IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003026

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Richard Paul Atkins
Date of birth:	28 May 1959
Date of death:	Between 31 May 2024 and 1 June 2024
Cause of death:	1a : ISCHAEMIC HEART DISEASE IN A MAN WITH EPILEPSY
Place of death:	8 Moira Road Kilsyth Victoria 3137
Keywords:	In care; natural causes

INTRODUCTION

1. On 1 June 2024, Richard Paul Atkins was 65 years old when he was found deceased by his carers. At the time of his death, Richard lived in a Specialist Disability Accommodation at 8 Moira Road, Kilsyth, Victoria, 3137.

2. Richard was born and raised in eastern suburbs of Victoria and had three other siblings. Richard was born with an intellectual disability and epilepsy; this was managed with medication across his life.

3. Richard had lived in the Moira Road residence since 2004 and shared his home with four other people under the management and care of Scope Australia.[1] Richard was diagnosed with the following conditions including: intellectual disability, autism, epilepsy, hyponatremia, hypertension, osteoporosis, transient ischemic attacks, deep vein thrombosis in the lower calf and left knee fracture.[2]

4. In the lead up to his death, Richard had a decline in his mobility as he had reportedly become more reliant on support staff when walking and was observed to drift diagonally. He had three reported falls on 3 March 2024, 12 April 2024 and 25 April 2024. On 17 May 2024, Richard was assessed for a suitable walker and received this two days before his death on 29 May 2024.

5. Richard slept in a hi-low bed that he operated independently. He also had an epilepsy seizure mat that was positioned under his mattress and was connected to an alert alarm in the Scope staff office where staff slept overnight.

THE CORONIAL INVESTIGATION

6. Richard'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.

[1] *Coronial Brief*, Statement of Lisa Maree Evans (Scope Australia).
[2] Ibid.

7. Because Richard was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling[3] at the time of his death, his passing was determined to be 'in care' and, as such, is subject to a mandatory inquest, unless the cause of death is a natural one, pursuant to section 52(3A) of the Act, which is indeed the case here.

8. 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.

9. 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.

10. Victoria Police assigned Leading Senior Constable David Gleeson to be the Coronial Investigator for the investigation of Richard's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Richard Paul Atkins 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]

12. In considering the issues associated with this finding, I have been mindful of Richard's 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.

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[3] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

[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.

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

Circumstances in which the death occurred

13. On 31 May 2024, Richard arrived home from his regular day program and had afternoon tea as was his usual routine. He had some rest in his bedroom through the evening and completed his evening routine with staff checking on him at 10:00 pm.[5]

14. The following morning on 1 June 2024, at around 8:00 am, Scope staff entered Richard's bedroom to check on him and administer his morning medication. Scope staff attempted to wake Richard but noticed that he was not responding and did not appear to be breathing. Scope staff commenced resuscitation and called triple zero emergency services.[6]

15. Ambulance paramedics arrived shortly at 8:13 am and took over resuscitation attempts but pronounced Richard deceased shortly after. Police members attended the premises at 9:55 am to conduct an investigation and did not uncover anything suspicious about his passing.[7]

Identity of the deceased

16. On 1 June 2024, Richard Paul Atkins, born 28 May 1959, was visually identified by their support worker, Romy Gray.

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

Medical cause of death

18. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 June 2024 and provided a written report of his findings dated 3 December 2024.

19. The post-mortem examination revealed the following:

    a) Neuropathological findings evidenced known epilepsy, mild astrocytosis left amygdala and marginal cerebellar Purkinje cell loss;

    b) Moderate to severe triple vessel coronary artery atherosclerosis; and

[5] *Coronial Brief*¸ Statement of Lisa Maree Evans (Scope Australia)
[6] Ibid.
[7] *Coronial Brief*, Statement of Leading Senior Constable David Gleeson.

c) There was bandlike replacement fibrosis in the lateral wall of the left ventricle accompanied with adipose and aplasia raising the possibly of underlying cardiomyopathy although these features were not widespread. There was no myocarditis or myocyte disarray; and

d) The most likely cause for the fibrosis is ischaemic in nature due to coronary artery atherosclerosis. Given that the features can be seen in some forms of cardiomyopathy, particular arrhythmogenic cardiomyopathy, family follow-up was initiated.

20. Toxicological analysis of post-mortem samples identified the presence of carbamazepine (~7.5 mg/L), phenytoin (~5.1 mg/L) and trace amounts of paracetamol.

21. Dr Bouwer provided an opinion that the medical cause of death was 1(a) ISCHAEMIC HEART DISEASE IN A MAN WITH EPILEPSY and I accept his opinion.

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 Paul Atkins, born 28 May 1959;

b) the death occurred between 31 May 2024 and 1 June 2024 at 8 Moira Road, Kilsyth, Victoria, 3137, from 1(a) ISCHAEMIC HEART DISEASE IN A MAN WITH EPILEPSY; and

c) the death occurred in the circumstances described above.

23. At all material times, Richard's care was reasonable and appropriate.

24. As Richard was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[8] I am satisfied by the available evidence that Richard's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

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

[8] Section 52(2) of the Act.

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:

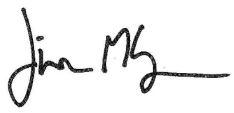
Pauline Atkins, Senior Next of Kin

Naomi Baquing, Scope Australia

Nick Abarno, National Disability Insurance Agency

Leading Senior Constable David Gleeson, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 08 October 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.