IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 1270

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Judge John Cain
Deceased:	John Anderson McCormack
Date of birth:	25 May 1962
Date of death:	7 March 2023
Cause of death:	1(a) Pulmonary Thromboembolism
Place of death:	Royal Melbourne Hospital 300 Grattan Street Parkville

INTRODUCTION

1. On 1 August 2023, having commenced an investigation into the death of Mr John Anderson McCormack (Mr McCormack) I discontinued that investigation pursuant to section 17 of the Coroners Act 2008 (the Act). It has now come to my attention that Mr McCormack's death was a death that is referred to in section 4(2)(c) of the Act as Mr McCormack was immediately before death placed in care or custody. In those circumstances I am required by the Act to make findings with respect to the circumstances of Mr McCormack's death. I have accordingly determined to continue the investigation notwithstanding my previous determination and make findings with respect to the circumstances of Mr McCormack's death.

2. On 7 March 2023 Mr McCormack was 60 years old when he died at The Royal Melbourne Hospital, 300 Grattan Street Parkville. At the time, Mr McCormack lived in Specialist Disability Accommodation (SDA) located at 129 Rathcown Road Reservoir Victoria where he had lived since 2015. The National Disability Insurance Service (NDIS) had provided a Care Package for Mr McCormack and the Care package included funding of his SDA accommodation at 129 Rathcown Road Reservoir.

3. The National Disability Insurance Agency (NDIA) had approved the most recent NDIS Care plan for Mr McCormack and the plan was approved to commence from 1 June 2022.

4. In his NDIS plan Mr McCormack stated:

> *I have a very supportive family who play an active role in my support needs. I attend family functions and special events, which I thoroughly enjoy. I love music (ABBA), and working on succulents and vegetables in the garden. I enjoy attending live shows/music several times a year and going to the Royal Melbourne Show.*
>
> *I reside at 129 Rathcown Road Reservoir with 5 other house mates, I have been living in this SDA facility since 2015 and am pleased to have moved here. My brother Craig whom has a similar disability lives locally in another residence in reservoir.*
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> *I attend genU day program Monday to Friday, I am transported via a taxi. picked up at 8.30am and returning around 3.30pm. I call my sister Anne on a weekly basis every Wednesday evening for a chat. I am very involved with my housemates and we will often go out together. We attend Plenty Valley Dance Group each Tuesday night and a Disco at ATSS Mill Park on a Thursday. Over the weekends I like to go shopping at Northland or Summerhill shopping centre.*

These activities have been disrupted due to COVID more recently, but I am starting to return to them.

THE CORONIAL INVESTIGATION

5. Mr McCormack'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. However, 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]

6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Mr McCormack. 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

Identity of the deceased

9. On 7 March 2023, John Anderson McCormack, born 25 May 1962, was visually identified by his sister, Lisa McCormack, who signed a formal Statement of Identification to this effect.

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[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] 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.

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

Medical cause of death

11. Forensic Pathologist Dr Michael Duffy, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on Mr McCormack's body in the mortuary on 10 March 2023 and provided a written report of his findings dated 9 May 2023.

12. Dr Duffy provided an opinion that the medical cause of death was.

    1 (a) Pulmonary Thromboembolism

13. Dr Duffy considered that Mr McCormack's death was due to natural causes.

14. I accept Dr Duffy's opinion.

Circumstances in which the death occurred.

15. Mr McCormack had been a resident at SDA accommodation at 129 Rathcown Road Reservoir since 2015. Mr McCormack suffered from Huntington's disease.

16. On 21 February 2023 Mr McCormack was admitted to the Austin Hospital after the staff at his supported accommodation witnessed him having a tonic-clonic seizure on background of known epilepsy. The cause of the episode is unclear. While at the Austin Hospital, Mr McCormack was intubated for airway protection and support in the setting of seizures and vomiting.

17. On 22 February 2023 Mr McCormack was transported to the Royal Melbourne Hospital ICU ward for further specialist treatment. Whilst in the ICU Mr McCormack was in a fluctuating conscious state with hypoactive delirium and a prolonged postictal period and prolonged failure to wake was noted. Mr McCormack was intubated for a total of 8 days and 9 hours and was extubated on 2 March 2023 and treated for aspiration/ventilator associated pneumonia.

18. On 7 March 2023 a MET call was made which was upgraded to a Code Blue when Mr McCormack was found to have poor/no respiratory effort and non-reactive pupils. Cardiac pulmonary resuscitation was commenced however Mr McCormack was unable to be revived and was pronounced deceased at 18:35 pm.

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

    a) the identity of the deceased was John Anderson McCormack, born 25 May 1962;

    b) the death occurred on 7 March 2023 at The Royal Melbourne Hospital 300 Grattan Street Parkville Victoria,

    the cause of Mr McCormack's death was *1 (a) Pulmonary Thromboembolism* and,

    c) the death occurred in the circumstances described above.

20. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SDA operator that caused or contributed to Mr McCormack's death.

21. I note that Mr McCormack's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Mr McCormack died from natural causes and that no further investigation is required. Accordingly, 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 Mr McCormack's death on the papers.

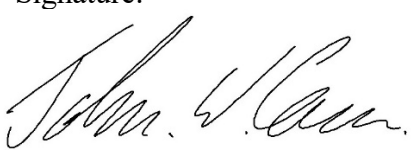
22. I convey my sincere condolences to Mr McCormack's family and his carers and friends for their loss.

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:

Lisa McCormack, senior next of kin

Signature:



Judge John Cain
STATE CORONER
Date: 3 January 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.