychogeriatric Nursing Home and was on a waiting list for transfer.

20. PDR's main health concerns in 2025 related to his reduced mobility, he required a wheelchair when travelling long distances, experienced near-choking episodes, and dizziness. On 31 March 2025, he was reviewed by a speech pathologist at the Austin Hospital who found that PDR had oesophageal dysmotility and placed him on a modified diet to mitigate his choking risk.

21. Throughout 2025, staff at Thomas Embling observed no signs of acute illness in PDR, he was adhering to his medications and was eating and drinking well. Nursing staff recorded his vital signs daily which were largely within normal limits except for the occasional reading of raised blood pressure.

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

### Circumstances in which the death occurred

22. On 3 May 2025, PDR reported to staff that he was experiencing nausea and was observed vomiting at 1.40pm. Nursing staff took PDR's vital signs, and a medical emergency was declared due to a significant drop in his blood pressure. PDR was placed under constant observations and an on-call registrar attended for review.

23. At 2.15pm, an electrocardiogram was performed with no notable findings, and emergency services were contacted. At 2.23pm, PDR vomited again and experienced faecal incontinence.

24. Ambulance Victoria paramedics arrived at 2.40pm. At this time, PDR reported dizziness, abdominal cramps, and feeling cold. At 2.55pm, PDR was transferred via ambulance from Thomas Embling to the emergency department of the Austin Hospital (**the Austin**).

25. At the Austin, a computed tomography (**CT**) scan of PDR's abdomen and pelvis was suggestive of acute interstitial oedematous pancreatitis. PDR was commenced on supportive treatment of intravenous fluid therapy, analgesia, and anti-emetics.

26. On 5 May 2025, staff from the Austin observed a deterioration of PDR's haemodynamic status, which indicated a worsening of his condition.

27. Staff from the Austin had a conversation with PDR's son, and goals of comfort care for PDR were discussed. On 6 May 2025, he was transferred to the palliative care ward.

28. PDR was declared deceased on 12 May 2025 at 9.40pm.

29. Thomas Embling completed a 'Brief Incident Review Report' into the events of 3 May 2025. The report noted that in the week prior to the incident, there were no indications of any obvious deterioration in PDR's health. However, some of his prescribed medications were rarely associated with the side effect of pancreatitis.

30. The report noted that on 24 March 2025, PDR's creatinine level was slightly elevated and the results were signed by a registrar but without a written name or date. PDR's chronic kidney disease was also referenced in his Physical Health Summary but not in his Consumer Pathway Plan.

31. The report recommended that discussions with the registrar group and general practitioners take place to ensure abnormal blood results are followed up. The report also recommended that all active physical health conditions that require ongoing oversight are included in the Consumer Pathway Plan, with a transition away from the Physical Health Summary.

**Identity of the deceased**

32. On 12 May 2025, PDR, born 1946, was identified by a staff member of Thomas Embling Hospital, Rejina Karian.

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

**Medical cause of death**

34. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 14 May 2025 and provided a written report of his findings dated 15 May 2025.

35. The post-mortem examination and CT scan revealed peripancreatic oedema and streakiness, renal cysts, increased lung markings, and coronary artery calcification.

36. Dr Young provided an opinion that the medical cause of death was *"1(a) Acute pancreatitis"*.

37. Dr Young considered that death was due to natural causes.

38. I accept Dr Young's opinion.

## FURTHER INVESTIGATION

### Coroners Prevention Unit review

39. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**)[2] regarding the health care PDR received proximate to his death while at Thomas Embling.

40. The CPU reviewed PDR's medical records pertaining to his care and considered that the care provided was reasonable.

41. The CPU stated that the cause of PDR's pancreatitis was unclear, and that while some of his antipsychotic medication may cause pancreatitis in rare circumstances, they had not done so in the decades that he had been taking them. The CPU also noted that PDR needed the medications and that the alternatives were far more toxic.

42. In conclusion, the CPU found no areas of concern with PDR's medical management and considered that his death could not be predicted, and thus, could not be prevented.

43. I accept the advice of the CPU on these matters.

## FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was PDR, born 1946;

    (b) the death occurred on 12 May 2025 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, from acute pancreatitis; and

[2] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

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

I convey my sincere condolences to PDR'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:

EVH, senior next of kin
Austin Health
Victorian Government Solicitor's Office
Forensicare (care of Lander & Rogers)
Senior Constable Sarah Beagley, Victoria Police, Coroner's Investigator

Signature:


Coroner Sarah Gebert

Date: 27 February 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.