IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 6212**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**BRIAN MAHER**
Date of birth:	**23 NOVEMBER 1973**
Date of death:	**10 DECEMBER 2017**
Cause of death:	**BILATERAL PNEUMONIA IN A MAN WITH DOWNS SYNDROME**
Place of death:	**QUEEN ELIZABETH CENTRE** **102 ASCOT STREET SOUTH** **BALLARAT VICTORIA 3350**

HIS HONOUR:

BACKGROUND

1. Brian Maher was born on 23 November 1973 and was 44 years old at the time of his death. Brian had Downs Syndrome and resided at a Department of Health and Human Services supported independent living accommodation in Wendouree.

2. Brian had a number of health issues including arthritis, epilepsy, heart problems and gout.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Brian's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] 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 that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Brian Maher was visually identified by Vivienne Hunter on 10 December 2017. Identity is not disputed and requires no further investigation.

[6] (1938) 60 CLR 336.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 12 December 2017, Professor Stephen Cordner, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on the body of Brian Maher and provided written report dated 16 January 2018, concluding a reasonable cause of death to be "I(a) Bilateral pneumonia in a man with Downs Syndrome". I accept his opinion in relation to the cause of death.

13. Prof. Cordner stated that Brian's death was due to natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

14. At 5:30pm on 2 December 2017, Brian ate his dinner and by 6:00pm he was short of breath. By approximately 8:00pm, Brian's is breathing worsened and he was transported by ambulance to Ballarat Hospital, where he was admitted to the Emergency Department. Despite initial care, Brian condition continued to deteriorate and on 3 December 2017, he was palliated. Brian passed away on 10 December 2017.

FINDINGS

15. Having investigated Brian's death and having considered all of the available evidence, I am satisfied that no further investigation is required.

16. I find that the care provided to Brian Maher by the Department of Health and Human Services and Ballarat Health Services was reasonable and appropriate in the circumstances.

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

    (a) that the identity of the deceased was Brian Maher, born 23 November 1973;

    (b) that Brian Maher, who had Downs Syndrome, died on 10 December 2017, at 102 Ascot Street South, Ballarat Victoria from bilateral pneumonia; and

    (a) that the death occurred in the circumstances described in the paragraphs above.

18. I convey my sincerest sympathy to Brian's family and friends.

19. Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

    (a) Brian's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 29 March 2019