IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006025

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Murray Noel Haggar
Date of birth:	09 July 1958
Date of death:	29 October 2023
Cause of death:	1(a) COMPLICATIONS FOLLOWING A MALIGNANT BOWEL OBSTRUCTION IN A MAN WITH MULTIPLE COMORBIDITIES (PALLIATED)
Place of death:	Wantirna Hospital 251 Mountain Highway Wantirna Victoria 3152

INTRODUCTION

1. On 29 October 2023, Murray Noel Haggar (Mr Haggar) was 65 years old when he died at Wantirna Hospital 251 Mountain Highway Wantirna.

2. At the time of his death, Mr Haggar lived in Specialist Disability Accommodation (SDA) located at 30 Illoura Avenue Ringwood East Victoria 3135. The National Disability Insurance Service (NDIS) had provided a Care Package for Mr Haggar and the Care package included funding of his SDA accommodation at 30 Illoura Avenue Ringwood East.

3. Mr Haggar had a history cerebral palsy and intellectual disability.

4. The National Disability Insurance Agency (NDIA) had approved the most recent NDIS Care plan for Mr Haggar and the plan was approved to commence from 25 August 2022 to 25 August 2023 and had been extended for a further 12 months.

5. In his NDIS plan Mr Haggar stated:

   That his goal was to continue to attend day service with support and be able to attend community and social activities of his choice on weekends such as movies/musical shows etc. He also wanted to keep in touch with his siblings and mum as he enjoyed these visits.

6. Mr Haggar required on going assistance and support with his day-to-day needs. He enjoyed listening to music and participated in any outings that were arranged and enjoyed these activities.

THE CORONIAL INVESTIGATION

1. Mr Haggar'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. In addition, if a person satisfies the definition of a person placed 'in care' immediately before death, the death is reportable even if it appears to have been from natural causes[1].

[1] See the definition of *"reportable death*" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act.

2. 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.

3. 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.

4. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Haggar'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.

5. This finding draws on the totality of the coronial investigation into the death of Murray Noel Haggar 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.[2]

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

Circumstances in which the death occurred

6. Mr Haggar was a 65-year-old man who resided in specialist disability accommodation (SDA). He initially presented to Eastern Health in July 2023 with recurrent chronic constipation and atonic bowel.

7. He was admitted to Eastern Health in August 2023 and was found to have new radiological features of distal transverse colon narrowing highly suspicious for malignancy. A decision was made early on from discussions with the surgical team and his family not to commence operative management.

[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.

8. His most recent admission to Maroondah Hospital on 2 September 2023 was following another episode of chronic constipation which was non-resolving despite medical management which evolved into a malignant bowel obstruction. He was transferred to the Wantirna Palliative Care unit on 21 September 2023 for end-of-life care. He had subsequent slow deterioration and sadly died on 29 October 2023.

Identity of the deceased

9. On 29 October 2023 Murray Noel Haggar, born 9 July 1958, was visually identified by his sister, Sandra Gayle Kogelman.

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

Medical cause of death

11. Specialist Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 30 October 2023 and provided a written report of her findings dated 31 October 2023

12. The post-mortem examination did not show any significant injuries that may have caused or contributed to death. The post-mortem CT scan showed a grossly distended large bowel with faecal loading and features suggestive of pneumonia within the lungs. There was no evidence of acute skeletal trauma.

13. Dr Zhou provided an opinion that the medical cause of death was

    1 (a) COMPLICATIONS FOLLOWING A MALIGNANT BOWEL OBSTRUCTION IN A MAN WITH MULTIPLE COMORBIDITIES (PALLIATED).

14. On the basis of the information available to Dr Zhou, she formed the opinion that this death was due to natural causes

15. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Murray Noel Haggar, born 09 July 1958;

b) the death occurred on 29 October 2023 at Wantirna Hospital 251 Mountain Highway, Wantirna Victoria 3152, from COMPLICATIONS FOLLOWING A MALIGNANT BOWEL OBSTRUCTION IN A MAN WITH MULTIPLE COMORBIDITIES (PALLIATED); and

c) the death occurred in the circumstances described above and was from natural causes.

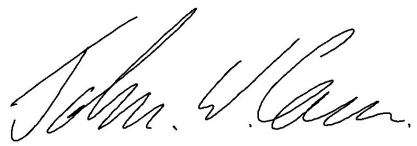
I convey my sincere condolences to Murray's family for their loss.

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.

Sandra Kogelman, Senior Next of Kin

Acting Sergeant Sean Rickard Coroner's Investigator

Signature:



Judge John Cain
STATE CORONER
Date:21 May 2024

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.