IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003628

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Amanda Lee Turner
Date of birth:	22 November 1960
Date of death:	3 July 2023
Cause of death:	1a: Pneumonia in a woman with cerebral palsy (palliated)
Place of death:	Benalla Health, 45-63 Coster Street, Benalla Victoria
Keywords:	In care – Natural causes – Specialist Disability Accommodation; NDIS

INTRODUCTION

1. Amanda Lee Turner was 62 years old when she died at Benalla Health from pneumonia on 3 July 2023.

2. Amanda had cerebral palsy and a mild intellectual disability and she received NDIS-funded independent living support. For most of her life, Amanda was able to walk independently and communicate verbally, however as she aged, her mobility declined and she required additional support for walking and used non-verbal gestures to communicate.[1]

3. Toward the end of 2022, Amanda's ability to swallow became difficult,[2] and in consultation with her Speech Pathologist, the decision was made by her family to transition her to enteral feeds.[3] On 16 January 2023, Amanda was admitted to Wangaratta Hospital for insertion of Percutaneous Endoscopic Gastrostomy (**PEG**) tube.[4]

4. Following the insertion of her PEG, Amanda experienced prolonged gastric issues, including pain at the site of her PEG insertion and persistent loose bowels.[5] She also experienced several chest infections and blood in her faeces which were managed by her General Practitioner (**GP**), and a stomal nurse and treating clinicians at Northeast Health Wangaratta. Despite the collaborative care received, she did not make any notable improvements to her weight or wellbeing.[6]

5. On 7 June 2023, Amanda's carers had concerns as to her condition and arranged her to be assessed by medical practitioners who determined her condition had deteriorated. Amanda then attended the Urgent Care Centre for further management and admission to hospital.[7]

6. On 8 June 2023, Amanda commenced a combination of trial treatments including medications, intravenous and PEG antibiotics, and medical, nursing and allied health input. As she appeared to improve in her overall health, she was discharged from Benalla Health on 13 June.[8]

7. Over the course of her life, Amanda frequently participated in community activities and enjoyed attending cafes, visiting friends at the local community hub and going to the park and

[1] Coronial brief, Statement of Simone Anderson, Service Manager, Yooralla.
[2] Coronial brief, Statement of Gweneth Turner and Statement of Simone Anderson, Service Manager, Yooralla.
[3] A tube supplying liquid nutrition directly into the stomach or small intestine.
[4] A percutaneous endoscopic gastrostomy (PEG) tube is a medical device inserted through the abdominal wall directly into the stomach to deliver nutrition, fluids and medications.
[5] Coronial brief, Statement of Dr Ursula Read and Statement of Simone Anderson, Service Manager, Yooralla.
[6] Coronial brief, Statement of Dr Ursula Read and Statement of Dr Andrew Hawthorne, Benalla Church Street.
[7] Coronial brief, Statement of A/Professor Dr Ken Cheng, Executive Director of Medical Services, Benalla Health.
[8] Ibid.

pool.[9] In the year prior to her death, Amanda enjoyed interacting with the carers in her home and listening to music.[10] She lived with four other residents and was supported by her mother, Gweneth Turner (**Gwen**) and her sister, Tracey Reid (**Tracey**) who visited frequently.

THE CORONIAL INVESTIGATION

8. The investigation into Amanda's death was initially undertaken by former Coroner John Olle on the understanding that Amanda's death was not a reportable death and that she died of natural causes. Findings were made on 3 August 2023.

9. It later became apparent that at the time of her death, Amanda resided in Specialist Disability Accommodation (**SDA**) at Yooralla, 11-13 George Say Court in Benalla, a facility enrolled under the National Disability Insurance Scheme (**NDIS**). This means that Amanda was a person who was in care at the time of her death and her death was a reportable death within the meaning of s4 the *Coroner's Act* 2008. The investigation was reopened in August 2025, to ensure that the investigation considered the circumstances of Amanda's living arrangements in an SDA dwelling.

10. Amanda's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she 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. Deaths in care are reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of people in care 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.

11. 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] Coronial brief, Statement of Gweneth Turner and Simone Anderson, Service Manager, Yooralla.
[10] National Disability Insurance Scheme (NDIS) Plan of Amanda Turner dated 5 May 2023.

12. 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.

13. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Amanda'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.

14. As referred to above, Coroner John Olle originally held carriage of this investigation when he made his finding dated 3 August 2023.[11] After the finding was set aside in circumstances referred to above, I assumed carriage of the matter in August 2025 for the purposes of conducting additional investigative steps and making any further findings.

15. This finding draws on the totality of the coronial investigation into the death of Amanda Lee Turner 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.[12]

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

Circumstances in which the death occurred

16. On 26 June 2023, Amanda's carers called an ambulance as she appeared to have developed a worsening cough, chest infection and hypoxia.[13] She was assessed with aspiration pneumonitis,[14] and an inpatient stay at Benalla was proposed to the family. In discussion with Gwen, it was agreed to transition Amanda to end of life care.

[11] Finding into death and determination to discontinue investigation into the death of Amanda Lee Turner dated 3 August 2023.

[12] 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.

[13] A medical condition whereby the body, or part of it, does not receive enough oxygen to function properly.

[14] Aspiration pneumonitis is a sudden, non-infectious lung inflammation caused by inhaling gastric acid, food, or liquids into the airway.

17. Between 27 June and 3 July 2023, Amanda received regular nursing and comfort care. At about 9:45pm on 3 July 2023, Amanda died peacefully in the presence of her family.[15]

Identity of the deceased

18. On 5 July 2023, Amanda Lee Turner, born 22 November 1960, was visually identified by her sister, Tracey Reid.

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

Medical cause of death

20. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Amanda Turner on 6 July 2023 and provided a written report of her findings dated 7 July 2023.

21. Dr Zhou provided an opinion that the medical cause of death is appropriately formulated as '*1(a) Pneumonia in a woman with cerebral palsy (palliated)'.*

22. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

23. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Amanda Lee Turner, born 22 November 1960;

    b) the death occurred on 03 July 2023 at Benalla Health 45-63 Coster Street Benalla Victoria 3672, from pneumonia in a woman with cerebral palsy (palliated); and

    c) the death occurred in the circumstances described above.

24. Having considered all the evidence, I am satisfied that Amanda'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 Amanda's death and to finalise the investigation in chambers.

[15] Benalla Health medical records of Amanda Lee Turner.

25. Amanda had significant disabilities as set out above. I acknowledge the invaluable support Gwen, Tracey and her family provided Amanda throughout her life and during her end-of-life care. I also acknowledge the significant level of care provided by Amanda's carers during her time at Yooralla, as it afforded Amanda human dignity and the ability to participate in the community throughout her life. Dignity and community are core principles to the NDIS, and Amanda's care aligned closely with these aspirations.

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

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:

Gweneth Turner, Senior Next of Kin

National Disability Insurance Agency

Yooralla

Benalla Health

Senior Constable Jax Brown, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 20 October 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.