MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Geoffrey Brian Homan

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Geoffrey Brian Homan;

b) Geoffrey Brian Homan was born on 8 March 1937. He was aged 83 years at the time of his death. He lived by himself in a one-bedroom unit in Ravenswood, being the property of Housing Tasmania and managed by Community Housing Limited. He has two daughters to his former marriage and he previously worked as a gas meter technician. Mr Homan lived a reclusive lifestyle, being largely estranged from his former wife and daughters and having no friends. He was physically frail but self-sufficient in his daily living.

Mr Homan had consumed alcohol in excessive quantities for many years although it is unclear whether he ceased alcohol consumption before his death. There are no records indicating Mr Homan had suffered from any diagnosed mental health issues. Mr Homan rarely visited his general practitioner, was not prescribed regular medications and chose not to receive support from any services.

Medical records from Tasmanian Health Service revealed that he presented to the Launceston General Hospital (LGH) on 20 December 2019 with chest pain. He was diagnosed as having suffered a myocardial infarction (heart attack). After initial investigations, Mr Homan disconnected himself from his cardiac monitor, declined the proposed angiogram and discharged himself against medical advice. At this time, hospital treating staff recorded that Mr Homan said that he wished to "just *die at home as he is 82 and it's a waste of time at his age*". He declined follow-up and was unable to be contacted by his general practitioner. Although he was prescribed various medications for his cardiac condition upon discharge, he did not continue to take them.

On 12 June 2020, Mr Homan again presented to the LGH, having suffered another myocardial infarction. He remained as an inpatient until his discharge on 17 June. Following his discharge, he was prescribed several cardiac-related medications, including blood thinning medications.

On 16 June 2020, Mr Homan underwent a diagnostic coronary angiogram which revealed severe calcific triple vessel disease with significant left ventricular systolic dysfunction. He was assessed by the cardiologist as being too high risk for coronary artery bypass surgery and percutaneous interventions. It was recommended in his discharge summary to his general practitioners that he should continue with optimal medical management. His general practitioner tried to call him upon receipt of the discharge summary but was unable to make contact with him.

The last known contact with Mr Homan was by CHL housing officer, Ms Chenae Simpson. On 18 June, Ms Simpson made a phone call to Mr Homan for a welfare check during the COVID-19 pandemic. In that discussion, Mr Homan told Ms Simpson that he had all the support he required and that he was physically very well. This check resulted in a recorded "low" vulnerability assessment concerning his tenancy.

From 18 June 2020 until 21 December 2020, CHL housing officers made multiple attempts to contact Mr Homan by phone calls and letters to arrange a virtual property inspection and a welfare check but they were unsuccessful in making contact with him. A CHL housing officer visited the property on 14 September 2020 in an attempted welfare check but there was no answer to the door. During this period, CHL received calls from one of Mr Homan's neighbours that she had not seen him for several months. However, there is an indication in the CHL records that a neighbour had seen Mr Homan in early October 2020. Mr Homan did not answer the telephone when a CHL housing officer tried to call him for a welfare check on 18 November 2020.

A CHL housing officer also made two unsuccessful attempts to visit Mr Homan's property on 8 and 16 December 2020 respectively. On these occasions, Mr Homan did not respond to the door knocks. There were no further attempts made by CHL to enter the property on these occasions.

On 21 December 2020, Ms Simpson attended the unit complex in which Mr Homan lived on matters relating to tenants in other units in the complex. Ms Simpson decided that she would visit Mr Homan's unit since she had the master key. In her affidavit, Ms Simpson stated that she thought Mr Homan may have vacated the property as it was not uncommon for tenants not to give notice.

Upon entering the unit, Ms Simpson sighted a male lying on the bed obviously deceased. Ms Simpson contacted CHL management who, in turn, called Tasmania Police. Police officers arrived shortly thereafter and investigated the scene. They noted that the body was in a decomposed state, with a hospital identification bracelet attached to the left wrist. They located a wallet containing cash, numerous items of value and testamentary documents. The front door key of the unit and various medications, mostly unopened, were found left on the dining room table. The officers concluded that there were no suspicious circumstances at the scene.

The forensic pathologist conducting the autopsy noted no signs of violence or injury upon the body. He identified the presence of severe calcified coronary atherosclerosis of all three arteries and considered that this condition caused death. I accept the opinion of the forensic pathologist and, in doing so, I rule out suicide and drug overdose as causes of death. I note that Mr Homan was positively identified by DNA comparison with his daughter.

c) Mr Homan's death was due to natural causes, being ischaemic myocardial fibrotic heart disease due to or as a consequence of severe calcified coronary atherosclerosis and stenosis.

d) Mr Homan died between 18 June 2020 and 21 December 2020 at Ravenswood, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Homan's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavit confirming life extinct;
- Affidavits and DNA report regarding identification of Mr Homan;
- Affidavit of the forensic pathologist who conducted the autopsy;
- Affidavit of Kelly Leigh Bradley, Mr Homan's daughter;
- Affidavit of Chenae Simpson, Mr Homan's Housing Officer from CHL;
- Tasmanian Health Service records for Mr Homan;
- Report to the Coroner from CHL together with relevant policies; and
- CHL records of client contact history for Mr Homan.

Comments and Recommendations

I am unable to determine exactly when, in the six-month period between 18 June and 21 December 2020, Mr Homan died. He was reclusive by choice and therefore isolated from family and friendship connections and social supports. His rent was being paid to CHL by automatic deductions from his bank account. He had chosen not to nominate a next of kin or emergency contact for his tenancy records with CHL.

In the tenancy of his unit, Mr Homan was entitled to quiet enjoyment with only limited exceptions by law allowing CHL (as landlord or agent for the landlord) to enter the unit without notice.[1]

CHL, by its policies and practices, provides assistance and support to its tenants for the primary purpose of sustaining their tenancies. To this end, welfare checks with tenants are conducted by the housing officers. Regular property inspections are also conducted as part of managing the properties.

Mr Homan was elderly, frail and reclusive. It was foreseeable that he might pass away in his unit without anyone, including neighbours, becoming aware of that fact for a significant period of time. In the 6-month period in question, CHL received information about him which suggested that he may have been absent or that there was a welfare concern. Equally, it also had information that he was alive and in occupation of his unit. CHL was unable to contact Mr Homan in the course of its regular operations during this 6-month period but its officers, understandably, did not believe that Mr Homan was deceased.

I do not consider that CHL's duties extended to taking a more proactive approach to making contact with Mr Homan during this period for the purpose of ensuring that he was alive and well. I therefore make no criticism of that organisation.

I convey my sincere condolences to the family of Geoffrey Brian Homan.

Dated: 24 February 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner

[1] Section 50 and section 56 of the Residential Tenancy Act 1997