IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006653

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Darren J. Bracken
Deceased:	John Llewellyn Williams
Date of birth:	19 September 1947
Date of death:	8 December 2020
Cause of death:	1(a) CONGESTIVE CARDIAC FAILURE IN A MAN WITH CARDIOMEGALY
Place of death:	3 / 34 Napier Street, Mornington, Victoria, 3931
Keywords	Natural Causes, In Care, Community treatment order.

INTRODUCTION

1. On 8 December 2020, John Llewellyn Williams was 73 years old when he was discovered by police and Psychiatric nurse Rockach deceased in his home at 3/34 Napier Street Mornington. Immediately before his death Mr Williams lived alone at that address and was subject to a community treatment order. Mr Williams suffered from bi-polar disorder, very high blood pressure but refused to undergo tests and treatment.

Police and Mr Rockach went to Mr Williams' address to collect him and admit him to the Frankston Hospital after he had failed to attend appointments for treatment and was not taking some of his medication and did not answer telephone calls.

2. At the time of his death Mr Williams was divorced and had three adult children with whom he was not close.

THE CORONIAL INVESTIGATION

3. Mr Williams' death was reported to the Coroner because 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, as Mr Williams was given that he was subject to a Community Treatment Order, requires must be reported to the Coroner, even if the death appears to have been from natural causes.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the deceased's identity, the cause of death, and its 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.

5. Under the Act, coroners also have the important functions of helping to reduce the number of preventable deaths, promoting public health and safety and facilitating the administration of justice through the making of comments or recommendations about any matter connected to the death under investigation.

6. This finding draws on the totality of the coronial investigation into the death of John Llewellyn Williams. 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.[1]

[1] 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

7. Police and a psychiatric nurse form the Frankston Hospital, nurse Rockach went to Mr Williams' home just after midday on 8 December 2020 to take Mr Williams to the Frankston Hospital for treatment and found him collapsed and apparently deceased on the kitchen floor. Police found newspapers at the deceased's home, the most recent one dated 4 December 2020.

8. At the time of his death Mr Williams was subject to a Community Treatment Order in relation to his medical conditions. A Community Treatment Order facilitated Mr Williams receiving essential treatment while he lived in the community (at his home). The Order provided that under certain conditions, including him not undergoing that treatment, that Mr Williams could be taken to hospital to be treated. Mr Williams had last seen his general practitioner Dr Chen at the Rosebud Super Clinic on 3 November 2020. According to Dr Chen Mr Williams had very high blood pressure but refused blood tests and treatment.

Identity of the deceased

9. On 8 December 2020 Gary Rockach, a psychiatric nurse who had been treating Mr Williams for approximately 18 months identified the deceased as John Llewellyn Williams, born 19 September 1947.

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

Medical cause of death

11. On 16 December 2020 Dr C Zhou a legally qualified medical practitioner and fellow in Anatomical Pathology practising at the Victorian Institute of Forensic Medicine conducted an autopsy on Mr Williams' body and in the resultant report dated 28 January 2021opined that the cause of Mr Williams' death was "*congestive cardiac failure in a man with cardiomegaly.*".

12. Toxicological analysis of post mortem samples revealed Hydroxyrisperidone (a medication prescribed for psychiatric conditions) and Paracetamol.

13. I accept Dr Zhou's opinion that Mr Williams died from 'natural causes.

14. Pursuant to section 67(1) of the *Coroners Act 2008* I make find that :

a) The identity of the deceased was John Llewellyn Williams, born 19 September 1947.

b) Mr Williams died on or about 8 December 2020 at 3 / 34 Napier Street, Mornington, Victoria from congestive cardiac failure in a man with cardiomegaly and

c) his death occurred in the circumstances described above.

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:

Mr C Williams, Senior Next of Kin

Signature:

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Coroner Darren J. Bracken

Date : 13 September 2022.

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.