



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 006188**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Ingrid Giles
Deceased:	Judith Gail Longhurst
Date of birth:	21 September 1950
Date of death:	23 October 2024
Cause of death:	1a: CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Place of death:	39 Thomas Street Hampton Victoria 3188
Keywords:	In care, Specialist Disability Accommodation, SDA, supported independent living, disability, natural causes

## INTRODUCTION

1. On 23 October 2024, Judith Gail Longhurst<sup>1</sup> was 74 years old when she died at Mary Macauley House (**MMH**) in Hampton, where she had been a resident for many years.
2. MMH is a Specialist Disability Accommodation (**SDA**) dwelling and Judith received Supported Independent Living (**SIL**) and therapy services from Scope (Aust) Limited (**Scope**) at her home.
3. Judith's medical history included cerebral palsy, migraines, depression, spondylolisthesis, large hiatus hernia, hypercholesterolemia, anaemia and dysphagia. Judith used a wheelchair for mobility and was supported by Scope staff members for many daily activities, including meal preparation, personal care and administering medication.
4. Judith was also supported by her brother, Craig Longhurst (**Craig**), who lives overseas and with whom she communicated frequently. Craig recalled that Judith "*loved living at MHH and having the company and friendship of the residents and staff.*" Due to MMH being sold, Judith and the other residents were advised that they would need to relocate. While ultimately it was confirmed that the residents would all move together to a new home, Craig recalls that Judith was "*depressed*" and "*anxious*" about the upcoming move.

## THE CORONIAL INVESTIGATION

5. Judith'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 in Victoria who was an '*SDA resident residing in an SDA enrolled dwelling*' immediately prior to her death.
6. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort, and is reflected in the definition of a '*person placed in custody or care*' in section 3(1) of the Act, read in conjunction with Regulation 7 of the Coroners Regulations 2019.
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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<sup>1</sup> Referred to throughout my finding as 'Judith' unless more formality is required.

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. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Judith's passing was due to natural causes and there are no further issues I have identified that require the hearing of viva voce evidence.
10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Judith's death. The Coronial Investigator conducted inquiries on the Court's 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 the death of Judith Gail Longhurst 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.<sup>2</sup>

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

### **Circumstances in which the death occurred**

12. On 18 September 2024, Judith was taken by ambulance and admitted to Alfred Hospital after experiencing a persistent cough during the day and loose bowel movements. Judith was then transferred to Caulfield Hospital later that day and admitted with likely community acquired pneumonia and a picornavirus respiratory infection. On 19 September 2024, Judith was

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<sup>2</sup> 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.

discharged with the plan for her to continue taking antibiotics and to attend an appointment with her General Practitioner (GP). On 4 October 2024, Judith was reviewed by her GP, who prescribed her a further course of antibiotics.

13. On 8 October 2024, Scope staff observed that Judith appeared sad and tired. She had been declining food and water and had lost approximately 7.7kg after she was discharged from hospital. The following day, Judith attended a further appointment with her GP, who increased her antidepressant medication.
14. On 22 October 2024, Judith vomited twice while in bed. Scope staff organised a same day appointment with her GP, who ordered a blood test and arranged for computed tomography (CT) scans of her chest, abdomen and pelvis for the following day to investigate the cause of her weight loss.
15. At approximately 6:30am on 23 October 2024, staff entered Judith's bedroom to conduct a routine check. They observed that she was unresponsive and did not have a pulse. Emergency services were contacted and Cardiopulmonary Resuscitation (CPR) was attempted but Judith could not be revived and was pronounced deceased by paramedics at 7:10am.

### **Identity of the deceased**

16. On 23 October 2024, Judith Gail Longhurst, born 21 September 1950, was visually identified by her Scope carer.
17. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

18. On 29 October 2024, Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy and reviewed a post-mortem CT scan and other relevant materials. Dr Young provided a written report of his findings dated 31 December 2024.
19. Dr Young found that Judith's lungs showed chronic bronchitis and emphysema in the lungs, without evidence of residual pneumonia. He considered that chronic obstructive pulmonary disease (COPD) is a chronic disease process that incorporates both chronic bronchitis (inflammation in airways) and emphysema (enlargement of small airspaces) in the lungs. While cigarette smoking is the most significant risk factor for COPD, it may occur for other

reasons, including that chronic inflammation from dysphagia and aspiration may compound respiratory compromise. Death can occur from respiratory arrest.

20. Toxicological analysis of post-mortem samples identified the presence of sertraline and mirtazapine at therapeutic levels.
21. Dr Young provided an opinion that the medical cause of death was '*1(a) chronic obstructive pulmonary disease.*'
22. Dr Young provided an opinion that the cause of death was due to natural causes.
23. I accept Dr Young's opinion.

## **FINDINGS AND CONCLUSION**

24. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
  - a) the identity of the deceased was Judith Gail Longhurst, born 21 September 1950;
  - b) the death occurred on 23 October 2024 at 39 Thomas Street Hampton Victoria 3188 from '*1a: chronic obstructive pulmonary disease*'; and
  - c) the death occurred in the circumstances described above.
25. Having considered all the available evidence, I find that Judith'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 her death and to finalise the investigation of her death by way of a written finding.
26. The available evidence does not support a finding that there was any want of clinical management or care on the part of Scope or its staff that caused or contributed to Judith's death. The factual matrix of Judith's death does not, therefore, support a conclusion that Judith being 'in care' at the time of her death – according to the Act – had a causal relationship with her death. In such circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to Judith's family, friends and carers for their loss and note their reflections and memories of Judith, including that she was a talented artist with an impressive collection of work.

## ORDERS AND DIRECTIONS

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:

Craig Longhurst, Senior Next of Kin

Scope (Aust) Ltd

Senior Constable Liam Carolan, Coronial Investigator

Signature:



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Coroner Ingrid Giles

Date: 19 March 2026

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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.

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