FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1187/08

Inquest into the Death of PAUL KENNETH STEPHENS

Delivered On:	13th May, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne 3000
Hearing Dates:	13th May, 2011
Findings of:	JUDGE JENNIFER COATE
Place of death:	14/18 Alfrick Road, Croydon, Victoria 3136
Police Coronial Support Unit (PCSU):	Senior Constable Kelly Ramsey

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Court reference: 1187/08

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER COATE, State Coroner

having investigated the death of:

Details of deceased:

Surname: STEPHENS
First name: PAUL
Address: 14/18 Alfrick Road, Croydon, Victoria 3136

AND having held an inquest in relation to this death on 13th May, 2011
at Melbourne
find that the identity of the deceased was PAUL KENNETH STEPHENS
and death occurred on or about 21st March, 2008

at 14/18 Alfrick Road, Croydon, Victoria 3136

from
1a. ISCHAEMIC HEART DISEASE
1b. CORONARY ATHEROSCLEROSIS AND THROMBOSIS

in the following circumstances:

1. Paul Stephens ("Paul") was a 42-year-old man with a mild intellectual disability. In about April 1990 Paul was assessed as within the target group to receive services under the former Intellectually Disabled Persons Services Act. The police investigation also revealed that Paul had a history of asthma, drug use, Hepatitis C and a disability.

2. A report was received from the Department of Human Services in the wake of Paul's death. It revealed a considerable history of difficulty with drugs and alcohol and criminal offending over a number of years. Indeed, at the time of Paul's death he was on parole having been released from Loddon Prison on 1.8 2007. This parole order was due to expire on 1 February 2009. His performance on parole could best be described as "*patchy*".

3. The police investigation revealed that Paul appeared to have been estranged from his family for many years although the family were aware that Paul had a long term drug problem. Indeed, according to the manager of Disability Services who prepared the report for the coroner, Paul had

not kept contact with his family and had named his Disability Services case manager as his next-of-kin. Paul's financial affairs were being managed by State Trustees.

4. At the time of his death, Paul was residing in a supported residential placement provided to him by Disability Client Services.

5. In about August or September 2007 at the Salvation Army rehabilitation centre in the Basin, Paul met a woman by the name of Vicki Flanagan. In about November 2007 Paul moved into the address at Alfrick Road with Vicki Flanagan. That living arrangement appears to have been one in which Paul received some friendship support and care.

6. Ms Flanagan described to the police that the night before Paul's death, Paul had not been feeling well.

7. Ms Flanagan, when interviewed by the police, stated that she believed she was the last person to see Paul alive having seen him the night before. She checked on him in the morning between about 1045 and 1100am, at which time she knocked on the door and looked in to check on Paul. She stated that she thought something was wrong and she walked in and realised that Paul had passed away. She rang for an ambulance which attended and the attending paramedics confirmed that Paul had passed away, probably some hours earlier.

8. Ms Flanagan further stated that she believed that Paul had been drinking more than normal over the last few days and had vomited a couple of times over the last three days. She also stated to the police that Paul had complained of pain in both his arms the night before and took panadol for the pain.

9. The police were called to Paul's home and found no sign of any struggle and were of the view that Paul appeared to have died in his sleep.

10. According to the post-mortem report prepared by a Forensic Pathologist, Dr Shelley Robertson of the Victorian Institute of Forensic Medicine (VIFM), Paul died from natural causes with evidence of coronary thrombosis and atherosclerosis found on post-mortem examination. Dr Robertson found that it was likely that the symptoms being experienced by Paul prior to his death, vomiting and pains in his arms, were manifestations of ischaemic heart disease.

11. The deceased also had high levels of bupronorphene along with therapeutic levels of benzodiazepines and evidence of cannabis use. Dr Robertson found that these toxicological findings were unlikely to have contributed directly to Paul's death given his level of underlying heart disease.

12. Dr Robertson also found that Paul had Hepatitis C serology and inflammatory changes in the liver often seen in chronic intravenous drug users.

13. Paul's treating doctor, Dr David Ross provided a report to the police as part of the coronial investigation. Dr Ross stated in the report that he had seen Paul a number of times from 23 January 2008. He stated that Paul came to him for assistance in dealing with his polysubstance abuse. He noted that Paul had a history of heroin dependence and drug seeking for benzodiazepines from multiple doctors and from "*the street*". Dr Ross stated that he put Paul on Suboxone to control his opiate dependence. He also gave Paul daily Valium to control his acute withdrawals.

14. It was Dr Ross' view that as at February 2008 Paul was still engaging in "*drug seeking behaviour*". Dr Ross last saw Paul on March 5, 2008.

Conclusion

15. Given the opinion of Dr Robertson as to Paul's cause of death, and her opinion that she did not consider that his post mortem toxicological analysis contributed to his cause of death, I am satisfied that it is not necessary to examine in any further detail the circumstances surrounding Paul's death.

16. I am satisfied on the evidence that Paul was appropriately housed and had been maintaining contact with Disability Services support staff. Further, after a short period of discomfort in the days before his death, he passed away as a result of underlying natural disease.

Signature:

Judge Jennifer Coate
State Coroner
Date: 13th May, 2011

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

1. Mr P. Stephens
2. Mr Bob Hastings, Commissioner, Corrections Victoria
3. Principal Solicitor, Department of Human Services
4. Office of Correctional Services Review
5. S/C Steven Heywood, Investigating Member