IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001886

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Glenn Charles Cook
Date of birth:	2 April 1959
Date of death:	9 April 2025
Cause of death:	1a : CARDIAC HYPERTROPHY AND CORONARY ARTERY DISEASE 2 : OBESITY- WHO CLASS II, HYPERCHOLESTEROLAEMIA
Place of death:	258 Wilson Street Colac, Victoria 3250
Keywords:	In care; Specialist Disability Accommodation; SDA resident; Natural causes; Obesity

INTRODUCTION

1. On 9 April 2025, Glenn Charles Cook was 66 years old when he died at home. At the time of his death, Glenn lived in Specialist Disability Accommodation (**SDA**) at 258 Wilson Street, Colac, Victoria, 3250.

2. Glenn was the youngest of three, and his parents were Val and Robert Cook. The family resided in Ocean Grove and Glenn enjoyed a stable upbringing.[1]

3. Glenn had a moderate intellectual disability and was non-verbal, using only a few words to communicate.[2] His past medical history included bipolar affective disorder, severe arthritis, a total left hip replacement, hypercholesterolaemia as well as mobility challenges.[3] According to his general practitioner, Dr Shruthi Venkatesh, Glenn was obese with a Body Mass Index score of 35.[4]

4. For 13 years, Glenn resided in institutionalised care at Colanda Residential Services in Colac. In 2019, he relocated to an SDA dwelling operated by Homes Victoria, part of the Department of Families, Fairness and Housing. While in care, he received Supported Independent Living (**SIL**) services for all personal activities of daily living from SCOPE, a National Disability Insurance Scheme (**NDIS**) provider.[5] He resided there until his passing.

5. Glenn was described as a "generally happy man", who enjoyed action movies and motorbikes.[6]

THE CORONIAL INVESTIGATION

6. Glenn'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.

[1] *Coronial Brief*, Statement of Kerry Gorski.
[2] *Coronial Brief*, Statement of Dr Shruthi Venkatesh.
[3] *Coronial Brief*, Statement of Nicole Elizabeth Standfield.
[4] *Coronial Brief*, Statement of Dr Shruthi Venkatesh.
[5] *Coronial Brief*, Statement of Nicole Elizabeth Standfield.
[6] Ibid.

7. Because Glenn was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling[7] at the time of his death, his passing was determined to be 'in care' and, as such, is subject to a mandatory further investigation, pursuant to section 52(3A) of the Act. These findings are the result of that investigation.

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. Victoria Police assigned First Constable Lane Buckwell to be the Coronial Investigator for the investigation of Glenn'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.

11. This finding draws on the totality of the coronial investigation into the death of Glenn Charles Cook 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.[8]

12. In considering the issues associated with this finding, I have been mindful of Glenn's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

[7] See Regulation 7(1)(d) of the Coroners Regulations 2019.

[8] 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

Circumstances in which the death occurred

13. On the morning of 9 April 2025, Glenn was observed by staff members talking rapidly, holding food in his mouth and not interacting with staff. These behaviours indicated deteriorating mental health and at 8:10 am, staff administered quetiapine in accordance with his Mental Health Management plan.[9]

14. Glenn then remained in his bedroom, with staff intermittently checking on him.

15. At about 8:45 am, staff returned to his bedroom and found him struggling to breathe. Staff members attempted to reposition him to increase his breathing activity but were unable to do so. They subsequently made their first call to emergency services.[10]

16. While awaiting the arrival of Ambulance Victoria (**AV**), Glenn's condition deteriorated and a second call to emergency services was made. The call taker stayed on the phone with staff members until the arrival of AV paramedics at about 9:22 am.

17. Upon AV arrival, Glenn was moved to the floor and paramedics commenced cardiopulmonary resuscitation (**CPR**). Notwithstanding these efforts, CPR was unsuccessful and Glenn was declared deceased at about 10:15 am.

Identity of the deceased

18. On 9 September 2025, Glenn Charles Cook, born 2 April 1959, was visually identified by his carer, Peter Lucas.

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

Medical cause of death

20. Forensic Pathologist Dr K.B. Janitha Ruwan Dayananda from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 11 April 2025 and provided a written report of their findings dated 19 August 2025.

[9] *Coronial Brief*, Statement of Nicole Elizabeth Standfield.
[10] Ibid.

21. The post-mortem examination revealed cardiac hypertrophy[11] and severe coronary artery atherosclerosis[12] in the left anterior descending coronary artery. Dr Dayananda noted that hypertension is a common cause for cardiac hypertrophy due to increased cardiac activity against systemic blood pressure leading to compensatory hypertrophy. A hypertrophic heart makes it more vulnerable for ischeamia due to increased demand, making an individual more vulnerable to cardiac arrhythmia and sudden cardiac death.

22. Dr Dayananda further noted that small vessel disease of the myocardium is caused by damaged to the microvasculature of the heart. This damage can result from various factors, including high blood pressure, high cholesterol, obesity, and diabetes mellitus.

23. The post-mortem computerised tomography (**CT**) scan showed distended large bowel loops filled with gas and fluid, faecal impaction in the rectum, left total hip replacement, bilateral renal cysts and left 3rd anterior rib fracture.

24. Toxicological analysis of post-mortem samples identified the presence of carbamazepine (~ 8.4 mg/L) and its metabolite carbamazepine 0,11-epoxide (~ 4.0 mg/L) and olanzapine (~ 0.3 mg/L).

25. Based on the all the information available, Dr Dayananda formed the opinion that Glenn's death was due to natural causes.

26. Dr Dayananda provided an opinion that the medical cause of death was 1(a) CARDIAC HYPERTROPHY AND CORONARY ARTERY DISEASE, secondary to 2: OBESITY- WHO CLASS II, HYPERCHOLESTEROLAEMIA and I accept their opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Glenn Charles Cook, born 2 April 1959;

    b) the death occurred on 9 April 2025 at 258 Wilson Street, Colac, Victoria 3250, from 1(a) CARDIAC HYPERTROPHY AND CORONARY ARTERY DISEASE secondary to 2: OBESITY- WHO CLASS II, HYPERCHOLESTEROLAEMIA; and

[11] Cardiac hypertrophy is the thickening of the heart muscle, making it harder for the heart to pump blood.
[12] Atherosclerosis is the buildup of fats, cholesterol and other substances in and on the artery walls.

c) the death occurred in the circumstances described above.

28. Having considered all of the circumstances, I am satisfied that Glenn's care was reasonable and appropriate at all material times.

29. As Glenn was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[13] I am satisfied by the available evidence that Glenn's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Glenn'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.

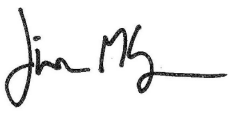
I direct that a copy of this finding be provided to the following:

Kerry Gorski, Senior Next of Kin

Scope (Aust) Ltd.

First Constable Lane Buckwell, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 18 February 2026

[13] Section 52(2) of the Act.

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.