IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000437

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	CM
Date of birth:	25 July 1968
Date of death:	23 January 2024
Cause of death:	1a: DIABETIC KETOACIDOSIS
Place of death:	35 McPhee Street Hamilton Victoria 3300
Keywords:	'In care' death, natural causes

INTRODUCTION

1. On 23 January 2024, CM was 55 years old when he was discovered deceased in his bedroom at his residential care facility (**the facility**). At the time of his death, CM lived at 35 McPhee Street, Hamilton, Victoria, 3300 at the facility administered by SCOPE Disability Support Services.[1]

Background[2]

2. CM was born with severe disabilities following complications at birth. According to his sister, DM, CM's disabilities resulted from a lack of oxygen to his brain immediately after he was born.

3. CM was non-verbal and, initially, he was unable to walk. After numerous surgical procedures, however, he 'learnt to walk as a teenager'.

Residential care

4. CM lived at home until he was about twelve years old. During this time CM only attended a day training centre in Warrnambool to assist him to cope with his disabilities. In his teenage years, however, CM moved to an institution in Colac where he learned to walk. He lived at the Colac institution until he was about 20 years old.

5. CM left the institution in Colac when his family found a group home for him in Hamilton which 'had 24-hour supervision'. Although this facility had moved to a different location while CM was a resident there, CM remained at the same facility 'for 34 years' until his death.[3]

6. According to DM, the staff at the facility were professional and took good care of her brother. CM's family appreciated all the staff did for him at their facility. DM described the manner in which the staff cared for CM as 'fantastic' and he 'loved living at the house in Hamilton'.

Health concerns

[1] CM was a participant in the National Disability Insurance Scheme (**NDIS**).
[2] Coronial Brief of Evidence [**CB**], statement of DM.
[3] CB, Statement of Anthony McCormick, General Manager, Scope (Aust) Ltd

7. Apart from his physical and mental disabilities, CM did not suffer 'ongoing medical issues in his youth'. However, when he was about 40 years old, CM was diagnosed with Type 2 Diabetes Mellitus which was managed by medication and by adapting his diet.

8. In the 'last couple of years' leading to his death, CM 'started having a few turns' which was diagnosed as 'a form of epilepsy'. Despite his disabilities, however, CM was always happy and 'enjoyed being around' his family and friends.[4]

Medical management of CM's health concerns[5]

9. Dr Alan Reid of the Hamilton Medial Group (**HMG**) was CM's usual doctor (**GP**). According to Dr Reid, CM had been his patient since February 2021.

10. Dr Reid observed a decline in CM's health over a period of several months leading to 'his passing'. During the same period CM 'required several trips to the Western District Hospital Emergency Department' (**ED**) where he consulted a specialist medical team to assist in the management of CM's complex health concerns.

11. Dr Reid also referred CM to consultant Neurologist and Physician, Dr Michael McVeigh. According to Dr McVeigh, 'in the months leading up' to his 'passing' CM was 'approaching the terminal phase of his life'.

THE CORONIAL INVESTIGATION

12. CM'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.

13. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects that the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

[4] CB, statement of DM.
[5] CB, statements of Dr Alan Reid and Dr Michael McVeigh, Consultant Physician and Neurologist.

14. Immediately before his death, CM was a person placed in care. However, section 52(3A) of the Act provides an exception to the position under section 52(2), that the coroner is not required to hold an Inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an Inquest into CM's death.

15. 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.

16. 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.

17. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of CM'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.

18. This finding draws on the totality of the coronial investigation into the death of CM 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.[6]

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

Circumstances in which the death occurred[7]

19. On 16 January 2024, Scope staff observed that CM's appetite was suppressed. He declined 'oral intake including his medication'. Scope staff then conveyed CM to the ED where he was assessed and subsequently discharged. The ED clinicians advised Scope staff to monitor CM.

[6] 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.

[7] CB, statement of Anthony McCormick

On the same day, when Scope staff, who were attending to CM at the time, observed that he was having a seizure, they administered medication to treat his symptoms.

20. On 17 January 2024, Scope staff alerted emergency services when CM started vomiting. CM was then conveyed to the ED by ambulance. After ED clinicians assessed CM, he was sent home and attending staff were advised to monitor him. Dr Renfrey of the HMG attended to CM and assessed his blood sugar levels which was found to be 'consistently high' despite 'reduced oral intake'. Dr Renfrey did not have any immediate concerns but advised the Scope staff to continue to monitor CM's condition.

21. In the days that followed, Scope staff reported that CM 'enjoyed most of his meals and appeared [to be] happy'. However, between 21-22 January 2024, Scope staff observed that CM was 'weak and lethargic'. On the same day, Scope staff initiated a telehealth consultation with CM's GP which was conducted in the presence of CM's father JM.

22. According to Anthony McCormick, Scope General Manager, JM advised the GP that 'he did not want his son to endure medical investigation, intravenous fluid/medications, nasogastric or PEG feeding'. JM also 'asked the GP to respect [his son's] choice to decline all oral intake including medications'.

23. On 23 January 2024, when his condition continued to decline, Scope staff informed CM's family of his 'sleep disturbances', 'reduced strength' and 'shallow breathing'. According to Mr McCormick, CM's family told Scope staff that they wanted CM 'to be comfortable and pain free in his current home'.

24. At approximately 3 pm, CM passed away.

Identity of the deceased

25. On 23 January 2024, CM, born 25 July 1968, was visually identified by Scope staff member, Angela Hollis, who signed a formal Statement of Identification.

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

Medical cause of death[8]

27. Forensic Pathology Fellow Dr Michael Duffy of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination upon the body of CM under the supervision of Forensic Pathologist, Dr Judith Fronczek, on 24 January 2024 and provided a written report of his findings dated 10 April 2024.

28. In the execution of his duties, Dr Duffy considered the following sources documents:

    i. Victoria Police Report of Death, *Form 83*;
    ii. The VIFM contact log from Coronial Admissions and Enquiries (**CAE**);
    iii. Post-mortem computed tomography (**CT**) scan;
    iv. Documents from the residential facility;
    v. VIFM Toxicology Report; and
    vi. Melbourne Health Pathology Vitreous Humour Report.

29. The post-mortem examination did not reveal any features inconsistent with the CM's medical history and Dr Duffy opined that the death was due to natural causes.

30. Toxicological analysis of post-mortem samples identified the presence of the following common drugs, poisons and products of metabolic processes:

    i. Acetone;[9]
    ii. Isopropanol;[10]
    iii. Levetiracetam;[11]
    iv. Metformin;[12]
    v. Olanzapine;[13]

31. Dr Duffy provided an opinion that the medical cause of death was 1(a) DIABETIC KETOACIDOSIS.

[8] CB, Medical Examiner's Report.
[9] An organic compound, acetone is the simplest ketone which occurs in the bloodstream when the lack of insulin disallows glucose to be used as energy. When the body uses fatty acids as a substitute ketones or acetone is produced which renders the blood acidic. Diabetic ketoacidosis is a catastrophic metabolic event which may lead to death.
[10] An organic compound with a pungent alcoholic odour.
[11] A novel anticonsvulsant medication indicated, *inter alia*, in the treatment of generalised tonic-clonic seizures in patients with epilepsy.
[12] An antihyperglycaemic medication indicated to control Type 2 Diabetes Mellitus.
[13] Indicated for the treatment of schizophrenia and bipolar disorder.

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 CM, born 25 July 1968;

   b) the death occurred on 23 January 2024 at 35 McPhee Street Hamilton Victoria 3300.

   c) I accept and adopt the medical cause of death as ascribed by Dr Duffy and I find that CM died from diabetic ketoacidosis.

2. Having considered the factual matrix within which the death occurred, I am satisfied that the weight of the available evidence does not support a conclusion that a causal nexus existed between the fact that CM was 'in care' at the time of his death and the medical cause of his death. Consequently, on the evidence available to me, I am unable to find that CM's status as a person who was 'in care' at the time of his death, is connected with or contributed to the medical cause of his death.

3. Further, the weight of the available evidence supports a conclusion that the medical care CM received while he was 'in care' at the facility in Hamilton administered by Scope Disability Support Services as well as the medical care he received from the clinicians of the Hamilton Medical Group and the Western District Hospital Emergency Department in the period leading to his death was reasonable in the circumstances. Accordingly, I find that CM died by natural causes.

I convey my sincere condolences to CM'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:

JM & SM, Senior Next of Kin

Scope (Aust) Ltd

National Disability Insurance Agency

First Constable Aaron Gillan, Coroner's Investigator

Signature:

Coroner John Olle
Date: 6 January 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.