IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002195

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Michael John O'Connell
Date of birth:	7 March 1966
Date of death:	27 April 2023
Cause of death:	1(a) Pneumonia 2 Down's syndrome
Place of death:	32 Oregan Street, Stawell, Victoria, 3380
Keywords:	In care; natural causes

INTRODUCTION

1. On 27 April 2023, Mr Michael John O'Connell was 57 years old when he was found deceased at his specialist disability residential accommodation. At the time of his death, Mr O'Connell lived at 32 Oregan Street, Stawell, a supported living facility operated by Possability.[1]

2. Mr O'Connell was diagnosed with Down's syndrome at birth, and his medical history included ongoing cognitive decline as a complication of Alzheimer's disease.

THE CORONIAL INVESTIGATION

3. Mr O'Connell'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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Mr O'Connell was a 'person placed in custody or care' within the meaning of section 4 of the Act, as he was 'a prescribed class of person'[2] due to his status as an 'SDA[3] resident residing in an SDA enrolled dwelling'.

4. 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.

5. 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.

6. Victoria Police assigned First Constable Alex Javni to be the Coroner's Investigator for the investigation of Mr O'Connell's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – including Mr O'Connell's mother, his general practitioner and carers – and submitted a coronial brief of evidence.

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[1] A disability support services provider
[2] *Coroners Act 2008* – section 4(2)(j)(i)
[3] Specialist Disability Accommodation

7. This finding draws on the totality of the coronial investigation into the death of Mr O'Connell 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.[4]

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

Circumstances in which the death occurred

8. Mr O'Connell's health started to deteriorate in 2020 and he began to withdraw from daily activities. Mr O'Connell's occupational therapist noted increased anxiety and that he would not leave his bedroom without prompting.

9. On 15 March 2023, Mr O'Connell was seen by his general practitioner, Dr Christian Ezeobi, who completed a comprehensive health review. Dr Ezeobi noted ongoing cognitive decline but no other decline in his overall health. It was also noted that Mr O'Connell was very agitated and refused examination, although this was not unusual behaviour.

10. On 26 April 2023 at about 7.30am, a supervisor at Possability, John Pollock, observed that Mr O'Connell looked "limp" and thought he was about to have a seizure – however this did not eventuate.

11. At about 10.30am, Mr Pollock took Mr O'Connell for a drive around Lake Londsdale, returning at about 12.15pm. Mr Pollock noted that Mr O'Connell had soiled himself three times during the trip, which was unusual.

12. At about 2.00pm, Mr O'Connell indicated that he wanted to go to bed and was noted to be agitated. He refused medication at this time, but Mr Pollock was able to administer the medication a short time later. Mr O'Connell spent the afternoon sitting on the couch, then went to his room at about 9.00pm.

13. At 6.43am on 27 April 2023, disability support worker, Steven Collins, tried to wake Mr O'Connell but he was unresponsive. Mr Collins immediately called 000 and commenced cardiopulmonary resuscitation. Paramedics arrived on scene soon afterwards and continued

[4] 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.

resuscitation attempts, however they were unable to revive Mr O'Connell and he was pronounced deceased at 7.25am.

Identity of the deceased

14. On 27 April 2023, Mr O'Connell, born 7 March 1966, was visually identified by his support worker, Steven Collins.

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

Medical cause of death

16. Senior Forensic Pathologist, Dr Paul Bedford of the Victorian Institute of Forensic Medicine, conducted an autopsy on 4 May 2023 and provided a written report of his findings dated 13 June 2023.

17. The autopsy and CT scan examination revealed evidence of pneumonia, mainly involving the left lung. The heart did not show fibrosis however there was moderate coronary artery atheroma on section. Some chronic inflammatory activity was noted in the thyroid gland. No acute changes were seen in the brain. Other organs examined were within normal limits for Mr O'Connell's age.

18. Toxicological analysis of post-mortem samples identified the presence of mirtazapine,[5] diazepam and its metabolites nordiazepam and oxazepam,[6] lorazepam,[7] and carbamazepine.[8]

19. Biochemistry testing showed an increased C-reactive protein, in keeping with infection.

20. Dr Bedford provided an opinion that the medical cause of death was '1 (a) Pneumonia' with a contributing factor of '2 Down's syndrome'. Dr Bedford further opined that Mr O'Connell's death was due to natural causes.

21. I accept Dr Bedford's opinion.

[5] Mirtazapine is indicated for the treatment of depression.
[6] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[7] Lorazepam is a benzodiazepine drug prescribed for the treatment of insomnia and anxiety associated with depressive symptoms and as a pre-operative medication.
[8] Carbamazepine is an antiepileptic drug indicated for partial and tonic clonic seizures, neuropathic pain and bipolar disorder.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Michael John O'Connell, born 7 March 1966;

    b) the death occurred on 27 April 2023 at 32 Oregan Street, Stawell, Victoria, 3380, from pneumonia with a contributing factor of Down's syndrome; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr O'Connell's family and his carers 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:

Margaret Hayward Bryant, Senior Next of Kin

First Constable Alex Javni, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 15 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.