MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Sean Erwin Mansell

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

a) The identity of the deceased is Sean Erwin Mansell (Mr Mansell);

b) Mr Mansell's death occurred in the circumstances set out in this finding;

c) The cause of Mr Mansell's death cannot be determined; and

d) Mr Mansell died between 23 and 24 November 2021 at Kingston, Tasmania.

In making these findings I have had regard to the evidence gained in the comprehensive investigation into Mr Mansell's death which includes:

- the Police Report of Death for the Coroner;
- affidavits as to identity and life extinct;
- affidavit of the forensic pathologist Dr Andrew Reid;
- affidavit of Mr Neil McLachlan – Troup, forensic scientist at Forensic Science Service Tasmania;
- affidavit of Ms Sinsa Mansell, senior next of kin; and
- forensic and other evidence.

Background

Mr Mansell was born on 21 February 1964. He was 57 years of age, single and he resided on his own in accommodation provided by Centre Care Evolve at Kingston at the date of his death. Mr Mansell was born in northern Tasmania and was the youngest of six siblings. He was taken into the care of the State when he was very young. He had a very difficult upbringing which included time spent in childrens' homes and detention centres. His daughter advised the Coroners' office he was an alcoholic before he had reached the age of 10. No doubt his education was significantly impacted by these events.

Mr Mansell was homeless and lived on the streets for the majority of his life. This brought him into contact with the criminal justice system and with offenders who had criminal records. In his youth and as an adult Mr Mansell was no stranger to the courts. He was convicted of a number of offences and spent periods of time in prison. From about 2013, when Mr Mansell was 49 years of age, the frequency and seriousness of his offending reduced significantly.

In 2015 Mr Mansell was the victim of a very serious assault in Launceston at the hands of three assailants who were subsequently identified, charged, convicted and sentenced to periods of imprisonment. The facts of that assault are that Mr Mansell had with him $140 in cash and two bottles of alcohol he intended to drink in a park. As he was walking along, he heard voices in a laneway and went to investigate. He found the three assailants also drinking. At their invitation Mr Mansell joined them and consumed one of his bottles before starting on the second bottle. For reasons unknown, one of the assailants kicked Mr Mansell and caused him to fall to the ground. One of the other men then kicked him while he was on the ground. The three men all then kicked Mr Mansell over a period of about 15 to 20 minutes, at least 20 times to the head and body. They continued despite obvious injuries to Mr Mansell and despite him asking them on numerous occasions to stop. They then left the area and obtained some food and returned a number of hours later at about 4.00am. Mr Mansell was still in the laneway and he was assaulted again by being kicked. They then set fire to his hair and beard more than once. The three men then left. At about 7.20am a member of the public found Mr Mansell still lying in the laneway. An ambulance was called and Mr Mansell was taken to hospital. Police were also called. Mr Mansell was intoxicated and badly injured. Those injuries required surgery and included fractures to his facial bones, specifically a fracture to the medial wall of the right orbit, and a fracture to the right orbital floor, fractures to the tip of the nasal bone, and to the lateral wall of the right maxillary sinus. He had fractured ribs and numerous abrasions and bruising to his knees, elbows, back, stomach and rib area. In addition a CT scan disclosed a three to four mm haemorrhagic contusion in the right parietal area of the brain.

Dr Reid has indicated some of the medical records he inspected suggested Mr Mansell acquired a brain injury as a child whereas other records suggest the brain injury occurred because of the assault mentioned above. Post-mortem and ante-mortem CT scans showed evidence of a previous right parietal craniectomy. This is a procedure which involves removal of a portion of a person's skull which helps relieve extra pressure on the brain. I find this procedure was performed after the assault given the resultant haemorrhagic contusion which was found on the CT scan taken after the assault.

Despite Mr Mansell's difficult life circumstances and the fact he was never married he had a daughter, Sinsa Mansell, and a son, Harley Mansell. In 2018 Ms Mansell organised community housing in Hobart for her father. The next year he moved to the unit in Kingston which was provided by Centre Care Evolve. Both Mr Mansell's daughter and son cared for their father until they travelled overseas for work. From that point the National Disability Insurance Scheme provided assistance through the provision of a support worker, a cleaner and meals on wheels in 2019. Mr Mansell enjoyed playing golf and eight ball. He also attended a men's group every Tuesday and played in a local band. At the date of his death he was close to both his children.

Circumstances leading to Mr Mansell's Death

At 8.30am on 24 November 2021, Mr Mansell's support worker and his next-door neighbour, Mr Freeman, knocked on Mr Mansell's door as they normally would. Mr Freeman had taken on the role of prompting Mr Mansell to take his medication each morning and night. There was no answer. Mr Mansell's cleaner then arrived and he could also not raise Mr Mansell. Mr Freeman opened the front door, which is normally unlocked, and observed Mr Mansell lying on a bed in the lounge room. Mr Freeman assumed Mr Mansell was asleep.

Mr Freeman again knocked on Mr Mansell's front door at about 10.00am but again he could not raise Mr Mansell. Mr Freeman then went to purchase petrol and on his return at approximately 10.30am he again entered Mr Mansell's unit and determined Mr Mansell was deceased. He immediately called emergency services.

Investigations

When police arrived at 10.50am ambulance officers were already in attendance and they confirmed Mr Mansell was deceased. Attending police searched and examined Mr Mansell's unit and found no signs of any suspicious activity. They briefed officers from the Criminal Investigation Branch (CIB) and Forensics Unit (FU) of Tasmania police. Officers from CIB and the FU determined they would not attend the scene because they agreed with the investigating officers that there were no suspicious circumstances surrounding Mr Mansell's death. This death was reportable under the *Coroners Act* 1995 because it occurred in this State, was unexpected and its cause was unknown[1].

Ms Mansell, the senior next of kin, objected, as is her right, to any invasive post-mortem examination. She did however agree to a non-invasive post-mortem which could involve a

[1] See the definition of *reportable death* in s3 of the *Coroners Act* 1995.

CT scan, review of any medical records, external examination of the body and the taking of a blood sample.

The non-invasive post-mortem showed features of self-neglect and gastrointestinal haemorrhage (melena), no evidence of recent trauma, unchanged appearances of previously seen neurological involution and obvious calcified pancreatitis. There was background history of multiple episodes associated with intoxication, alcohol withdrawal related seizures and a previous traumatic brain injury with craniectomy.

Dr Reid says those with alcohol dependence and complications related to such a condition are at risk of sudden death, with or without intoxication. The mechanism of death in those circumstances include seizures, gastrointestinal haemorrhage complications, liver and pancreatic failure and complications of abnormal metabolism which include alcoholic ketoacidosis.

The results of the toxicological analysis found no alcohol or acetone which is evidence of alcoholic ketoacidosis. However valproic acid, which is an anticonvulsants drug, and THC which is the active ingredient of cannabis were found. The concentration of THC was within the range reported to be associated with recent use, that is within hours, and the concentration of valproic acid was below a reported therapeutic range. Dr Reid says these drugs did not cause or contribute to Mr Mansell's death.

Dr Reid says, as a result of his post-mortem examination, Mr Mansell's cause of death is undetermined although he goes on to say that the cause of death is *possible* sudden unexpected death in epilepsy (SUDEP). This diagnosis is one of exclusion and is defined specifically as the *"sudden, unexpected, witnessed, or unwitnessed, non-traumatic, and non-drowning death in patients with epilepsy with or without evidence of a seizure and excluding documented status epilepticus equal to or greater than 30 minutes in duration, in which post-mortem examination does not reveal a structural or toxicologic cause for death".*

A diagnosis of epilepsy is a necessary precondition for the subsequent diagnosis of SUDEP. The underlying cause of the epilepsy in this case was, in Dr Reid's opinion, the acquired brain injury sustained in the assault mentioned above. It was also noted there was a history of alcohol withdrawal seizures.

Dr Reid goes on to say the category of *possible* SUDEP includes cases that otherwise meet the criteria for SUDEP but have *competing* causes of death. *Near* SUDEP describes cases in which cardiorespiratory arrest was reversed by resuscitation efforts with subsequent survival for more than one hour. Resuscitation was not possible in this case. Accordingly the subcategory of *near* SUDEP is not applicable. However, in this case, there were several

competing causes of death including gastrointestinal haemorrhage and chronic pancreatitis, tuberculosis and hepatitis C infection. Dr Reid says these conditions all significantly contributed to Mr Mansell's death.

Comments and Recommendations

The circumstances of Mr Mansell's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Mansell.

Dated: 28 June 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner