IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002092

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Shawn James Farlech
Date of birth:	6 February 1977
Date of death:	13 April 2024
Cause of death:	1(a) Pneumonia
Place of death:	Grampians Health Ballarat - Ballarat Base Hospital, 1 Drummond Street, North Ballarat Central, Victoria, 3350
Keywords:	Death in care; disability; natural causes

INTRODUCTION

1. On 13 April 2024, Shawn Farlech was 47 years old when he died at Grampians Health Ballarat. At the time of his death, Shawn lived in Specialist Disability Accommodation ('**SDA**') in Stawell.

2. Shawn was born on 6 February 1977 and at seven months old, contracted encephalitis. The infection resulted in an acquired brain injury whereby Shawn was non-verbal and required assistance with everyday tasks. According to Shawn's sister, Shawn transitioned to his SDA around the year 2000.

3. Shawn's medical history included epilepsy with seizures that occasionally led to falls, anxiety, depression, hyponatraemia and insomnia. He was treated by his General Practitioner with sodium valproate, lamotrigine, clonazepam, sertraline and diazepam.

4. On 8 April 2024, support workers observed Shawn to be unwell with a high temperature. He was transported to Stawell Regional Health and treated with fluids and IV antibiotics and discharged later that day.

5. On the morning of 9 April 2024, Shawn was located on the floor of his room by a support worker. He was noted to be unsteady on his feet and had a small cut below his eyebrow. Shawn was conveyed via ambulance to Stawell Regional Health and later transferred to Grampians Health Ballarat with influenza A and multilobar pneumonia.

6. Shawn's pneumonia was identified as severe, and he had persistent difficulty tolerating the oxygen mask which was required to maintain therapeutic oxygen saturation. He also presented with signs of severe sepsis including a persistently elevated respiratory rate and low blood pressure. During his admission at Grampians Health Ballarat, Shawn had multiple Medical Emergency Team calls and Intensive Care Unit reviews.

7. Prior to becoming unwell, Shawn would attend Pinnacle Powerhouse five days a week and enjoyed family visits. He was an active person who liked walking, exercising and keeping busy.

THE CORONIAL INVESTIGATION

8. Shawn's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Specifically, Shawn was immediately before his death 'a person placed in custody or care', as he was an SDA resident residing in an SDA enrolled

dwelling.[1] 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.

9. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or care. However, as Shawn's death was due to natural causes, I am not required to hold an Inquest.[2]

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Shawn'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.

12. This finding draws on the totality of the coronial investigation into the death of Shawn James Farlech 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.[3]

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

Circumstances in which the death occurred

13. On 13 April 2024, Shawn was reviewed by the Hospital Medical Officer of Grampians Health Ballarat who identified ongoing agitation and hypoxia. Shawn was observed to be distressed by his breathing difficulties and continued to remove his oxygen mask.

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[1] Regulation 7(d) of the *Coroners Regulations 2019.*
[2] Section 52(3A) of the *Coroners Act 2008.*
[3] 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.

14. Later that day, hospital staff discussed goals of care with Shawn's family who agreed to transition him to end of life comfort care. Shawn died at 8.55pm on 13 April 2024 in the presence of his mother, sister and support workers.

Identity of the deceased

15. On 13 April 2024, Shawn James Farlech, born 6 February 1977, was visually identified by his mother, Elma Thistlethwaite, who completed a Statement of Identification.

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

Medical cause of death

17. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Shawn Farlech on 15 April 2024. Dr Zhou considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log, E-Medical Deposition of Grampians Health Ballarat and medical records and provided a written report of her findings dated 18 April 2024.

18. The findings of the post mortem CT scan included multifocal increased bilateral markings and consolidation within the left lower lobe of the lungs, small pleural effusions and left posterior pleural calcifications. There we no acute intracranial pathology or skeletal injuries.

19. The findings at external examination were consistent with the reported circumstances of pneumonia.

20. Toxicological analysis of post-mortem toxicology samples was not indicated and was therefore not performed.

21. Dr Zhou provided an opinion that the medical cause of death was 1(a) PNEUMONIA.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Shawn James Farlech, born 6 February 1977;

   b) the death occurred on 13 April 2024 at Grampians Health Ballarat - Ballarat Base Hospital, 1 Drummond Street, North Ballarat Central, Victoria, 3350;

c) I accept and adopt the medical cause of death ascribed by Dr Zhou and I find that Shawn James Farlech, a man with an acquired brain injury, died from pneumonia.

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Shawn James Farlech's death was due to natural causes, and I find there is no relationship or causal connection between his death and his status as a person placed in custody or care immediately before his death.

I convey my sincere condolences to Shawn's family for their loss.

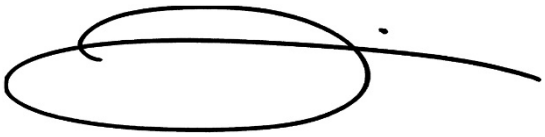
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Elma Thistlethwaite, Senior Next of Kin

First Constable Ryan Walsh, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 26 May 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.