IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004708

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Gary William Kennedy
Date of birth:	27 May 1951
Date of death:	18 August 2022
Cause of death:	1(a) Sudden death in a man with chronic aspiration pneumonia, covid-19 infection, schizophrenia and Parkinson's disease
Place of death:	53 Mcgibbony Street, Ararat, Victoria, 3377
Keywords:	Disability Care Facility, Ararat, aspiration pneumonia, COVID-19, schizophrenia, Parkinson’s Disease.

INTRODUCTION

1. On 18 August 2022, Gary William Kennedy was 71 years old when he died at his Disability Care Facility (**DCF**). At the time of his death, Gary lived at 53 Mcgibbony Street, Ararat, Victoria.

2. At the time of his death, Gary was a ward of the state with no known living relatives and had lived in the DCF for the past four years.[1] His medical conditions included Parkinson's disease, schizophrenia, absent seizures, decreased vision, and low mobility.[2]

3. At the time of his death, Gary was prescribed benzotropine, olanzapine, ostelin, pantoprazole, carbidopa and levodopa, valproate, thiamine, ferrograd, benserazide, metformin, clonazepam, Movicol, Coloxy with senna, molnupiravir, and vitamim B12.[3]

THE CORONIAL INVESTIGATION

4. Gary's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (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.

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.

[1] Victoria Police, Form 83 dated 18 August 2022, page 2.
[2] Medical Examiner's Report dated 13 October 2022, page 2.
[3] DCF, Emergency Client Profile – Gary Kennedy.

7. This finding draws on the totality of the coronial investigation into the death of Gary William Kennedy 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.[4]

8. In considering the issues associated with this finding, I have been mindful of Gary'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.

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

Circumstances in which the death occurred

9. On 18 August 2022 at approximately 7.30am, Gary was found unresponsive in his room by his carer, Pauline Maxwell. Ms Maxwell contacted emergency services and commenced cardiopulmonary resuscitation.[5]

10. Ambulance Victoria paramedics attended the scene and continued resuscitation efforts however Gary was unable to be revived and was verified as deceased at 8.00am.[6]

Identity of the deceased

11. On 18 August 2022, Gary William Kennedy, born 27 May 1951, was visually identified by his carer, Michelle Sobczak.

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

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[4] 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.

[5] Victoria Police, Form 83 dated 18 August 2022, page 2.

[6] Ambulance Victoria Verification of Death dated 18 August 2022.

Medical cause of death

13. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 30 August 2022 and provided a written report of her findings dated 13 October 2022.

14. The post-mortem examination revealed extensive chronic aspiration pneumonia. Other findings included pulmonary oedema, focal jejunal intraluminal remote gastrointestinal haemorrhage, cholelithiasis, multiple biliary hamartomas, minor hepatic steatosis, benign nephrosclerosis, a left kidney cyst, and acute-on-chronic oesophagitis and benign myopericytoma.

15. There was no post-mortem evidence of violence or injury contributing to death.

16. COVID-19 screening returned a positive result in the back of the nose but not in the lungs, with no evidence of COVID-19 related lung disease observed.

17. Toxicological analysis of post-mortem samples identified the presence of the clonazepam metabolite 7-aminoclonazepam, as well as valproic acid, metformin, and olanzapine.

18. Dr Glengarry noted that there was significant chronic lung disease in the form of chronic aspiration pneumonia with extensive bilateral histological changes. No acute pneumonia was observed, however. Risk factors for aspiration include comorbidities of schizophrenia, Parkinson's disease, absence seizures, poor vision, and poor mobility.

19. Dr Glengarry further noted that the autopsy showed that Gary had significant underlying natural disease in the setting of a superimposed COVID-19 infection. Whilst the precise mechanism of death was not determined with certainty, Dr Glengarry opined that the combined effects of Gary's multiple natural disease processes interacting with superimposed infection acted in concert to cause death.

20. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) sudden death in a man with chronic aspiration pneumonia, covid-19 infection, schizophrenia and Parkinson's disease.

21. Dr Glengarry further opined that, on the basis of the available information, the death was due to natural causes.

22. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Gary William Kennedy, born 27 May 1951;

    b) the death occurred on 18 August 2022 at 53 Mcgibbony Street, Ararat, Victoria, 3377, from *sudden death in a man with chronic aspiration pneumonia, covid-19 infection, schizophrenia and Parkinson's disease*; and

    c) the death occurred in the circumstances described above.

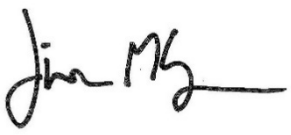
I convey my sincere condolences to Gary's family for their loss.

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:

Leading Senior Constable R. L. Murdoch, Victoria Police, Reporting Member

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 27 October 2022

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.