IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005797

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Neil Douglas Heaton
Date of birth:	03 April 1956
Date of death:	18 October 2023
Cause of death:	1a : PNEUMONIA IN THE SETTING OF ASPIRATION AND POSTERIOR RIB FRACTURES
Place of death:	4/16 Leopold Street Alfredton Victoria 3350
Keywords:	In care, natural causes

INTRODUCTION

1. On 18 October 2023, Neil Douglas Heaton was 67 years old when he was found unresponsive at his home in Alfredton, Victoria. At the time of his death, Neil lived in Supported Disability Accommodation (SDA).

2. Neil had an extensive medical history including intellectual disability, diabetes, dementia, obstructive sleep apnoea, deafness, blindness, bowel obstruction and aspiration pneumonia and schizo-effective disorder. As a result of his high-level needs Neil had been under the care of McCallum Disability Services since 2003 and he had care workers who attended to his needs.

3. Neil was often visited by and had the support of his brother, Alan. Neil enjoyed drawing and music; he was very social.

THE CORONIAL INVESTIGATION

4. Neil'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 as is the case here.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Neil Douglas Heaton. 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]

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

Circumstances in which the death occurred

8. On 18 October 2023, Neil's disability support worker conducted a check on Neil at around 12 am. At that time the disability support worker noticed that Neil was not moving, and, on further examination Neil was not breathing.

9. The disability support worker immediately called 000 and commenced CPR on Neil.

10. When officers from Ambulance Victoria arrived, they took over resuscitation efforts, however Neil could not be successfully resuscitated.

11. Neil was declared deceased at the scene.

12. A police investigation ruled out any suspicious circumstances.

Identity of the deceased

13. On 18 October 2023, Neil Douglas Heaton, born 03 April 1956, was visually identified by his carer, June Sutton Ryan, who had looked after Neil for 2 years.

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

Medical cause of death

15. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 23 October 2023 and provided a written report of his findings dated 27 December 2023.

16. The post-mortem examination revealed no evidence of violence or injury contributing to Neil's death, and no evidence of substantial natural disease. However, rib fractures were identified and showed radiological signs of chronicity, suggesting they were likely sustained

[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.

days or even weeks prior to Neil's death. Rib fractures are a known risk factor in the development of pneumonia as they limit respiratory movement.

17. Toxicological analysis of post-mortem samples identified the presence of several therapeutic drugs however these drugs were not at significant levels and did not contribute to Neil's death.

18. Dr De Boer provided an opinion that the medical cause of death was 1(a) PNEUMONIA IN THE SETTING OF ASPIRATION AND POSTERIOR RIB FRACTURES.

19. I accept Dr De Boer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Neil Douglas Heaton, born 03 April 1956;

    b) the death occurred on 18 October 2023 at 4/16 Leopold Street Alfredton Victoria3350 from:
    1(a) PNEUMONIA IN THE SETTING OF ASPIRATION AND POSTERIOR RIB FRACTURES,

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Neil's family for their loss. I direct that a copy of this finding be provided to the following:
Alan Hedges, Senior Next of Kin

Signature:

CORONER LEVEASQUE PETERSON
DATE: 22 JANUARY 2025

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.