IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000387

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Terrence Michael O'Sullivan
Date of birth:	14 May 1967
Date of death:	19 January 2025
Cause of death:	1a : Lung abscess and bronchopneumonia
Place of death:	6 Young Street Sunshine West Victoria 3020
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 19 January 2025, Terrence Michael O'Sullivan was 57 years old he was located deceased at home. He is dearly missed by his family including sister, Leigh Heskey.

2. At the time of his death, Mr O'Sullivan resided at a Home@Scope facility in Sunshine West. a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Mr O'Sullivan received funded daily independent living support due to his disability which included diagnoses of intellectual disability, rubella, blindness and deafness. He used a wheelchair and a hoist to mobilise and had been living in care since his childhood.

THE CORONIAL INVESTIGATION

3. Mr O'Sullivan's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to his death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

4. 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.

5. 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.

6. This finding draws on the totality of the coronial investigation into the death of Terrence Michael O'Sullivan. Whilst I have reviewed all the material, I will only refer to that which is

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

7. On 12 January 2025, Terrence's carers observed a pressure wound on his left hip. It was not an open wound or ulcer, but the skin was discoloured. He was transported to hospital and admitted to hospital. Terrence was easily agitated by clinicians' attempts to assess him; however, they determined that he was otherwise well.

8. Terrence was discharged from hospital on 13 January 2025. At the time he had a patent (clear) airway, no shortness of breath and equal fall and rise of his chest. He had a reduced alertness which was normal for him[3] and did not have a fever. Clinicians instructed his carers to return Terrence to the Emergency Department if he developed a fever, or if his symptoms otherwise changed.

9. On the morning of 19 January 2025, a carer found Terrence deceased in his bed. He had been well the night before.

Identity of the deceased

10. On 19 January 2025, Terrence Michael O'Sullivan, born 14 May 1967, was visually identified by his carer, Jennifer Buultjens.

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

Medical cause of death

12. Forensic Pathologist Dr Chong Zhou of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 21 January 2025 and provided a written report of her findings dated 25 February 2025.

13. The post-mortem examination revealed an abscess within the left lower lobe of the lungs, on the background of patchy pneumonia. Pneumonia is an inflammatory and infective condition

[2] 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.

[3] Terrence had a Glasgow Coma Scale score of 11.

of the lungs. In this case, it was caused by *Klebsiella oxytoca* bacteria which was grown on microbiology of the abscess and the left main bronchus swab. Dr Zhou explained that pneumonia and a lung abscess can lead to death via respiratory failure and/or sepsis.

14. Also identified was a urinary tract infection with chronic cystitis (inflammation of the bladder) and acute prostatitis (inflammation of the prostate gland). Urine microbiology showed growth of *Lactobacillus species* bacteria. A small amount of *Lactobacillus species* can be found in a male's urine as part of the normal microbiome; however, a significant presence could be pathogenic.

15. Due to Terrence's history of epilepsy, Dr Zhou explained that it is recognised individuals with a history of seizures may die suddenly and unexpectedly. However, given the findings of significant acute infective processes in the body which are sufficient to explain death, Dr Zhou favoured that his history of epilepsy was non-contributory.

16. There was no evidence of any injuries which may have caused or contributed to death.

17. Toxicological analysis of post-mortem samples detected quetiapine[4] and valproic acid.[5]

18. Dr Zhou provided an opinion that the medical cause of death was 1(a) *Lung abscess and bronchopneumonia.*

19. Dr Zhou provided an opinion that the cause of death was due to natural causes.

20. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Terrence Michael O'Sullivan, born 14 May 1967;

    b) the death occurred on 18 or 19 January 2025 at 6 Young Street Sunshine West Victoria 3020 from *1(a): Lung abscess and bronchopneumonia*; and

    c) the death occurred in the circumstances described above.

[4] An antipsychotic.
[5] An anticonvulsant.

22. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff that caused or contributed to Mr O'Sullivan's death.

23. Having considered all the available evidence, I find that Mr O'Sullivan's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr O'Sullivan's death in chambers.

I extend my sincere condolences to Mr O'Sullivan's family, friends and carers for their loss.

Pursuant to section 73(1B) of the Act, this finding is to 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:

Leigh Heskey, Senior Next of Kin

Home@Scope

Western Health

First Constable Alexandra Kranjec, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 06 January 2026

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.