IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002264

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Leo Patrick O'Sullivan
Date of birth:	14 August 1966
Date of death:	22 April 2024
Cause of death:	1(a): complications of Down's Syndrome and Dysphagia - aspiration pneumonia
Place of death:	45 Denman Street East Geelong Victoria 3219
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 22 April 2024, Mr Leo Patrick O'Sullivan was 57 years old when he died in a palliative care facility operated by Gen U (formerly known as Karingal). Mr O'Sullivan's death was expected.

2. Prior to entering palliative care, Mr O'Sullivan lived in specialist disability accommodation. Mr O'Sullivan was unable to live independently due to his history of Down's Syndrome and intellectual disability. Mr O'Sullivan was also diagnosed with Alzheimer's disease four years prior to his death.

3. Mr O'Sullivan was the second youngest of eleven siblings. He had a loving and supportive family, who visited him regularly. He also had a fulfilling career in supported employment, receiving a service aware in 2006 for 20 years of employment and competed in a broad range of sports including gymnastics, swimming, baton relays and ten pin bowling. Mr O'Sullivan was awarded an honorary black belt by his local Zen' Chin Karate Dojo.

THE CORONIAL INVESTIGATION

4. Mr O'Sullivan's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr O'Sullivan was a 'person placed in care' within the meaning of the Act and was residing in specialist disability accommodation immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

5. 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.

6. 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.

7. Victoria Police assigned First Constable Reanna Grant to be the Coronial Investigator for the investigation of Mr O'Sullivan's death. First Constable Grant complied a coronial brief which included statements from family, the forensic pathologist, treating clinicians and investigating officers.

8. This finding draws on the totality of the coronial investigation into the death of Mr O'Sullivan including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

9. In 2019, Mr O'Sullivan was diagnosed with Alzheimer's disease. His condition progressively deteriorated which complicated his significant care needs.

10. In 2024, Mr O'Sullivan was placed in palliative care. His death was expected and he died on 22 April 2024.

Identity of the deceased

11. On 22 April 2024, Mr O'Sullivan, born 14 August 1966, was visually identified by treating clinician, Dr Joseph Virgona.

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

Medical cause of death

13. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on 23 April 2023 and reviewed the post-mortem computed tomography scan and Police Report of Death (Form 83). Dr Beer provided a written report of his findings dated 24 April 2024.

14. The post-mortem examination and computed tomography scan revealed findings in keeping with the clinical history.

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

15. Dr Beer provided an opinion that the medical cause of death was 1(a) complications of Down's Syndrome and dysphagia - aspiration pneumonia.

16. I accept and adopt Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr Leo Patrick O'Sullivan, born 14 August 1966;

    b) the death occurred on 22 April 2024 at 45 Denman Street, East Geelong, Victoria, 3219, from 1(a) complications of Down's Syndrome and Dysphagia - aspiration pneumonia; and

    c) the death occurred in the circumstances described above.

18. The available evidence does not support a finding that there was any want of clinician management or care on the part of Gen U staff that caused or contributed to Mr O'Sullivan's death.

19. Having considered all the available evidence, I find that Mr O'Sullivan's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 53(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr O'Sullivan's death in chambers.

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

Ms Faye O'Sullivan, Senior Next of Kin

First Constable Reanna Grant, Coronial Investigator

Gen U

Signature:

Coroner Leveasque Peterson

Date: 27 May 2025

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.