IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002005

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	David William James Hearn
Date of birth:	21 May 1967
Date of death:	14 April 2025
Cause of death:	1a : Aspiration pneumonia in a man with cerebral palsy, intellectual disability and Lennox-Gastaut syndrome
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade Fitzroy Victoria 3065
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes, aspiration pneumonia

INTRODUCTION

1. On 14 April 2025, David William James Hearn was 57 years old when he died after a short hospital admission. At the time, David lived in Supported Disability Accommodation (**SDA**) in Kew.

2. David's medical history included Lennox-Gastaut syndrome and cerebral palsy. He required assistance for all tasks of daily living and was nonspeaking. He experienced recurrent episodes of aspiration pneumonia and received nutrition via a percutaneous endoscopic gastronomy (**PEG**) tube.[1]

THE CORONIAL INVESTIGATION

3. David's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a *'person placed in custody or care'* within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling 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.

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. This finding draws on the totality of the coronial investigation into the death of David William James Hearn. Whilst I have reviewed all the material, I will only refer to that which is directly

[1] A tube surgically inserted from the abdominal wall directly to the stomach in instances when oral intake is not sufficient to maintain adequate nutrition.

relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

7. On 13 April 2024, disability support workers noticed that David was experiencing difficulties breathing and appeared mottled. They contacted emergency services. Ambulance Victoria arrived and assessed David; he did not have a fever or tachycardia but was borderline hypotensive. He was initially hypoxic with a low blood oxygen saturation of 70%.

8. David was transported to St Vincent's Hospital Melbourne and upon admission, was drowsy, he had laboured breathing and a respiratory rate of 40-60 breaths per minute.[3] A chest x-ray showed right sided pneumonia. He was in a state of respiratory acidosis – a form of Type 2 respiratory failure.[4]

9. Clinicians commenced intravenous antibiotics and contacted David's mother, Barbara Hearn, to inform her of his poor prognosis.[5] With Barbara's agreement, clinicians continued to administer antibiotics and supplemental oxygen and also initiated comfort measures including morphine.

10. During the afternoon of 14 April 2025, clinicians reviewed David, and he demonstrated bronchial breathing[6] with shallow breaths. That evening, following further discussion with David's family, clinicians ceased active treatment and prioritised his comfort.

11. At 8:45pm on 14 April 2025, David was declared deceased.

Identity of the deceased

12. On 15 April 20225, David William James Hearn, born 21 May 1967, was visually identified by his mother, Barbara Hearn.

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[2] 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.

[3] An average respiratory rate for an adult is between 12 and 20 breaths per minute.

[4] Respiratory acidosis occurs the lungs cannot remove carbon dioxide from the blood, causing the blood to become acidic.

[5] I note that Barbara was David's Medical Treatment Decision Maker.

[6] Bronchial breathing can indicate an underlying lung problem, such as pneumonia.

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

Medical cause of death

14. Forensic Pathologist Dr Gregory Young of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 16 April 2025 and provided a written report of his findings dated 17 April 2025.

15. The post-mortem examination revealed signs of medical intervention. A post-mortem computed tomography (**CT**) scan showed consolidated lungs with changes worse in the right lung (including calcification) than the left and opacified right frontal sinus.

16. Toxicological analysis of post-mortem samples detected medication consistent with the medical history.

17. Dr Young provided an opinion that the medical cause of death was 1(a) *Aspiration pneumonia in a man with cerebral palsy, intellectual disability and Lennox-Gastaut syndrome.* He stated that the death was due to natural causes.

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

FINDINGS AND CONCLUSION

19. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was David William James Hearn, born 21 May 1967;

    b) the death occurred on 14 April 2025 at St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy Victoria 3065, from 1(a) *Aspiration pneumonia in a man with cerebral palsy, intellectual disability and Lennox-Gastaut syndrome*; and

    c) the death occurred in the circumstances described above.

20. I am satisfied that David's death occurred due to natural causes and as such, pursuant to the carveout under section 52(3A) of the Act, have determined not to hold an inquest into his death.

I convey my sincere condolences to David'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:

Barbara Hearn, Senior Next of Kin

St Vincent's Hospital Melbourne

Senior Constable Lara Zukowski, reporting member, Victoria Police

Signature:

Coroner Leveasque Peterson

Date: 18 November 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.