IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 003938

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Warrick Francis O'Donnell
Date of birth:	4 November 1975
Date of death:	12 July 2026
Cause of death:	Middle and anterior cerebral artery infarct
Place of death:	The Royal Melbourne Hospital 300 Grattan Street, Parkville Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 12 July 2026, Warrick Francis O'Donnell was 50 years old when he passed away at the Royal Melbourne Hospital in Parkville. At the time of his death, Mr O'Donnell lived in a residential care facility in Coburg managed by Scope Australia. His medical history included birth asphyxia, anxiety and cerebral palsy. He also had an intellectual disability.

THE CORONIAL INVESTIGATION

2. Mr O'Donnell'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 or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. Mr O'Donnell was a person in care at the time of his death and he was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to s52(3A) of the Act given that Mr O'Donnell's death was from natural causes.

3. 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.

4. 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.

5. This finding draws on the totality of the coronial investigation into Mr O'Donnell's death, including information obtained from his health records and the National Disability Insurance Agency. While 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

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

Circumstances in which the death occurred

6. On 4 July 2026, staff reported that Mr O'Donnell had been well throughout the day. In the evening, he was observed to become less responsive and vocal which was unusual for Mr O'Donnell. Staff contacted emergency services at around 5.00pm and he was transported to the Royal Melbourne Hospital by Ambulance Victoria.

7. When Mr O'Donnell arrived at hospital, he was noted to be in an altered conscious state. A computed tomography (**CT**) scan showed that Mr O'Donnell had suffered a stroke which was incompatible with life. He was transitioned to comfort care and passed away with family present on 12 July 2026. He was pronounced deceased at 2.49am.

Identity of the deceased

8. On 12 July 2026, Warrick Francis O'Donnell, born 4 November 1975, was visually identified by his father, Terence Francis O'Donnell.

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

Medical cause of death

10. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine conducted an examination on 14 July 2026 and provided a written report of her findings dated 15 July 2026.

11. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Fronczek expressed the opinion that the death was due to natural causes.

12. Dr Fronczek provided an opinion that the medical cause of death was: 1*(a) Middle and anterior cerebral artery infarct*.

13. I accept Dr Fronczek's opinion.

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

FINDINGS AND CONCLUSION

14. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Warrick Francis O'Donnell, born 4 November 1975;

    b) the death occurred on 12 July 2026 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from middle and anterior cerebral artery infarct; and

    c) the death occurred in the circumstances described above.

15. As noted above, Mr O'Donnell's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr O'Donnell died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr O'Donnell'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:

Terence O'Donnell & Valerie O'Donnell, Senior Next of Kin

Scope Australia

Constable Lachlan McManus, Coronial Investigator

Signature:

Coroner David Ryan

Date: 03 September 2026

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.