IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005772

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Patricia Elizabeth Davidson
Date of birth:	18 October 1970
Date of death:	01 October 2024
Cause of death:	1a : PNEUMONIA
Place of death:	Sunshine Hospital 176 Furlong Road,Victoria 3021
Keywords:	In care, SDA resident, pneumonia, natural causes death

INTRODUCTION

1. On 1 October 2024, Patricia Elizabeth Davidson **(Patricia)** was 53 years old when she died at Sunshine Hospital. She is survived by her sister, Barbara Ray **(Barbara)**.

2. At the time of her death, Patricia was a Specialist Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 39 Henry Street, Melton Victoria 3337. Possability Victoria was the care provider, and Patricia had resided at the facility since 2019.

3. Patricia's medical history included bipolar affective disorder, intellectual disability, autism, epilepsy, hypothyroidism, drug induced Parkinsonism and Parkinson's Disease (diagnosed February 2020). Patricia was wheelchair bound and required 24-hour care. She received funding under the National Disability Insurance scheme.

4. Patricia enjoyed arts and crafts and dancing. She was described by Barbara as living a full life, being active and social to the best of her abilities.

5. Patricia's general wellbeing had declined over the past 2-3 years due to the onset of Parkinson's Disease. She required increasing assistance with all aspects of daily living and ambulation.

THE CORONIAL INVESTIGATION

6. Patricia's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody[1] is a mandatory report to the coroner, even if the death appears to have been from natural causes. Patricia was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as she was *"a prescribed person or a person belonging to a prescribed class of person"* due to her status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

7. 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

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[1] See the definition of 'reportable death' in section 4 of Act, especially section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) of the Act

[2] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Patricia's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Patricia Elizabeth Davidson 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.[3]

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

Circumstances in which the death occurred

11. On 24 September 2024, Patricia finished her dinner as normal in the lounge. According to Possability carer, Peter Churchill **(Peter)**, she appeared to be in her *'usual happy state'* and retired to bed at approximately 8pm.

12. At approximately 5.45am on 25 September 2024, Peter heard Patricia coughing and attended to check on her. Peter observed that Patricia had vomited and rolled her into the recovery position. Whilst in the recovery position, Patricia vomited again and Peter contacted emergency services.

13. Following the arrival of paramedics, Patricia was transported to the Emergency Department at Sunshine Hospital. The medical deposition noted that on admission, she was hypoxic, tachypnoeic, tachycardic and febrile.

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[3] 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.

14. Patricia was commenced on treatment for a suspected aspiration pneumonia with intravenous antibiotics, fluids and other relevant treatment. During her admission under the general medicine team, she remained critically unwell and had recurrent Medical Emergency Team calls for hypoxia, reduced Glasgow Coma Score, and tachypnoea. She had further aspiration events during her admission and despite continued ward based management, she continued to deteriorate and progressively become more hypoxic.

15. Patricia was subsequently transitioned to end of life care on the 27 September 2024 and died peacefully on 1 October 2024.

Identity of the deceased

16. On 1 October 2024, Patricia Elizabeth Davidson, born 18 October 1970, was visually identified by her sister, Barbara Ray.

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

Medical cause of death

18. Associate Professor and Forensic Pathologist Dr Sarah Parsons **(A/Prof Parsons)** from the Victorian Institute of Forensic Medicine conducted an external examination on 3 October 2024 and provided a written report of her findings dated 7 October 2024.

19. The post-mortem CT scan confirmed the presence of pneumonia. Other findings included cerebral atrophy, bibasal consolidation upper lobes of the lungs.

20. A/Prof Parsons provided an opinion that the medical cause of death was 1(a) Pneumonia. A/Prof Parsons stated that on the basis of the available information, she considered the death was due to natural causes.

21. I accept A/Prof Parsons' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Patricia Elizabeth Davidson, born 18 October 1970;

    b) the death occurred on 1 October 2024 at Sunshine Hospital, 176 Furlong Road Victoria 3021, from pneumonia; and

c) the death occurred in the circumstances described above.

23. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Patricia died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to Patricia'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:

Barbara Ray, Senior Next of Kin

First Constable Taylor Tzouroutis, Coronial Investigator

National Disability Insurance Agency

Signature:

Coroner Dimitra Dubrow

Date: 10 June 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.