IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2607

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**James Kenneth Cowl**
Date of birth:	23 December 1949
Date of death:	3 June 2018
Cause of death:	Cardiomegaly
Place of death:	1 Irwin Street, Ararat Victoria 3377

INTRODUCTION

1. James Kenneth Cowl was a 68-year-old man who was under the care of the Department of Health and Human Services (**DHHS**). He lived in a DHHS residential care house located at 1 Irwin Street, Ararat Victoria 3377 (Irwin Street facility) at the time of his death.

2. Mr Cowl was found unresponsive in his bed by a support worker on 3 June 2018. Resuscitation efforts were not successful and Mr Cowl died the same day from cardiomegaly.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Cowl's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. 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.

6. The Coroner's Investigator, Senior Constable Samantha Cubley prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, support workers, the forensic pathologist who examined Mr Cowl, treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

9. In considering the issues associated with this finding, I have been mindful of Mr Cowl's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

10. Mr Cowl had been in 'care' from a very young age.[2] The DHHS *Restrictive Interventions- legacy document* details that Mr Cowl went into care at Kew Cottages[3] at the age of six.[4]

11. Mr Cowl lived in the Aradale Asylum[5] before moving to the DHHS run Princess Street, Ararat residential facility and then finally to the Irwin Street facility.[6]

12. Mr Cowl's general practitioner, Dr Derek Pope, details that Mr Cowl had a history of 'intellectual disability, chronic schizophrenia, diverticular disease of the colon, non-insulin dependent diabetes, atrial fibrillation, and severe cardiomyopathy/ cardiac failure'.[7] Various DHHS documentation, including Mr Cowl's mental health plan, support plan and client profile list the formal psychiatric diagnosis of schizophrenia- 295.60 residual type as per DSM 1V[8].

13. As he got older, Mr Cowl was told during previous hospital visits that his heart was quite weak.[9] Mr Cowl was seen regularly by Dr Pope at the Ararat Medical Centre. In addition, Mr Cowl was also seen by a cardiologist and a dietician for his diabetes management.[10]

14. Mr Cowl moved to the Irwin Street facility approximately eight weeks before his death. He moved because of his age and health care needs.[11] He seemed to take the move 'in his stride', appearing happy during the final weeks of his life.[12]

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[1] This is 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.

[2] Statement of Beverley Williams dated 13 November 2018, Coronial Brief.

[3] Kew Cottages (1887- 2008) decommissioned psychiatric hospital. The Children's Cottages at Kew were first opened in 1887, established as a ward of the Kew Asylum. They provided separate accommodation and educational instruction for children with intellectual disabilities and some wards of the state.

[4] Restrictive Intervention- legacy document, Department of Health and Human Services undated, Coronial Brief.

[5] Aradale Asylum was an Australian psychiatric hospital, located in Ararat. It closed in 1998.

[6] Statement of Joanne Vincent dated 9 October 2018, Coronial Brief.

[7] Statement of Derek Pope of Ararat Medical Centre dated 9 October 2018, Coronial Brief.

[8] DSM 1V: Diagnostic and Statistical Manual of Mental Disorders.

[9] Statement of Beverley Williams dated 13 November 2018, Coronial Brief.

[10] Statement of Derek Pope of Ararat Medical Centre dated 9 October 2018, Coronial Brief.

15. There were approximately eight residents living at the Irwin Street facility.[13] Mr Cowl's cousin, Beverley Williams states that Mr Cowl 'would always be happy and I would describe his environment at the residential care house as exceptional. The staff were absolutely fabulous! He considered them his family… he was extremely well looked after at Irwin Street.'[14]

16. Mr Cowl was last seen by Dr Pope on 29 May 2018 for his routine referral to his cardiologist. The attending support workers reported that he appeared to be stable, with no worsening of his exercise tolerance or dyspnoea. 'A recent echocardiogram, however, showed severe worsening cardiomyopathy with very poor cardiac function…' Dr Pope informed Mr Cowl and the support workers of this.[15]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. On Sunday, 3 June 2018 at approximately 8.30am, support worker, Joanne Vincent, went into Mr Cowl's room. She asked Mr Cowl if he wanted to get up or have a sleep in. After having 'a bit of a laugh and a bit of a chat', Mr Cowl chose to have a sleep in.[16]

18. At approximately 11.00am, another support worker by the name of Patrick Monaghan, checked on Mr Cowl.[17] Mr Cowl was unresponsive and not breathing.[18]

19. Mr Monaghan called out to Ms Vincent. Together, they managed to move Mr Cowl to the floor and commenced cardiopulmonary resuscitation (**CPR**). Ms Vincent states that Mr Cowl was not responsive and they called emergency services.[19]

20. Paramedics arrived at the scene and declared Mr Cowl deceased.[20]

IDENTITY AND CAUSE OF DEATH

21. On 8 June 2018, David Cowl visually identified the body of his brother, James Kenneth Cowl, born 23 December 1949. Identity is not in dispute and requires no further investigation.

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[11] Statement of Joanne Vincent dated 9 October 2018, Coronial Brief.
[12] Statement Steve Walker dated 9 October 2018, Coronial Brief.
[13] Statement of Joanne Vincent dated 9 October 2018, Coronial Brief.
[14] Statement of Beverley Williams dated 13 November 2018, Coronial Brief.
[15] Statement of Derek Pope of Ararat Medical centre dated 9 October 2018, Coronial Brief.
[16] Statement of Joanne Vincent dated 9 October 2018, Coronial Brief.
[17] Ibid.
[18] Statement of Senior Constable Samantha Cubley dated 24 October 2018, Coronial Brief.
[19] Statement of Joanne Vincent dated 9 October 2018, Coronial Brief.
[20] Statement of Senior Constable Samantha Cubley dated 24 October 2018, Coronial Brief.

22. On 8 June 2018, Dr Ross Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Cowl's body and reviewed a post mortem computed tomography (**CT scan**), medical notes from Ararat Medical Centre and the Police Report of Death for the Coroner. Dr Young provided a written report, dated 20 July 2018, in which he formulated the cause of death as '*I(a) Cardiomegaly*'.

23. Toxicological analysis of post mortem samples taken from Mr Cowl identified the presence of bisoprolol[21] and olanzapine[22].

24. Dr Young commented that the autopsy showed an enlarged heart (heart weight of 564 grams) with myocardial fibrosis and myocyte hypertrophy. Only mild coronary artery atherosclerosis was noted.

25. Cardiomegaly is enlargement of the heart, not in keeping with normal physiological change in an individual. The predicted normal heart weight in a man of 67-68 kilograms body weight is approximately 322 grams, with a 95th percentile of 425 grams. The predicted heart weight in a man of 169-170 centimetres height is approximately 312 grams, with a 95th percentile of 440 grams. Increased heart mass is correlated with increased cardiac mortality and morbidity and is an independent risk factor for sudden death. Cardiomegaly is commonly associated with hypertension.

26. Rib fractures were seen at autopsy that were consistent with CPR. There was no post mortem evidence of any other injuries that may have caused or contributed to death.

27. I accept Dr Young's opinion as to cause of death.

FINDINGS AND CONCLUSION

28. I note Ms Williams' praise for the DHHS run Irwin Street facility. Specifically, that she cannot speak highly enough of the staff and that the facility has set the benchmark for care.[23]

29. I express my sincere condolences to Mr Cowl's family for their loss.

30. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

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[21] Bisoprolol is a synthetic beta-adrenergic blocking agent for the treatment of hypertension.
[22] Olanzapine is indicated for the treatment of schizophrenia and related psychosis. It can also be used for mood stabilization and as an anti-manic drug.
[23] Statement of Beverley Williams dated 13 November 2018, Coronial Brief.

(a) The identity of the deceased was James Kenneth Cowl, born 23 December 1949;

(b) The death occurred on 3 June 2018 at 1 Irwin Street, Ararat Victoria 3377 from cardiomegaly; and

(c) The death occurred in the circumstances described above.

31. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

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

(a) Mr David Cowl, senior next of kin

(b) Beverley Williams, interested party

(c) Senior Constable Samantha Cubley, Coroner's Investigator

Signature:

SIMON McGREGOR

CORONER

Date: 30 July 2019