IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007148

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to section 76A of the Coroners Act 2008 (Vic) on 25 August 2026[1]

Findings of:	Coroner Kate Despot
Deceased:	Julie Jane Lambert
Date of birth:	18 October 1957
Date of death:	08 December 2024
Cause of death:	1a : ASPIRATION PNEUMONIA IN A WOMAN WITH ADVANCED MULTIPLE SCLEROSIS
Place of death:	Sandringham Hospital 193 Bluff Road Sandringham Victoria 3191
Keywords:	In care, Specialist Disability Accommodation, Natural Causes.

[1] This finding is an amended version of the Finding Without Inquest into the Death of Julie Jane Lamber dated 15 July 2026. Paragraph 13 has been amended pursuant to section 76A of the Coroners Act 2008 (Vic) as it included a typographical error.

INTRODUCTION

1. On 08 December 2024, Julie Jane Lambert (**Ms Lambert**) was 67 years old when she died at Sandringham Hospital which was administered by Alfred Health as it was then known.[2]

2. At the time of her death, Ms Lambert lived at 5 Station Avenue Mckinnon, Victoria. Ms Lambert was a National Disability Insurance Scheme (**NDIS)** participant and resided in a specialist disability accommodation **(SDA)** enrolled dwelling.

3. Ms Lambert had been living in her SDA enrolled dwelling since 18 October 2018. While living in her SDA enrolled dwelling, Ms Lambert received support including assistance with personal hygiene, meals and taking her medication, amongst others.

4. Her medical history included deep vein thrombosis, multiple sclerosis and trigeminal neuralgia.[3]

5. In the seven-month period prior to her death, Ms Lambert had eight admissions to hospital for respiratory tract and urinary infections. Around the same time, transient changes in her consciousness and function were noted.

6. In the months leading to her death, Ms Lambert's condition deteriorated to the extent that she required support from the palliative care team at Bethlehem Hospital.

7. On 18 November 2024, when her care team attended for her morning routine care, Ms Lambert was found to have an altered state of consciousness. She was then conveyed by ambulance to hospital where she was diagnosed with COVID-19 and urinary tract infections. Ms Lambert was treated at The Alfred for approximately four days.

8. On 22 November 2024, after she was discharged from hospital, attending staff at her SDA enrolled dwelling noted that Ms Lambert had 'increased lethargy'. Although she maintained her usual routines, her appetite had decreased and her coughing continued.

THE CORONIAL INVESTIGATION

9. Ms Lambert's death was reported to the coroner as it 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'

[2] On 1 January 2026, Alfred Health merged with various other healthcare service providers for form a new entity, Bayside Health.

within the meaning of the Act, as she resided in a SDA enrolled dwelling immediately prior to her death.[4].

10. Ms Lambert'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. As she resided in an SDA enrolled dwelling immediately prior to her death, Ms Lambert falls within the ambit of the cohort of people considered to be 'in care' at the time of her death.[5]

11. Ms Lambert was a person in care pursuant to section 3 of the Act. The death of a person in care is a mandatory report to the coroner, even if the death appears to be due to natural causes.

12. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects that the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

13. Immediately before her death, Ms Lambert was a person placed in care. However, section 52(3A) of the Act provides an exception to the position under section 52(2), that the coroner is not required to hold an Inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an Inquest into Julie Jane Lambert's death.

14. 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.

15. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Lambert's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and prepared a coronial brief of evidence.

[4] s4(2)(c)
[5] s4(2)(c)

16. This finding draws on the totality of the coronial investigation into the death of Julie Jane Lambert. 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.[6]

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

Circumstances in which the death occurred

17. On 7 December 2024, attending staff at the SDA where Ms Lambert was living noted that she was sweating and experiencing difficulty with her breathing. When she became unresponsive, the attending staff contacted the Bethlehem palliative care nurse and called an ambulance. Ms Lambert was then conveyed to Sandringham Hospital.[7]

18. Upon arrival at Sandringham Hospital, attending staff noted that Ms Lambert was in 'respiratory distress', had 'intermittent apnoeic episodes' and her need for oxygen therapy was 'escalating'.[8]

19. Doctors concluded that the likelihood of an 'aspiration event' had caused the sudden deterioration in Ms Lambert's condition. After a multi-disciplinary team considered Ms Lambert's prognosis, the decision was made to refer her to palliative care.

20. On 8 December 2024 at 8pm, Ms Lambert sadly passed away.

Identity of the deceased

21. On 8 December 2024, Julie Jane Lambert, born 18 October 1957, was visually identified by her sister, Tanya Calderwood, who signed a formal Statement of Identification.[9]

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

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[6] 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.

[7] Court File, Letter from Claro Aged Care & Disability Services dated 10 September 2025.

[8] Alfred Health, E-Medical Deposition Form.

[9] Statement of Identification.

Medical cause of death[10]

23. Forensic Pathologist Dr Joanne Ho of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 10 December 2024 and provided a written report of her findings dated 16 December 2024.

24. The post-mortem examination revealed findings in keeping with the stated history. Dr Ho commented that aspiration pneumonia is a lung infection that occurs when food, liquid, vomit or saliva is inhaled into the lungs and 'can occur in people with multiple sclerosis'.

25. Dr Ho provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia in a woman with advanced multiple sclerosis. Dr Ho opined further that Ms Lambert's death was due to natural causes.

26. I accept Dr Ho's opinion.

FAMILY CONCERNS

27. On 11 December 2024, Ms Lambert's family communicated their concerns of care for my consideration. In summary, the family's concerns of care centred on the treatment Ms Lambert received by carers at her SDA enrolled dwelling.

28. I referred the matter to the Coroners Prevention Unit (**CPU**) for their review of the circumstances within which the death occurred. The CPU reviewed the available evidence including Ms Lambert's medical records in the context of the family's concerns of care.[11]

CPU REVIEW

29. The CPU noted that Ms Lambert was suffering from advanced multiple sclerosis which was incurable. In the lead-up to her death, Ms Lambert had multiple admissions to hospital for chest infections and related conditions which compounded the effects of her progressive neurological disease. The CPU concluded that Ms Lambert's death was not preventable given the progressive nature her neurological disease.

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[10] Medical Examiner's Report.

[11] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

30. I have considered the family's concerns of care in the context of all the available evidence and the advice of the CPU. Without wishing to diminish the experience of the family, their concerns are best directed to the relevant care provider.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Julie Jane Lambert, born 18 October 1957;

    b) her death occurred on 08 December 2024 at Sandringham Hospital 193 Bluff Road Sandringham Victoria 3191, from 1(a) Aspiration pneumonia in a woman with advanced multiple sclerosis; and

    c) her death occurred in the circumstances described above.

32. Section 52 of the Act requires an inquest to be held, except in circumstances where the death occurred by natural causes. In the circumstances, I am satisfied that Julie Jane Lambert died from natural causes and her death requires no further investigation. Accordingly, I exercise my discretion under section 52(3A) of the Act to not hold an inquest into Julie Jane Lambert's death.

I convey my sincere condolences to Ms Lambert's family and loved ones 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:

Paul Lambert, Senior Next of Kin

NDIS Quality Safeguards Commission

Bayside Health

Senior Constable Rebekah Oliver, Coroner's Investigator

Signature:

Coroner Kate DespotDate: 25 August 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.