IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006698

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Catherine Mary Stephen
Date of birth:	29 September 1961
Date of death:	17 November 2024
Cause of death:	1(a) NATURAL CAUSES UNASCERTAINED
Place of death:	Caritas Christi Hospice 104 Studley Park Road, Kew Victoria 3101
Keywords:	In care, natural causes

INTRODUCTION

1. On 17 November 2024, Catherine Mary Stephen was 63 years old when she passed away at Caritas Christi Hospice, Kew, after a period of palliative care. Prior to her death, Catherine resided at Specialist Disability Accommodation owned by Homes Victoria[1] at 3 Botanic Drive, Kew, Victoria. She received Supported Independent Living services from Scope (Aust) Limited (**Scope**).

2. Catherine was born on 29 September 1961 at the Preston and Northcote Community Hospital.[2] Shortly after she was born, Catherine suffered a brain haemorrhage which resulted in cerebral palsy with spastic quadriplegia and epilepsy.

3. Catherine also suffered kyphoscoliosis and through her late adult life she was fully bedbound and entirely dependent on carers for all activities of daily living.

4. The coronial brief reveals a story of unwavering and selfless care provided by Catherine's parents and siblings.

THE CORONIAL INVESTIGATION

5. Catherine'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 is a mandatory report to the coroner, even if the death appears to have been from natural causes. Catherine was a "person placed in custody or care" within the meaning of section 4 of the Act, as she was "a prescribed class of person"[3] due to her status as an "SDA[4] resident residing in an SDA enrolled dwelling".

6. Senior Constable (SC) Lynden Dorber-Binion acted as the Coronial Investigator for the investigation of Catherine's death. SC Dorber-Binion conducted inquiries on my behalf and compiled a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Catherine Mary Stephen, 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

[1] As part of the Victorian Department of Families, Fairness and Housing.
[2] Also known as 'PANCH' and operating from 1960 to 1998.
[3] Section 4(2)(j)(i), *Coroners Act 2008* (Vic).
[4] Specialist Disability Accommodation.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

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

Circumstances in which the death occurred

8. Catherine suffered recurrent episodes of aspiration pneumonia requiring hospital admission.

9. On 6 November 2024, Catherine was admitted to St Vincent's Hospital Melbourne for treatment of aspiration pneumonia with intravenous antibiotics. During this admission Catherine also had cardiac complications with atrial fibrillation and ventricular tachycardia. She was discharged with a plan for "hospital in the home" follow up.

10. After discharge Catherine's condition worsened and her family decided to transition her to palliative care. She was transferred to Caritas Christi Hospice on 15 November 2024 and passed away in the early hours of 17 November 2024 with her brother at her bedside.

Identity of the deceased

11. On 17 November 2024, Catherine Mary Stephen, born 29 September 1961, was visually identified by her brother, Paul Stephen.

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

Medical cause of death

13. Senior Forensic Pathologist Dr Brian Beer of the Victorian Institute of Forensic Medicine conducted an examination on 18 November 2024 and provided a written report of his findings dated 27 November 2024.

14. The post-mortem examination (including CT scan) revealed probable aspiration pneumonia. Also shown was a large pericardial effusion and large bilateral pleural effusions of unknown cause which would have significantly contributed to the death.

[5] 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. Dr Beer provided an opinion that the medical cause of death was '1(a) NATURAL CAUSES UNASCERTAINED'.

16. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Catherine Mary Stephen, born 29 September 1961;

    b) the death occurred on 17 November 2024 at Caritas Christi Hospice, 104 Studley Park Road, Kew, Victoria 3101, from NATURAL CAUSES UNASCERTAINED.

    c) the death occurred in the circumstances described above.

18. There is no evidence to suggest that the care provided to Catherine was anything other than appropriate.

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

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:

Colleen Bridgland, Senior Next of Kin

Scope (Aust) Ltd

St Vincent's Hospital

Senior Constable Lynden Dorber-Binion, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 21 August 2025

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.