MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the death of Michael Wayne Reardon

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

a) The identity of the deceased is Michael Wayne Reardon;

b) Mr Reardon died as a result of a complication of diabetes mellitus;

c) The cause of Mr Reardon's death was right lower lobe pneunmonia; and

d) Mr Reardon died on 9 January 2020 at 1 Reiby Street, Glenorchy, Tasmania.

1. In making the above findings I have had regard to the evidence gained in the investigation into Mr Reardon's death. The evidence includes:
   - Police Report of Death for the Coroner;
   - Affidavits establishing identity and life extinct;
   - Police body worn camera footage;
   - Report – Dr Michael Burke, Forensic Pathologist;
   - Report – Forensic Science Service Tasmania;
   - Report – Dr Anthony J Bell, Medical Advisor to the Coronial Division;
   - Medical records – Glenorchy Medical Centre;
   - Medical records – Tasmanian Health Service – Royal Hobart Hospital;
   - Medical Records – Mental Health Service;
   - Affidavit – Ms Susan Frendo, sworn 9 January 2020;
   - Police Record of Interview with Phillip John Reardon, conducted 9 January 2020;
   - Police Record of Interview with Julie Maree Reardon, conducted 9 January 2020;
   - Affidavit – First Class Constable Angela Ghedini, sworn 22 June 2020 (and photographs);

- Photographic and forensic evidence; and
- Coronial Investigation file – Jean May Reardon.

Introduction

2. Mr Michael Reardon died at home, aged 69 years, on 9 January 2020. He lived with his sister Julie, and brother Phillip. Michael suffered a number of medical conditions including schizophrenia and diabetes. He had one eye, urinary incontinence and suffered from venous insufficiency in his legs.
3. He was entirely dependent upon his brother and sister for care. Philip also apparently suffered schizophrenia. Michael's various medical conditions were treated by prescription medication prescribed by a general practitioner. Julie administered Michael's medication.
4. Michael moved in with Julie and Philip after their mother's death in September 2013. Mrs Reardon had also been cared for by Julie. Coroner McTaggart who investigated Mrs Reardon's death concluded that her death may well have been prevented if Julie and Philip had sought medical assistance for their mother earlier than they did. Coroner McTaggart concluded that Julie and Philip "were incompetent to deal with the changed state of health of their mother and the increased level of care required". The circumstances of Mrs Reardon's death are remarkably similar to the death of her son Michael.

Circumstances of death

5. Exactly what happened on 9 January 2020 is not entirely clear. Julie subsequently told investigators that at about 10.30am she gave Michael his medication along with two glasses of orange juice. Julie subsequently told investigators that she left the room briefly to go to the toilet and when she returned she found her brother dead in his chair in the living room of the house. Instead of calling emergency services, she telephoned her cousin Ms Frendo, claiming to have been unable to "get through" to police and emergency services. Ms Frendo said in her affidavit that she received the telephone call at 3.00pm from Julie who sounded "really distressed". By now, if Julie's account to investigators was correct, Michael had probably been dead for some hours.
6. Julie told Ms Frendo that Michael was dead and asked her to come over as she did not know what to do.
7. Ms Frendo immediately made her way to 1 Reiby Street, Glenorchy. When she arrived the front door was open. She described walking inside and seeing "stuff

piled up everywhere". I observe that police body worn camera footage and the scene photographs graphically illustrate the mess which confronted Ms Frendo.

8. Philip was apparently sitting in a chair at the kitchen table. Ms Frendo made her way through the piles of rubbish to where Michael was sitting in a sofa chair in the corner of the living room. He was clad only in a pair of blue underpants. She checked his wrist for a pulse but could not locate one. She described his upper body as feeling warm but his lower legs as "cold".
9. Ms Frendo telephoned 000 and asked for an ambulance (something which appears to have caused her no difficulty). An ambulance arrived shortly after. Ambulance paramedics found Michael to have low glucose levels, but were unable to resuscitate him. Paramedics called police.
10. Uniform, specialist forensic and officers from the Criminal Investigation Branch all attended and examined the scene and circumstances of Michael's death.

Investigation

11. The fact of Michael's death was reported in accordance with the requirements of the *Coroners Act* 1995. After formal identification by Ms Frendo, his body was taken to the Royal Hobart Hospital.
12. At the Royal Hobart Hospital, experienced forensic pathologist Dr Michael Burke performed a post-mortem examination on Michael's body. He provided a report in which he expressed the opinion that the cause of Michael's death was a complication of diabetes mellitus. The autopsy itself revealed no injury which could have caused or contributed to Michael's death. Post-mortem examination showed bronchopneumonia within the right lung. Toxicological analysis of samples taken at autopsy proved unremarkable.
13. I accept Dr Burke's opinion as to the cause of Michael's death.

Conclusion

14. Michael was entirely dependent upon Julie and Philip for his care. Philip, by reason of his own mental health, was unable to take any active role in relation to that care. I accept that in so far as the administration of medication is concerned, Julie performed adequately.
15. However, Michael lived in terrible conditions which suggests clearly that the care he was receiving was inadequate. Moreover, I simply cannot accept Julie's claim that she was unable to "get through" to emergency services to seek the help her brother desperately needed. It is to me a self-evident proposition that

if medical care had been sought earlier, then Michael may have had a chance to survive.

16. I observe this is the second occasion when a family member cared for by Julie has died in what were apparently avoidable circumstances.
17. This finding, in draft, was sent to Ms Julie Reardon and an opportunity extended to her to provide comments or any additional information about the circumstances of her brother's death. She did not respond to that invitation. I therefore proceed on the basis that none of these findings are disputed by her.

Comments and Recommendations

18. The circumstances of Mr Reardon's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.
19. I convey my sincere condolences to the family and loved ones of Mr Reardon.

Dated 8 April 2022 at Hobart in the State of Tasmania.

Simon Cooper

Coroner