IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 000753

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Sarah Gebert
Deceased:	PSD [redacted]
Date of birth:	[redacted] 1958
Date of death:	8 February 2025
Cause of death:	1(a) Acute oesophagitis complicated by gastrointestinal haemorrhage
Place of death:	Sunshine Hospital, 176 Furlong Road St Albans, Victoria
Key words:	*In care, acute oesophagitis, gastrointestinal haemorrhage, natural causes*

INTRODUCTION

1. On 8 February 2025, PSD was 66 years old when she died in hospital following a short illness.

2. At the time of her death, PSD lived in supported disability accommodation in Deer Park with three other residents.

THE CORONIAL INVESTIGATION

3. PSD '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.

4. 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.

5. 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.

6. Victoria Police assigned Constable Francis Keenan to be the Coroner's Investigator for the investigation of PSD 's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into PSD 's death, 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.[1]

Background

8. PSD 's medical history included cerebral palsy, gastro-oesophageal reflux disease with oesophagitis, hypertension, chronic pain, depression, sciatica, and gallstones. She was unable to stand independently and used a self-drive electric wheelchair.

9. PSD lived in supported disability accommodation serviced by Scope (Aust) Limited, where she received support for all daily living activities. She attended a day program three days per week also run by Scope where she learned new skills and made social connections.

10. PSD 's care provider stated she communicated verbally with the aid of a communication device but was at times difficult to understand. According to her general practitioner, the keyboard on this device malfunctioned about five years prior to death, after which time he relied on her carers for communication.

11. In 2017, PSD was diagnosed with reflux oesophagitis, oropharyngeal dysphagia, poor lingual control and delayed swallowing initiation. A speech therapist assessed her as being at risk of inhalation pneumonia and she was placed on a Mealtime Management Plan to manage this risk.

12. On 3 February 2025, PSD had her final appointment with her regular general practitioner at Sydenham Medical Centre for an annual health assessment. According to her doctor, PSD 's carer noted increased coughing and drooling which he attributed to reflux. He described her examination on that day as "unremarkable".

13. PSD s doctor stated her regular medications included Nexium, Tazac, Coversyl, Atenolol, Movicol, Norspan, Osteomol, Pristiq, Valium, Osteovit, Ferrograd C, and Sustagen power as needed.

[1] 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.

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

Circumstances in which the death occurred

14. On 5 February 2025, PSD felt unwell after returning home from her day program. Her carers said she looked tired, was crying and felt unwell. That night, she complained of a stomach-ache and said she felt sick. Staff reported she vomited a small amount and opened her bowels before saying she felt much better. PSD reportedly slept well overnight.

15. On the morning of 6 February 2025, PSD woke up feeling unwell. Throughout the morning, she complained of lower abdominal pain, vomited twice, and went to the toilet frequently. Staff observed "black bits" in her vomit and called emergency services.

16. Ambulance Victoria responded and transported PSD to Sunshine Hospital. A computed tomography (CT) scan revealed cholelithiasis with mild gallbladder wall thickening. She was reviewed by the surgical and gastroenterology teams, who determined her presentation was not consistent with cholelithiasis and formed the impression of a possible upper gastrointestinal bleed. During her admission, PSD had several episodes of coffee ground vomits and melena (black stool) was identified on examination.

17. PSD 's treating team determined not to do a gastroscopy because of her comorbidities, frailty, and anaesthetic risk, opting instead for conservative management with the agreement of PSD and her family. PSD was treated with intravenous proton pump inhibitors, clear fluids, and analgesia. Her treating team confirmed PSD 's wishes that she was not for cardiopulmonary resuscitation (CPR) or intubation.

18. Shortly before 4.00am on 8 February 2025, PSD experienced a large vomit with respiratory distress and hypoxia, consistent with a significant aspiration event. A Medical Emergency Team call was made, and she was reviewed by intensive care. Given her frailty, comorbidities, and established goals of care, she was not a candidate for intubation, ventilation, or operative intervention. PSD with provided with ward-based supportive measures including oxygen therapy, intravenous fluids and positioning.

19. PSD 's condition continued to deteriorate. Following discussions with her family, PSD was commenced on palliative medications (morphine and midazolam).

20. At 8.40am, PSD passed away peacefully with her sister by her side.

Identity of the deceased

21. On 8 February 2025, PSD [redacted], born [redacted] 1958, was visually identified by her sister, RBN [redacted].

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

Medical cause of death

23. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 11 February 2025 and provided a written report of his findings dated 17 June 2025.

24. The post-mortem examination revealed a history of gastro-oesophageal reflux disease complicated by severe acute oesophagitis and gastrointestinal haemorrhage. Stomach content was present in the large and small airways. Dr Bouwer explained this raised the possibility of an aspiration event likely in the terminal setting. There was no acute pneumonia. There were multiple hyperplastic polyps in the stomach, which Dr Bouwer explained may also be a potential cause of gastrointestinal haemorrhage. There was no evidence of peptic ulceration or tumour.

25. Dr Bouwer explained that severe acute oesophagitis is an intense inflammatory condition of the oesophageal mucosa, often caused by infections, reflux, certain medication or other agents. In extreme cases, inflammation can lead to mucosal ulceration and erosion of submucosal vessels, resulting in gastrointestinal haemorrhage. This complication may present clinically with haematemesis (vomiting blood) or melena (black stool) and can be life-threatening.

26. There was no post-mortem evidence of violence or injury contributing to death.

27. Dr Bouwer provided an opinion that the death was due to natural causes, and the medical cause of death was *"1(a) Acute oesophagitis complicated by gastrointestinal haemorrhage"*.

28. I accept Dr Bouwer's opinion.

FAMILY CONCERNS

29. In her statement to the Court dated 2 September 2025, PSD 's sister RBN [redacted] raised concerns about the medical care PSD received in hospital in the days leading up to her death.

In summary, these concerns related to the level of support PSD received during her hospital admission, including that:

(a) she was inappropriately offered whole tablets when they should have been crushed;

(b) a gastroscopy was not performed when it should have been; and

(c) PSD was unable to use the call button to summon a nurse for assistance, possibly resulting inadequate monitoring of her condition.

FURTHER INVESTIGATION

30. As part of my investigation, I invited Western Health to provide statements in response to RBN's concerns. In March 2026, Western Health provided the Court with a statement from Valerie Dibella, Director of Nursing and Midwifery and a supplementary statement from Dr Zina Valaydon, Deputy Head of Unit, Gastroenterology, and consultant gastroenterologist. Having reviewed these statements, I am of the view that they adequately address RBN's concerns for the purpose of my investigation.

Statement of Valerie Dibella

31. In her statement, Ms Dibella outlined the care PSD received during her admission.

32. At about 7.00pm on 6 February 2025, PSD was assessed by nursing and medical staff in the emergency room on admission. Ms Dibella stated that the electronic medical record documents at least seven further episodes of care during the remainder of the night, including assessments and observations, medical reviews, administering medications and updating RBN on PSD 's condition.

33. On the morning of 7 February 2025, the medical record document at least nine further episodes of care while PSD was in the emergency department, including administering medication, observations and reviews, suctioning to clear PSD 's airway, a chest x-ray, repositioning, and providing RBN with further updates.

34. At about 12.20pm, PSD was admitted to a ward where an initial nursing assessment was completed. Ms Dibella stated PSD 's carer provided hospital staff with information about her usual care needs, including that her carer normally administered her medications. Ms Dibella stated no documentation indicated that PSD 's medication required crushing or alteration.

35. At 2.46pm, a registered nurse documented that PSD was able to swallow tablets whole and her carer remained present at her bedside. Ms Dibella stated there were no concerns raised by PSD 's carer or documented by hospital staff regarding swallowing difficulties or the need for modified medication administration. Further, the pharmacy medication management plan did not indicate any requirement for medications to be crushed.

36. The medical record indicates that PSD 's carer was in attendance until about 10.00pm, during which time they provided direct support alongside nursing staff. Ms Dibella stated that during the periods where the carer was not present, the medical record indicates frequent staff attendance to care for PSD , including observations, assessments, medication administration, and responses to clinical changes in her condition. The medical record indicates there were a minimum of eleven episodes of care between 10.00pm and about 4.00am the following morning when the Medical Emergency Team was called.

37. One of the medications prescribed to PSD was oxycodone 5 mg immediate release tablets. Ms Dibella explained that crushing, breaking, or chewing these tablets disrupts the delivery mechanism, which can result in rapid release and absorption of the full dose and create a risk of potentially fatal overdose. For this reason, Ms Dibella stated administering oxycodone in whole tablet form was clinically appropriate and consistent with safe practice.

38. Ms Dibella stated that, although PSD may not have been able to independently use the nurse call bell, the combination of continuous carer presence into the evening of 7 February 2025 and frequent documented staff attendance indicates she had consistent access to assistance. Ms Dibella was of the view that there was no evidence to suggest that PSD was ever without support or unable to obtain assistance.

39. Ms Dibella stated Western Health continues to reinforce expectations regarding medication administration practices and documentation through education, policy review, and clinical governance processes to ensure the delivery of safe, respectful and appropriate care.

Supplementary statement of Dr Zina Valaydon

40. In her supplementary statement, Dr Valaydon set out the process by which the decision was made not to complete a gastroscopy.

41. Dr Valaydon referred to the electronic medical record, which indicated that a gastroscopy was discussed with PSD and RBN on 6 February 2025, but the risks of the procedure were

ultimately considered to outweigh the potential benefit due to PSD 's frailty, significant comorbidities, and overall clinical risk.

42. Dr Valaydon stated a conservative management approach was discussed with PSD and RBN, which included intravenous proton pump inhibitor therapy, close monitoring, and reassessment depending on clinical progress. The decision was made that endoscopy was not clinically appropriate at that stage, with a plan to reconsider should PSD 's condition change. Dr Valaydon stated that the medical record indicated PSD and RBN were understanding and accepting this plan.

43. Dr Valaydon stated that, when PSD 's condition deteriorated in the early hours of 8 February 2025, she was clinically unstable and not suitable for anaesthesia or invasive intervention. The medical record indicates the clinical management plan transitioned to supportive and palliative care measures in accordance with PSD 's goals of care, which Dr Valaydon stated was appropriate.

FINDINGS AND CONCLUSION

44. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was PSD [redacted] born [redacted] 1958;

    (b) the death occurred on 8 February 2025 at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, from acute oesophagitis complicated by gastrointestinal haemorrhage; and

    (c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1B) of the Act, I order that this finding be published (in redacted form) 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:

RBN [redacted], senior next of kin

Naomi Baquing, Scope (Aust) Ltd

Maria Scoles, Western Health

Constable Francis Keenan, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 30 July 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.