



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 003317

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Nicole Buckley
Date of birth:	25 June 1970
Date of death:	13 June 2024
Cause of death:	1(a) Metastatic breast cancer
Place of death:	Sunshine Hospital, 176 Furlong Rd, St Albans, Victoria
Key words:	In care, natural causes

Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal person.

Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 13 June 2024, Nicole Buckley was 53 years old when she passed away at Sunshine Hospital. At the time, Ms Buckley lived alone in Fraser Rise and was a proud Wurundjeri woman, had strong connections to her culture and community.
2. Ms Buckley had a significant medical history that included Dandy Walker syndrome treated with a ventriculoperitoneal shunt, an intellectual disability, thrombotic stroke, haemorrhagic stroke, hydrocephalus, gastro-oesophageal reflux disease, osteoarthritis, left upper limb ataxia, persisting bilateral horizontal nystagmus, bilateral lower limb hypertonia and hyperreflexia, hypercholesterolaemia, diverticulosis, severe allergies, and a history of falls.
3. Ms Buckley was more recently diagnosed with breast cancer which had also spread to her liver. In 2022, Ms Buckley underwent a left mastectomy.
4. Shortly after Ms Buckley was diagnosed with breast cancer, she broke her ankle and was hospitalised for a period.
5. Due to her care needs, Ms Buckley was receiving in-home care by nurses through Nurse 4 U. However, in March 2024, Ms Buckley was moved into a specialist disability accommodation (SDA) property run by Nurse 4 U, due to her deteriorating health and limited mobility. At this time, Ms Buckley was unable to walk or weight bear and required a mechanical hoist for transfers and a wheelchair for mobility. At the SDA, Ms Buckley had two carers on a 24-hour basis.
6. Ms Buckley enjoyed in-home activities like colouring and painting her nails. She occasionally enjoyed outings with her carers, although generally preferred to stay at home.

THE CORONIAL INVESTIGATION

7. Ms Buckley's passing was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.¹

¹ See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

8. 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. 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.
10. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Buckley's passing. 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.
11. This finding draws on the totality of the coronial investigation into Ms Buckley's passing, 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.²

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

Identity of the deceased

12. On 15 June 2024, Nicole Buckley, born 25 June 1970, was visually identified by her partner, Raymond Adams, who signed a formal Statement of Identification to this effect.
13. Identity is not in dispute and requires no further investigation.

Medical cause of death

14. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 19 June 2024 and provided a written report of her findings dated 24 June 2024.

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.

15. The post-mortem examination was consistent with the reported circumstances.
16. Dr Archer provided an opinion that the medical cause of death was “*I(a) Metastatic breast cancer*”.
17. Dr Archer concluded that death was due to natural causes.
18. I accept Dr Archer’s opinion.

Circumstances in which the death occurred

19. On 11 June 2024, Ms Buckley was admitted to Sunshine Hospital after care staff at her SDA observed her to have shallow breathing, lethargy, and drowsiness, after two days of coughing episodes and a decrease in her daily functioning, including not participating in her usual recreational activities.
20. Upon assessment, Ms Buckley showed signs of hypoactive delirium, dehydration, hypernatraemia and abnormal liver function tests, the cause of which was unclear at the time. An ultrasound of her liver also showed multiple metastases.
21. On 12 June 2024, Ms Buckley showed signs of deterioration, with episodes of hypoxia and hypotension. She was treated with intravenous (IV) fluids and a single dose of IV antibiotics.
22. Despite treatment, Ms Buckley’s condition continued to deteriorate, and she was reviewed by the palliative care team on 12 June 2024. Staff at the Sunshine Hospital discussed goals of care with Ms Buckley’s family and carers, and they were supportive of the transition to symptom management and comfort care.
23. On 13 June 2024, Ms Buckley was transferred to the palliative care ward where she was kept comfortable until she passed away at 4.04pm on 13 June 2024.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the Act I make the following findings:
 - (a) the identity of the deceased was Nicole Buckley, born 25 June 1970;
 - (b) the death occurred on 13 June 2024 at Sunshine Hospital, 176 Furlong Rd, St Albans, Victoria;
 - (c) the cause of Ms Buckley’s death was metastatic breast cancer;

- (d) immediately before death, Ms Buckley was a “*person placed in custody or care*” as defined in section 4 of the Act; and
- (e) the death occurred in the circumstances described above.

- 25. I convey my sincere condolences to Ms Buckley’s family for their loss.
- 26. 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.
- 27. I direct that a copy of this finding be provided to the following:
 - Raymond Adams, senior next of kin
 - Manager of the Specialist Disability Accommodation
 - Western Health
 - Coronial Investigator, Sen/Const Michelle Johnston, c/o OIC Sunshine Uniform

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 03 March 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.
