IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002041

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Gregory Walter Heenan
Date of birth:	15 April 1958
Date of death:	15 April 2025
Cause of death:	1(a): acute myocardial infarction 1(b): coronary artery atherosclerosis
Place of death:	Goulburn Valley Hospital 2/2-48 Graham Street Shepparton Victoria 3630
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

I, Coroner Leveasque Peterson, having investigated the death of Gregory Walter Heenan (**Gregory**) and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act* 2008 (**the Act**):

a) the identity of the deceased was Mr Gregory Walter Heenan, born 15 April 1958;

b) the death occurred on 15 April 2025 at Goulburn Valley Hospital, 2/2-48 Graham Street, Shepparton, Victoria 3630, from 1(a) acute myocardial infarction and 1(b) coronary artery atherosclerosis; and

c) the death occurred in the circumstances described below.

2. Gregory had an intellectual disability, and he was non verbal. His medical history also included hypercholesterolemia, osteopenia, osteoporosis and dysphagia. Prior to his death, Gregory lived in Shepparton, in a house with four other housemates where staff supported his daily needs. He had been in his accommodation since 2006. Before moving to specialist accommodation, Gregory had lived on the family farm with his parents. Gregory was part of a large and loving family with two sisters and three brothers. He enjoyed going for drives and being near the water.

3. Gregory's death was reported to the Coroner as it fell within the definition of a reportable death in the Act. Specifically, Gregory was immediately before his death, a person in care as he lived in Specialist Disability Accommodation (**SDA**) operated by Aruma Services Victoria Limited (**Aruma**). The death of a person in care is a mandatory report, even if the death was the result of natural causes.

4. Section 52 (2) of the Act prescribes when a coroner must hold an inquest into a death. This includes instances where the deceased was in care. However, as Gregory's death was due to natural causes, I am not required to hold an inquest.

Circumstances in which the death occurred

5. On 12 April 2025, Gregory was admitted to Goulburn Valley Hospital after a vomiting episode. Gregory was diagnosed with an ST-elevated myocardial infarction. He was not suitable for percutaneous coronary intervention or thrombolysis.

6. Gregory's condition after admission continued to deteriorate. He was transitioned to end of life comfort care, and died on 15 April 2025.

7. Forensic Pathologist Associate Professor Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) performed an examination on 18 April 2025 and provided a written report of his findings dated 22 April 2025.

8. The findings at postmortem computed tomography (**CT**) scan and external examination were consistent with the reported circumstances.

9. Associate Professor de Boer provided an opinion that the medical cause of death was 1(a) *acute myocardial infarction* and 1(b) *coronary artery atherosclerosis*.

10. I accept Associate Professor de Boer's opinion.

11. The available evidence indicated there were no issues with the quality of clinical management or care on the part of Aruma or Goulburn Valley Hospital that caused or contributed to Gregory's death.

12. Having considered all of the available evidence, I am satisfied that Gregory's death was due to natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Gregory's death in chambers.

13. I make no further findings with respect to the circumstances in which the death occurred, under section 67(2) of the Act, because I did not hold an inquest, and I find that:

    a) Gregory was not, immediately before his death, a person placed in custody or care; and

    b) There is no public interest to be served in making further findings regarding the circumstances surrounding Gregory's death.

I extend my sincere condolences to Gregory'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:

Denise Turner, Senior Next of Kin

Aruma Services Victoria Limited

Goulburn Valley Hospital

Signature:

Coroner Leveasque Peterson

Date: 07 July 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.