IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003752

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Lydia Christopherson
Date of birth:	21 January 1985
Date of death:	21 June 2024
Cause of death:	1a: Undifferentiated large right pleural effusion
Place of death:	Frankston Hospital, 2 Hastings Road Frankston, Victoria
Keywords:	In care – Natural causes – Specialist Disability Accommodation

INTRODUCTION

1. Lydia Christopherson was 39 years old when she died at Frankston Hospital from an undifferentiated large right pleural effusion on 21 June 2024.

2. Lydia is survived by her parents, Anne and Peter, four siblings Aiden, Kieran, Isabelle and Scarlett, and extended family. She loved spending time with her family and friends and going for walks in her community with the support of her carers.

3. Very early in her life, Lydia had a diagnosis of epilepsy which prompted significant and intrusive testing. She was later diagnosed with cerebral palsy and an associated significant intellectual disability.

4. In 2022, at the age of 37 years, Lydia moved out of the home she shared with her parents into supported accommodation in a house in Clyde North where she lived for a further two years. At the time of her death, Lydia lived in Specialist Disability Accommodation (**SDA**) at Clyde North with two other women with similar disabilities. She received National Disability Insurance Scheme (**NDIS**)-funded support from genU Karingal St Laurence (previously called Wongabeena).

5. Through these programs, Lydia received support with daily living and actively participating in her community. She spent Tuesdays shopping and at hydrotherapy, and Thursdays with carers from Care Needs. Lydia also regularly attended a day program at genU which she had done for over 20 years.

6. Lydia was supported by her family in her independence, and they were actively involved in her care and decision making in relation to all aspects of her life, while maintaining and respecting Lydia's autonomy and wishes.

THE CORONIAL INVESTIGATION

7. Lydia's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Lydia was a 'person placed in custody or care' within the meaning of the Act, as a person who was an SDA resident living in an SDA enrolled dwelling.

8. Dr Kim Harland registered the death of Lydia Christopherson, born 21 January 1985. As Lydia's treating medical practitioner, Dr Harland was satisfied that the medical cause of death

was an undifferentiated large right pleural effusion and noted that Lydia had other significant conditions contributing to the death. These were cerebral palsy with an associated intellectual disability, and epilepsy. Dr Harland lodged the completed death certificate with Births, Deaths and Marriages (**BDM**). Upon processing, BDM identified that Lydia met the criteria for a 'person placed in custody or care' and appropriately referred the matter to the Coroner.

9. Having consulted with a forensic pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), Coroner Olle accepted the cause of death as certified by Dr Harland on 21 June 2024.

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Lydia's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. In July 2025, I assumed carriage of the investigation into Lydia's death from then Coroner John Olle for the purpose of finalising the case and making findings.

14. This finding draws on the totality of the coronial investigation into the death of Lydia Christopherson 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.[1]

[1] 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. I also take the opportunity to note that the court has also greatly appreciated the detailed witness statement provided by Lydia's father Peter Chistopherson on behalf of the family and has placed great weight on this account.

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

Circumstances in which the death occurred

16. On 24 May 2024, staff at the SDA where Lydia resided raised concerns with her parents about Lydia's health given her decreased appetite. Her father gave an account of her being unwell for some weeks and that the staff were concerned about her. At this time, she returned home to her parents' house so she could have home cooked food be cared for by her family.

17. On 28 May 2024, Lydia's parents took her to Frankston Hospital to investigate her ongoing poor health. Lydia's family supported her through the diagnostic phase and were closely involved in discussions about her care. As part of the battery of tests, a computed tomography (**CT**) was conducted and identified a right-sided pleural node,[2] with a large pleural effusion.[3]

18. Following discussions with medical staff, Lydia's family decided not to have a biopsy performed. The family observed that as Lydia was not experiencing symptoms at this time and in the unlikely event of a malignancy, there would be no chemotherapy or radiotherapy, Lydia should come home without any further diagnosis or treatment.

19. On 1 June 2024, Lydia was discharged and returned home with her parents to celebrate her mother's 70th birthday. Her father described her on that day, as sitting in the family room enjoying good food with all her young nieces and nephews around her. After a night of celebrations, she went to bed at 8.30pm. In his statement to the Court, Lydia's father observed that she appeared fine that evening.

20. On 2 June 2024, Lydia was transported by ambulance and readmitted to Frankston Hospital as she was experiencing breathlessness. She experienced a seizure in the emergency department and was diagnosed with a chest infection, resulting from rapid progression of the pleural effusion.

21. Attempts were made to treat the effusion through intravenous antibiotics and the insertion of an intercostal catheter (**ICC**), but Lydia was highly distressed by the treatment. She refused

[2] An abnormal growth on the right lung.
[3] An accumulation of fluid in and around the lungs.

food, drink and medication during this period and repeatedly removed the ICC. Her father observed that she was resistant to the treatment and that she had decided enough was enough.

22. Following extensive consultation with medical staff, Lydia's family made the decision to remove the ICC and to place Lydia in palliative care. She was surrounded by her family until she passed away on 21 June 2024.

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 Lydia Christopherson, born 21 January 1985;

    b) the death occurred on 21 June 2024 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria 3199, from an undifferentiated large right pleural effusion; and

    c) the death occurred in the circumstances described above.

24. Not only did Lydia's family express no concerns with her care, but her father emphasised the high quality of support that she received and observed that her support team gave Lydia some normality to her life. I am satisfied that the ongoing support Lydia received from genU was provided in a manner that was reasonable, appropriate and supportive. Further, I note that Lydia's support team were acknowledged by her family to be responsive to ensuring the capacity of the NDIS to respond to Lydia's changing needs. The NDIS in the family's view, was a 'godsend'.

25. I observe that there was a demonstrably positive and respectful relationship between Lydia, Lydia's family and the care team and this worked to optimal effect for Lydia to have the capacity to live her life independently, with dignity and to participate in her community. Further, I note that this is an example of the NDIS working in the most effective possible way to support a woman to live her best life supported by her family and community.

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

I convey my sincere condolences to Lydia'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:

Peter and Anne Christopherson, Senior Next of Kin

National Disability Insurance Agency

Peninsula Health

Senior Constable Clinton Smith, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 12 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.