IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003332

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Christopher Francis O'Riley
Date of birth:	14 February 1968
Date of death:	15 June 2025
Cause of death:	1(a) Aspiration pneumonia complicating locally advanced non small carcinoma of lung
Place of death:	Royal Melbourne Hospital 300 Grattan Street Parkville Victoria 3050
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 15 June 2025, Christopher Francis O'Riley was 57 years old when he died at the Royal Melbourne Hospital, 300 Grattan Street, Parkville Victoria 3050.

2. At the time of his death, Christopher resided at 52 Clydesdale Road, Airport West, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Christopher received funded daily independent living support due to his complex medical and care needs, which was provided by disability service provider, Scope (Aust) Ltd.

3. Christopher was fostered by parents, Terrence and Anne O'Riley, from the age of three months. His biological mother was unable to care for him due to her diagnosis of schizophrenia and being in care herself. He was the much-loved brother to siblings Michael, Sean, Sue, Cathy, Tim and Jane.

4. As a young boy, Christopher was diagnosed with cancer and received treatment from the Royal Children's Hospital. At the age of 16, Christopher started to experience mental health issues and was eventually diagnosed with schizophrenia. Christopher's parents noted that his mental health issues prevented him from having a full-time job or a relationship.

5. When Christopher was about 26 years old, he was diagnosed with a frontal lobe tumour. His medical history also included an acquired brain injury, depression, epilepsy, dysphagia, type 2 diabetes, high blood pressure, hypothyroidism, reflux, gout, insomnia, tardive dyskinesia and left nephrectomy in 2016 due to grade 3 carcinoma.

6. In late-2020, Christopher experienced a series of seizures and was admitted to the Royal Melbourne Hospital (**RMH**). He was in hospital for nearly 12 months, followed by five months of rehabilitation. During this admission, Christopher's mobility and cognitive ability declined significantly and he became wheelchair bound.

THE CORONIAL INVESTIGATION

7. Christopher's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided

in an SDA enrolled dwelling immediately prior to his death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

8. 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.

9. 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.

10. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

11. This finding draws on the totality of the coronial investigation into the death of Christopher Francis O'Riley including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission. 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.[2]

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

[2] 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.

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

Identity of the deceased

12. On 15 June 2025, Christopher Francis O'Riley, born 14 February 1968, was visually identified by his sister, Jane O'Riley.

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

Medical cause of death

14. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 17 June 2025 and provided a written report of his findings dated 19 June 2025.

15. The post-mortem examination revealed findings consistent with the reported circumstances.

16. Examination of the post-mortem computed tomography (**CT**) scan showed a remote left craniotomy, left frontal encephalomalacia, right hilar mass, right-sided pulmonary consolidation and absent left kidney.

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

18. Dr Lynch's provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia complicating locally advanced non small carcinoma of lung.

19. Dr Lynch provided an opinion that the cause of death was due to natural causes.

20. I accept Dr Lynch's opinion as to the medical cause of death.

Circumstances in which the death occurred

21. In late-February 2025, Christopher's carers observed that he appeared more tired than usual and declined his food and medication. They booked an appointment for him to be reviewed by his general practitioner. While awaiting the appointment, staff became concerned that his condition continued to deteriorate, so they called Triple Zero. Christopher was transported to the RMH where he was diagnosed with lung cancer.

22. Due to the extent of the cancer, clinicians advised that chemotherapy and other aggressive treatment would not be in Christopher's best interests. Christopher's family and clinicians agreed to provide palliative and comfort care measures.

23. Christopher was discharged from the RMH back to his SDA on 11 March 2025. While he appeared to be happy that he was home, staff observed that he was often fatigued and preferred to stay at home, rather than participate in social outings.

24. Christopher's health declined over the following months. He remained at home during this time and was well-supported by the palliative care team and other clinicians. From 3 to 7 June 2025, Christopher was admitted to the RMH again due to increased facial swelling.

25. On 13 June 2025, Christopher's carers observed he was less responsive than usual and had drool running down the right side of his face. Carers called Triple Zero and paramedics transported Christopher to the RMH. Following a consultation between Christopher's family and RMH clinicians, Christopher was admitted to a palliative care ward. Christopher peacefully passed away on the morning of 15 June 2025, surrounded by his loved ones.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Christopher Francis O'Riley, born 14/02/1968;

    b) the death occurred on 15 June 2025 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville Victoria 3050 from aspiration pneumonia complicating locally advanced non small carcinoma of lung; and

    c) the death occurred in the circumstances described above.

27. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at the RMH, that caused or contributed to Christopher's death.

28. Having considered all the available evidence, I find that Christopher's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Christopher's death in chambers.

I convey my sincere condolences to Christopher's family, friends and carers 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:

Terence John O'Riley, Senior Next of Kin

Scope (Aust) Ltd

Senior Constable Jawaher Afaneh, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 09 October 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.