IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000008

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Margaret Mary Broderick
Date of birth:	13 August 1962
Date of death:	1 January 2025
Cause of death:	1a: Complications of WHO Class III obesity in a woman with epilepsy
Place of death:	20 Muscovy Drive, Grovedale, Victoria
Keywords:	In care – Natural causes – Specialist Disability Accommodation – SDA

INTRODUCTION

1. On 1 January 2025, Margaret Mary Broderick (Margaret) was 62 years old when she died at her specialist disability accommodation in Grovedale, Victoria, from complications of WHO Class III obesity.[1]

2. Margaret was born with an intellectual disability, which was identified when she was of kindergarten age. At the age of 13 years, she was also diagnosed with a mental health disorder, later known as schizophrenia and autism.[2]

3. At the time of her death, Margaret lived in a Specialist Disability Accommodation (**SDA**) facility operated by Scope Australia. Having been cared for by her family for most of her life, she moved into supported accommodation in October 2010 and remained a resident there until her death. Scope Australia is a registered National Disability Insurance Scheme (**NDIS**) provider that provides disability support services for people with complex intellectual, physical and multiple disabilities. The organisation provided a wide range of services to Margaret including supported accommodation that promotes independent living.

4. Margaret was active in the community and enjoyed going to shopping centres, eating out at cafes and pubs, cooking pasties, seeing movies and having beauty treatments.[3] She was very much loved and well supported by her siblings, and their partners. Her sister, Annette Curry (**Annette**), coordinated social outings, managed finances and assisted with medical appointments, amongst many other things.[4]

5. Margaret confirmed medical conditions included intellectual disability, autism spectrum disorder, schizophrenia (stable on clozapine), anxiety, epilepsy, obesity (BMI 48.2 with a 10 kg weight increase over the prior three years), obstructive sleep apnoea, chronic Type II Respiratory Failure related to obstructive sleep apnoea and obesity hypoventilation syndrome, and chronic constipation.[5]

6. Over the years leading up to her death, Dr Christopher Paulin (**Dr Paulin**) of Kardinia Health General Practice, noted a gradual decline in Margaret's chronic breathlessness, particularly on

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[1] Class III obesity is a severe health condition defined by a body mass index (BMI) of 40 or higher, formerly known as morbid obesity.
[2] Statement of Annette Curry, undated, Coronial Brief.
[3] Statement of Lisa Evans, dated 8 April 2025, Coronial Brief.
[4] Statement of Annette Curry, undated, Coronial Brief.
[5] Statement of Dr Christopher Paulin, dated 31 January 2025, Coronial Brief.

exertion, with oxygen saturations generally stable between 88–92%, which was her baseline.[6] Staff noted a deterioration in Margaret's respiratory function in the months prior to her death and described her being '*puffy and breathless*'.[7]

THE CORONIAL INVESTIGATION

7. Margaret'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**). The death of a person in care is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Margaret 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. The public policy rationale for this mandatory report to the Coroner arises because people residing in SDA dwellings are entirely dependent on the care of those providing services in SDA dwellings and this care needs to be subject to some independent consideration because of this vulnerability and dependence.

8. 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.

9. The investigation into Margaret's death was commenced by Coroner John Olle and I assumed carriage of the matter in July 2025, upon his retirement, to conclude the investigation and make findings.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Margaret's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, support workers, 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 Margaret Mary Broderick including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**). Whilst I have reviewed all the material, I will

[6] Statement of Dr Christopher Paulin, dated 31 January 2025, Coronial Brief.
[7] Statement of Lisa Evans, dated 8 April 2025, Coronial Brief.

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.[8]

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

Circumstances in which the death occurred

12. On 27 December 2024, Annette took Margaret to a regular monthly appointment with Dr Paulin to review her latest blood results and obtain her monthly clozapine script. The doctor had no concerns at that appointment.

13. On the evening of 31 December 2024, Annette spoke to Margaret by telephone to wish each other a Happy New Year, and they made arrangements to catch up on 1 January 2025. Annette described Margaret as sounding well.

14. On 1 January 2025, Margaret participated in her usual morning routine, appearing to be in good spirits. Staff supported her with personal care tasks.

15. At 11:50 am, a disability support worker assisted Margaret with toileting, and she returned to sit in her favourite chair in the lounge room. When asked if she would like lunch, she responded that she would have it later.

16. At 12:15 pm, a disability support worker called out to Margaret to inform her that her lunch was ready on the table. There was no response, which was noted as very unusual given her love of food. The staff member entered the lounge room, called Margaret's name, and found her unresponsive. Two other disability support workers were called, and they were also unsuccessful in rousing her. Triple Zero was called at 12:19am.

17. One of the disability support workers, Nicole Voysey, commenced CPR assisted by two other staff members.

18. At 12:39pm, Ambulance Victoria MICA crew arrived. They observed that Margaret had an asystolic cardiac rhythm and was cyanotic. At 12:44 pm, resuscitation was ceased as Margaret had already passed away.

[8] 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.

19. Victoria Police arrived at 1:00pm and commenced an investigation. Police did not identify any suspicious circumstances relating to Margaret's death.

Identity of the deceased

20. On 1 January 2025, Margaret Mary Broderick, born 13 August 1962, was visually identified by her sister, Annette Curry.

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

Medical cause of death

22. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 3 January 2025 and provided a written report of her findings dated 6 January 2025.

23. Toxicological analysis of post-mortem samples identified the presence of prescription medications. Alcohol or poisons were not detected.

24. Dr Zhou provided an opinion that the medical cause of death was 1(a) Complications of WHO Class III obesity in a woman with epilepsy.

25. Dr Zhou provided an opinion that the cause of death was due to natural causes.

26. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Margaret Mary Broderick, born 13 August 1962;

    b) Margaret's death occurred on 1 January 2025 at 20 Muscovy Drive, Grovedale, Victoria from complications of WHO Class III obesity in a woman with epilepsy; and

    c) her death occurred in the circumstances described above.

28. Having considered all the available evidence, I find that Margaret'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 Margaret's death in chambers.

29. I note that Margaret resided for a significant amount of her life in specialist disability accommodation under the care and support of Scope Australia with the active support and supervision of her family. I have considered the nature and range of supports available to Margaret and the quality of her care arrangements. Annette confirms that Margaret loved living at her home and that she enjoyed her great relationship with most of the staff.[9] Therefore, I am satisfied that the quality of her care was of a high standard and that to the extent of her challenges, Margaret was assisted to live, as much as possible, an independent life that was full of meaning and enjoyment, with the ongoing love and support of her family.

30. It is important to the community that Margaret was permitted by NDIS funding to pursue her independence, her prized activities and her relationships in a supported fashion at SCOPE. This gave her dignity and autonomy as she aged and based on reports to this court, it was clear that Margaret experienced a high quality of care to the end.

I convey my sincere condolences to Margaret's family, friends and carers for their unexpected and heartbreaking loss.

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:

[9] Statement of Annette Curry, undated, Coronial Brief.

Annette Curry, Senior Next of Kin

Scope Australia

National Disability Insurance Agency

Senior Constable Leanne Donnelly, Victoria Police, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 06 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.