IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000812

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Graham Keith Moore
Date of birth:	25 July 1967
Date of death:	11 February 2025
Cause of death:	1(a) Pneumonia Contributing factor(s) Trisomy 21 and early Alzheimer's dementia
Place of death:	Bendigo Hospital 100 Barnard Street Bendigo Victoria 3550
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 11 February 2025, Graham Keith Moore was 57 years old when he passed away at Bendigo Hospital.

2. At the time of his death, Graham resided at 1 Owen Street, Woodend, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Graham received funded daily independent living support due to his diagnosis of trisomy 21 (Down Syndrome).

3. Graham was born to parents, Keith and June Moore, and lived with them until he was about 35 years old. He had two brothers, Peter and Kevin, and two sisters, Helen and Marilyn. As Keith's health declined, June felt it would be preferrable for him to live in a home with his peers where he could readily access services. He accessed Windarring disability support services from the age of six until the time of his passing.

4. Graham's medical history included trisomy 21, Alzheimer's dementia, ventral hernia, haemochromatosis, hypothyroidism, achalasia, and benign prostatic hyperplasia. His medications included allopurinol, dutasteride/tamsulosin, quetiapine, pantoprazole, oxazepam (as needed), paracetamol (as needed) and diclofenac (as needed). In about 2022, Graham started to experience cognitive decline and was later diagnosed with early Alzheimer's dementia. His condition deteriorated quickly from this time, despite attempts by his clinicians to manage his symptoms.

THE CORONIAL INVESTIGATION

5. Graham's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to his death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

6. 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.

7. 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.

8. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

9. This finding draws on the totality of the coronial investigation into the death of Graham Keith Moore 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.[2]

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

Identity of the deceased

10. On 11 February 2025, Graham Keith Moore, born 25 July 1967, was visually identified by his carer, Siobhan Mele.

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

Medical cause of death

12. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 13 February 2025 and provided a written report of his findings dated 17 February 2025.

[2] 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.

13. The post-mortem examination revealed findings consistent with the reported circumstances.

14. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

15. Dr Bedford provided an opinion that the medical cause of death was 1(a) Pneumonia with contributing factors of trisomy 21 and early Alzheimer's dementia.

16. Dr Bedford provided an opinion that the cause of death was due to natural causes.

17. I accept Dr Bedford's opinion as to the medical cause of death.

Circumstances in which the death occurred

18. In the first week of January 2025, support staff at Graham's home reported that he became increasingly agitated, refused to leave his bedroom or accept any assistance from staff. His carers noted that he had difficulty sleeping and he appeared to be experiencing visual hallucinations.

19. In the early hours of 3 January 2025, Graham experienced an unwitnessed fall and staff noted he had been unable to sleep all night. Carers called for an ambulance, who attended and assessed Graham. They determined that he did not require transfer to hospital at the time. That afternoon, Graham experienced a second fall and became increasingly upset, so staff called for another ambulance. The staff called Graham's brother, Peter, and sister, Helen, and they all agreed to send Graham to Bendigo Hospital for further assessment.

20. From 4 to 15 January 2025, Graham was admitted to a General Medicine ward, then received care from geriatricians from 15 January 2025, for ongoing discharge planning. His main issues during the admission were urinary retention requiring an indwelling catheter, poor oral intake, poor sleep, decreased mobility and he regularly refused care from staff.

21. On 1 February 2025, Graham experienced an episode of hypotension and reduced consciousness, which was managed as an aspiration event with intravenous fluids and antibiotics. Despite these interventions, Graham's condition continued to deteriorate. Following consultation with Graham's family, he was transitioned to palliative care and passed away on the morning of 11 February 2025.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Graham Keith Moore, born 25 July 1967;

    b) the death occurred on 11 February 2025 at Bendigo Hospital, 100 Barnard Street Bendigo Victoria 3550 from pneumonia with contributing factors of trisomy 21 and early Alzheimer's dementia; and

    c) the death occurred in the circumstances described above.

23. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Bendigo Hospital, that caused or contributed to Graham's death.

24. Having considered all the available evidence, I find that Graham'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 his death and to finalise the investigation of Graham's death in chambers.

I convey my sincere condolences to Graham's family, friends and carers 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:

Helen Fisher, Senior Next of Kin

Bendigo Health

Senior Constable Brad Izzard, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 09 October 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.