IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007902

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Rowan David Tydell
Date of birth:	11/08/1962
Date of death:	11/11/2025
Cause of death:	1a: Pneumonia 2: Trisomy 21
Place of death:	The Royal Melbourne Hospital 300 Grattan Street Victoria 3050
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 11/11/2025, Rowan David Tydell **(Mr Tydell)** was 63 years old when he died at the Royal Melbourne Hospital, 300 Grattan Street Victoria from 1a : Pneumonia 2 : Trisomy 21.

THE CORONIAL INVESTIGATION

2. Mr Tydell's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to his death.[1] The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

3. 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.

4. This finding draws on the totality of the coronial investigation into the death of Rowan David Tydell. 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.[2]

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

Circumstances in which the death occurred

5. Prior to his death, Mr Tydell resided at his supported residential living facility situated at 24 Banksia Grove, Tullamarine. He had lived there since April 2025. Mr Tydell had a past relevant medical history which included down syndrome, Alzheimer's disease, epilepsy, and motor dyspraxia.

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[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

[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.

6. Mr Tydell required support for all daily living activities. He was mostly non-verbal but carers were able to interpret his gestures and body language to understand his needs.

7. On 10 November 2025, Mr Tydell presented to the Royal Melbourne Hospital after being unwell. He was diagnosed with pneumonia and admitted for treatment. After discussions with family, Mr Tydell was admitted to palliative care.

8. Sadly he passed away on 11 November 2025.

Identity of the deceased

9. On 14 November 2025, Rowan David Tydell, born 11/08/1962 was visually identified by Ms Cassar.

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

Medical cause of death

11. Adjunct Assoc. Prof. Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 14 November 2025 and provided a written report of his findings

12. Dr de Boer provided an opinion that the medical cause of death was 1(a) Pneumonia with contributing factors Trisomy 21.

13. Dr de Boer provided an opinion that the cause of death was due to natural causes.

14. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is Rowan David Tydell, born 11/08/1962;

    b) his death occurred on 11/11/2025 at the Royal Melbourne Hospital 300 Grattan Street Victoria 3050 from 1a : Pneumonia 2: Trisomy 21; and

    c) his death occurred in the circumstances described above.

16. Having considered all the available evidence, I find that Mr Tydell's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion

under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Tydell's death.

I convey my sincere condolences to Mr Tydell's family, loved ones and carers 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:

Faye Benson, Senior Next of Kin

Naomi Baquing, Scope Disability Services

Constable Melanie, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 03 June 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.