



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002635

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Paul Lawrie
Deceased:	Richard Watson
Date of birth:	15 January 1962
Date of death:	12 May 2024
Cause of death:	ASPIRATION PNEUMONIA COMPLICATING EPILEPSY IN THE SETTING OF DOWN SYNDROME
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria 3084
Keywords:	In care, natural causes, Supported Disability Accommodation, SDA

INTRODUCTION

1. On 12 May 2024, Richard Watson was 62 years old when he died at the Austin Hospital. At the time of his death, Richard lived at a specialist disability accommodation (SDA) in Bundoora, run by Claro Aged Care and Disability Support Services (**Bundoora House**).
2. Mr Watson was born with Down Syndrome, and his medical history included dementia, epilepsy, Parkinson's disease, C1 partial quadriplegia, asthma, COVID-19, and aspiration pneumonia.

THE CORONIAL INVESTIGATION

3. Mr Watson's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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 Watson 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'.
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. First Constable (FC) Rylee Haigh acted as the Coroner's Investigator for the investigation of Mr Watson's death. FC Haigh conducted inquiries on my behalf and compiled a coronial brief of evidence.

¹ *Coroners Act 2008* (Vic) s 4(2)(j)(i).

² Specialist Disability Accommodation.

7. This finding draws on the totality of the coronial investigation into the death of Richard Watson 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.³

BACKGROUND

8. Mr Watson was born with Down Syndrome and lived at Kew Cottages until he was approximately 20 years old, when he moved to another disability support organisation "Nadrasca" in Nunawading. While in the care of Nadrasca, he lived relatively independently, with about one carer for every four clients.
9. Mr Watson was described as a lovely gentleman who was quiet, calm, and very polite and cooperative. In about 2016, he started to get dementia. In 2018, he had a seizure which resulted in a fall causing a C1 partial quadriplegia and reduced verbal communication. As a result, Mr Watson became wheelchair bound and was moved to Bundoora House.
10. When Mr Watson arrived at Bundoora House, he was noted to be very quiet, underweight and in low spirits. Within a few years, he gained weight and his health and mental state improved. However, over the final three and a half years his health deteriorated. Mr Watson suffered swallowing difficulties, difficult to control seizures and recurrent aspiration pneumonia. He also had sleep apnoea and slept with a CPAP machine. By 2024 he had essentially become non-verbal. He had recurrent hospital admissions for pneumonia, asthma or seizures. He was also more dependent on supplemental oxygen. In the final six months, Mr Watson was admitted to the Austin Hospital at least monthly.

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

Circumstances in which the death occurred

11. On 3 April 2024, Mr Watson was taken to the emergency department of the Austin Hospital following a seizure. Carers from Bundoora House told hospital staff that Mr Watson's seizure had lasted approximately seven minutes, after which he had stopped breathing and support

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.

staff commenced cardiopulmonary resuscitation. Mr Watson began breathing again after 30 to 40 seconds.

12. Upon admission, medical staff arrived at a preliminary diagnosis of aspiration pneumonia, as a chest x-ray revealed a patchy left lower lobe opacification, associated with interstitial thickening. Mr Watson was treated with oral antibiotics and anti-epileptics and remained in hospital from that time on.
13. Mr Watson completed his course of oral antibiotics but had an ongoing requirement for supplemental oxygen.
14. On 5 May 2024, Mr Watson suffered an aspiration event followed by ongoing reduced consciousness.⁴
15. On 9 May 2024, Mr Watson was transferred to the palliative care unit for end-of-life care. Mr Watson passed away on 12 May 2024 at 11.15pm.

Identity of the deceased

16. On 13 May 2024, Richard Watson, born 15 January 1962, was visually identified by his friend, Dianne Mitchell.
17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an examination on 15 May 2024 and provided a written report of his findings dated 28 May 2024.
19. The post-mortem examination and CT scan revealed cerebral atrophy and a patchy increase in lung markings.
20. Dr Lynch provided an opinion that the death was due to natural causes, and the medical cause of death was "*1(a) Aspiration pneumonia complicating epilepsy in the setting of down syndrome*".
21. I accept Dr Lynch's opinion.

⁴ Mr Watson was noted to have a Glasgow Coma Scale score of 8 immediately following this event.

FINDINGS AND CONCLUSION

22. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Richard Watson, born 15 January 1962;
 - b) the death occurred on 12 May 2024 at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084, from aspiration pneumonia complicating epilepsy in the setting of down syndrome; and
 - c) the death occurred in the circumstances described above.
23. There is nothing to suggest that the care Mr Watson received at Bundoora House or the Austin Hospital was anything other than appropriate.

ACKNOWLEDGEMENTS

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

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

DIRECTIONS

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:

Dianne Mitchell, Senior Next of Kin

Austin Health

Claro Aged Care and Disability Support Services

First Constable Rylee Haigh, Coronial Investigator

Signature:



Coroner Paul Lawrie

Date: 19 March 2026

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.
