IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000096

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Jon Lewis
Date of birth:	12 June 1965
Date of death:	23 December 2022
Cause of death:	1(a) ISCHAEMIC HEART DISEASE IN A MAN WITH CHRONIC SCHIZOPHRENIA
Place of death:	Angus Martin House, 382 Nepean Highway, Frankston, Victoria, 3199
Keywords:	In care; natural causes

INTRODUCTION

1. On 23 December 2022, Jon Lewis was 57 years old when he died at Angus Martin House in Frankston, Victoria. Angus Martin House is specialist disability accommodation operated by Winteringham Housing Ltd (known as Winteringham).

THE CORONIAL INVESTIGATION

1. Mr Lewis' 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 Lewis 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"[1] due to his status as an "SDA[2] resident residing in an SDA enrolled dwelling".

2. 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.

3. 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.

4. Senior Constable (SC) Roy O'Hagan acted as the Coroner's Investigator for the investigation of Mr Lewis' death. SC O'Hagan conducted inquiries on my behalf and submitted a coronial brief of evidence.

5. This finding draws on the totality of the coronial investigation into the death of Mr Lewis including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[1] *Coroners Act 2008* – section 4(2)(j)(i)
[2] Specialist Disability Accommodation

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]

BACKGROUND

6. Mr Lewis moved into Angus Martin House on 29 December 2020, having previously been a resident at Eliza Park SRS in Frankston since 2022. He had no known surviving family members and was described by his carers as a quiet and simple man with a set daily routine who generally kept to himself. He liked to sing, use the internet, and record his favourite television shows. He did not smoke or take any illicit drugs.

7. Mr Lewis suffered chronic schizophrenia. He also had a medical history which included Type 2 diabetes, hypertension, congestive cardiac failure, mild systolic dysfunction, clozapine cardiomyopathy, coronary artery disease with stenting to the right coronary artery, and mild cognitive impairment.

8. Mr Lewis was prescribed a range of medications to treat these conditions. His medication was managed by staff at Angus Martin House, who reported that he was compliant with his medication regime.

9. Mr Lewis' mental health was reportedly stable in the years preceding his death, with no relapses or need for medication changes, and his cardiovascular health showed no signs of decline.

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

Circumstances in which the death occurred

10. On the evening of 23 December 2022 Mr Lewis had dinner in the dining area then retired to his room to listen to music.

11. At approximately 6.45pm, Mr Lewis reported to a staff member, Danielle Heath, that he was feeling unwell. He complained that he could not breathe, and that his heart was beating very fast. Ms Heath noted that looked grey and was very clammy. She sat Mr Lewis down on a chair in the office, sought assistance from other staff and called emergency services.

[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.

12. Ms Heath and her colleague, Karen Rimbaldo, assisted Mr Lewis to lie on the floor and a short time later he stopped breathing. Staff members immediately began cardiopulmonary resuscitation (**CPR**) with the aid of an automated external defibrillator until emergency services arrived.

13. Ambulance Victoria paramedics arrived at the scene at 6.28pm and took over efforts to resuscitate Mr Lewis. They found Mr Lewis was in full cardiac arrest with no cardiac output. Despite emergency treatment including continued CPR, Mr Lewis could not be saved and was confirmed deceased at the scene.

14. An investigation by Victoria Police and identified no suspicious circumstances or other concerns in connection with Mr Lewis' death.

Identity of the deceased

15. On 23 December 2022, Jon Lewis, born 12 June 1965, was visually identified by his carer, Danielle Heath.

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

Medical cause of death

17. Forensic Pathologist, Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 9 January 2023 and provided a written report of his findings dated 15 February 2023.

18. The post-mortem examination showed rib fractures consistent with CPR but no unexpected signs of trauma. A post-mortem CT scan showed an enlarged heart (cardiomegaly), coronary artery calcification, a right coronary artery stent, increased lung markings, bilateral "buckle" rib fractures and a small right haemothorax (both due to CPR), previous surgery to the right ankle, and no intracranial haemorrhage.

19. Dr Young noted that the mechanism of death was most likely to be an acute myocardial infarction or a fatal cardiac arrhythmia. He noted that Mr Lewis had hypertension and diabetes mellitus which are both significant risk factors for the development of ischaemic heart disease. In addition, people with schizophrenia have an increased risk of sudden cardiac death.

20. Toxicological analysis of post-mortem samples identified the presence of venlafaxine, desmethylvenlafaxine, mirtazapine, olanzapine, amiodarone, bisoprolol and prazosin. This

was in keeping with Mr Lewis' anti-psychotic, anti-depressant and anti-hypertensive medications, and emergency treatment.

21. Dr Young provided an opinion that Mr Lewis's death was due to natural causes and the medical cause of death was 1 (a) Ischaemic heart disease in a man with chronic schizophrenia.

22. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jon Lewis, born 12 June 1965;

    b) the death occurred on 23 December 2022 at Angus Martin House, 382 Nepean Highway, Frankston, Victoria, 3199, from ischaemic heart disease in a man with chronic schizophrenia; and

    c) the death occurred in the circumstances described above.

24. I am satisfied that Mr Lewis' death was due to natural causes.

25. There is no evidence to suggest any deficit of care prior to Mr Lewis' death.

I convey my sincere condolences to Mr Lewis' friends and carers for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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:

Senior Constable Roy O'Hagan, Coroner's Investigator

The Proper Officer, Winteringham Housing Ltd

Signature:

Coroner Paul Lawrie

Date : 10 May 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.