IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000867

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Tracey Ellen Maree Wood
Date of birth:	01 October 1964
Date of death:	14 February 2025
Cause of death:	1a : PNEUMONIA WITH LARGE PLEURAL EFFUSION 2 : DOWNS SYNDROME, ALZHEIMER'S DISEASE, EPILEPSY
Place of death:	University Hospital Geelong, Barwon Health Bellerine Street, Geelong Victoria 3220
Keywords:	In care, SDA resident, pneumonia, natural causes death

INTRODUCTION

1. On 14 February 2025, Tracey Ellen Maree Wood **(Ms Wood)** was 60 years old when she died at the University Hospital Geelong (Barwon Health). She is survived by her brother, Darcy Wood.

2. Ms Wood's medical history included Trisomy 21, epilepsy, dysphagia and Alzheimer's disease. At the time of her death, Ms Wood resided in Specialist Disability Accommodation **(SDA)** at 20 Muscovy Drive in Grovedale. She received supported independent living services from Scope (Aust) Ltd **(Scope)** and required support for all daily living activities. Ms Wood received funding under the National Disability Insurance Scheme.

BACKGROUND

3. To assist the coronial investigation, the Court requested a statement from Scope regarding the care and support provided to Ms Wood and observations regarding her health in the period proximate to her passing. Scope's Chief Operating Officer Lisa Evans **(Ms Evans)** provided a comprehensive statement on 1 July 2025.

4. Ms Evans noted that on 30 April 2024, Ms Wood had a Comprehensive Health Assessment Program completed by Dr Pei Sue Lee **(Dr Lee)** of the Waurn Ponds Medical Centre. Ms Wood again attended Dr Lee on 1 November 2024 on the background of increased tics. At this appointment, Ms Wood was referred to a neurologist.

5. Ms Wood's Mealtime Management Plan **(MMP)** was also reviewed and updated by Speech Pathologist Thien Truong **(Ms Truong)**. Ms Truong visited Ms Wood on 29 November 2024 and noticed that she had a persistent wet sounding cough. Ms Truong requested that Scope staff monitor this and if the cough worsened, to book in a review with a General Practitioner.

6. On 31 October 2024, Ms Wood was reviewed by a Neurology Registrar at Barwon Health. The health management appointment form stated that the tics were *"likely myoclonic jerks which may be seizure related in the setting of epilepsy and trisomy 21."* A six-month follow up was scheduled for June 2025.

7. On 28 January 2025 Ms Wood was reviewed at the Waurn Ponds Medical Centre due to 'loose' chest sounds. It was noted that her chest was clear with no antibiotics required.

8. On 30 and 31 January 2025, Ms Wood was reviewed by Ms Truong. Her MMP was updated with Ms Truong's recommendation that staff check Ms Wood's positioning and alertness during mealtimes.

THE CORONIAL INVESTIGATION

9. Ms Wood's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] 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. In this instance, Ms Wood was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as she was *"a prescribed person or a person belonging to a prescribed class of person"* due to her status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

10. 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.

11. This finding draws on the totality of the coronial investigation into the death of Tracey Ellen Maree Wood including evidence provided to and obtained by the Court. 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.[3]

[1] Section 4(1), 4(2)(c) of the Act.
[2] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5.
[3] 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

12. On 1 February 2025, Ms Wood's MMP was again updated to reflect instructions from Ms Troung to provide half meal size and downgrade fluid to extremely thick. Ms Wood was observed by Scope staff to be eating and drinking well, with no coughing noted.

13. On 5 February 2025, Ms Wood was reviewed by Dr Lee as Scope staff had observed her to be coughing during her meals in the preceding days. Dr Lee requested a chest x-ray and a video fluoroscopy referral.

14. On 6 February 2025, Ms Truong emailed Scope staff as well as Ms Wood's brother a copy of notes taken during a meeting with a Barwon Health Speech Pathologist. The request for the video fluoroscopic swallowing study was declined by Barwon Health due to Ms Wood's advanced age in down syndrome, her cognitive status and degeneration due to Alzheimer's disease. Minutes from the meeting outlined that "*Ms Wood is unlikely to choke and die due to a highly modified oral intake, which cannot be further modified"*. A video fluoroscopy completed in 2023 indicated that Ms Wood was likely to be aspirating on small amounts of diet and fluids, and a repeat swallowing study was unlikely to yield any further useful information.

15. On 8 February 2025, Scope staff observed that Ms Wood appeared to be "really struggling" with her oral intake. Subsequently, a decision was made to call for an ambulance. Ms Wood was transported to the University Hospital Geelong.

16. The medical deposition from the hospital noted that Ms Wood's oxygen desaturated to 91% and she had a slightly raised white cell count, a high C-reactive protein, and a chest x-ray showing a moderate sized left pleural opacity. She was admitted under the general medical team, and there were discussions with her family regarding goals of care. A decision was made for ward-based care with a trial of conservative management.

17. Subsequently, Ms Wood had periods of low oxygen saturations below 80% and two Medical Emergency Team **(MET)** calls were made on 9 February 2025. Further discussions were held with Ms Wood's family and a decision was made to transfer Ms Wood to palliative care. Ms Wood passed away on 14 February 2025 at 12.50am.

Identity of the deceased

18. On 14 February 2025, Tracey Ellen Maree Wood, born 01 October 1964, was visually identified by her brother, Darcy Wood.

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

Medical cause of death

20. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an external examination on 17 February 2025 and provided a written report of her findings dated 16 May 2025.

21. The post-mortem CT scan showed grossly dilated lateral ventricles, a huge left pleural effusion with complete whiteout of the left hemithorax, small right pleural effusion with patchy increase in lung markings, fatty liver, metalwork around the left ankle, and scoliosis.

22. Dr Baber provided an opinion that the medical cause of death was *1(a) Pneumonia with large pleural effusion, 2) Downs Syndrome, Alzheimer's Disease, Epilepsy.* Dr Baber was of the opinion that the death was due to natural causes.

23. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Tracey Ellen Maree Wood, born 01 October 1964;

    b) the death occurred on 14 February 2025 at the University Hospital Geelong, Barwon Health Bellerine Street Geelong, Victoria 3220 from pneumonia with large pleural effusion with contributing factors of Downs Syndrome, Alzheimer's Disease and Epilepsy; and

    c) the death occurred in the circumstances described above.

25. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. Having considered the evidence and the medical report from Dr Baber, I am satisfied that Ms Wood died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death

I convey my sincere condolences to Ms Wood's family 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:

Darcy Wood, Senior Next of Kin

Lorraine Judd, Barwon Health

Naomi Baquing, Scope

National Disability Insurance Scheme

Senior Constable Nelson Shields, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 22 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.