



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001008

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of Robyn Julia Richards

Delivered On:	25 May 2026
Delivered At:	Southbank, Victoria
Hearing Dates:	25 May 2026
Findings of:	Coroner Paul Lawrie
Representation:	No appearances
Assisting the Coroner:	Bemani Abeysinghe, Coroner's Solicitor
Keywords	In care, Specialist Disability Accommodation, SDA

INTRODUCTION

1. On 20 February 2025, Ms Richards was 69 years old when she passed away at the Austin Hospital in Heidelberg, Victoria.
2. At the time of her death, Ms Richards resided in Macleod, Victoria, at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). The SDA was operated by Araluen, a registered NDIS provider. Ms Richards received funded daily independent living support through the NDIS.
3. Ms Richards was born with cerebral palsy and an intellectual disability and was diagnosed with B cell acute lymphoblastic leukaemia later in life.
4. Ms Richards mobilised with the assistance of a 4-wheel walker.

CORONIAL INVESTIGATION AND INQUEST

5. 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.
6. 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.
7. Pursuant to section 4(2)(c) of the *Coroners Act 2008* (**the Act**), the death of a person who was immediately before their death ‘a person placed in custody or care’, falls within the

definition of a reportable death. A person in Victoria who is an SDA resident¹ residing in an SDA enrolled dwelling² is a person ‘in care’ within the meaning of the Act.³ The death of a person in care is a mandatory report to the Coroner, regardless of the apparent cause of death.

8. I am satisfied that Ms Richards was an SDA resident residing in an SDA enrolled dwelling, and therefore she was a person ‘in care’ for the purposes of the Act. Accordingly, pursuant to section 52(2)(b) of the Act, an inquest is mandatory where the apparent cause of death is not wholly attributable to natural causes.
9. I determined that the inquest should proceed in a summary manner as the evidence may be regarded as complete and uncontentious, and it is appropriate for the evidence to be admitted in a summary form without the need to examine witnesses. The inquest took place on 25 May 2026.
10. Senior Constable (SC) James Doney of Victoria Police acted as the Coronial Investigator for the investigation of Ms Richards’ death. SC Doney conducted inquiries on my behalf, including taking statements from family, treating medical practitioners, clinicians and support workers, and submitted a coronial brief of evidence.
11. This finding draws on the totality of the coronial investigation into the death of Robyn Julia Richards including the 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.⁴

¹ ‘SDA resident’ means a person with a disability – (a) who receives, or is eligible to receive, funded daily independent living support; and (b) who is residing, or proposes to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement, Residential Tenancies Act 1997 – s.3(1)

² *Residential Tenancies Act 1997* – s.3(1) (definition of ‘SDA enrolled dwelling’).

³ *Coroners Regulations 2019* – r.7(1)(d).

⁴ 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. At approximately 7.45pm on 1 February 2025, Ms Richards had an unwitnessed fall in a corridor at the SDA dwelling where she resided. Support workers heard Ms Richards scream and went to assist her. They found Ms Richards on the ground on top of her 4-wheel walker.
13. Support worker, Samundra Kunwar recalled that Ms Richards got up without assistance, and moved to the kitchen where she asked for a cup of coffee.
14. As a result of the fall, Ms Richards had a skin abrasion on the lower side of her left eye but otherwise appeared to be uninjured.
15. Ms Richards was reviewed by Ambulance Victoria paramedics shortly afterwards. They dressed the cut to her face and determined that she did not need to go to hospital. An incident report prepared by staff at Araluen recorded that the paramedics also consulted with a doctor by telephone. Staff continued to observe Ms Richards overnight.
16. Mr Kunwar stated that Ms Richards' health had been declining prior to the fall. She had been eating less and had dizzy spells, although this was the first time she had fallen. In the days prior to the fall, staff had also alerted the palliative care team of Ms Richards' declining health.
17. On 3 February 2025, Ms Richards was seen by a general practitioner for review and redressing of the wound to her face, but no additional concerns were noted.
18. On 6 February 2025, Ms Richards was admitted to the Austin Hospital emergency department with acute agitation, altered conscious state and seizure like activity that had been witnessed by the support workers at the SDA. Her admission was in the context of the

fall five days earlier and it was also noted that she was suffering with lethargy, loss of appetite, nausea and vomiting over approximately three weeks.

19. Computed tomography (CT) imaging of the brain showed bilateral multifocal subarachnoid haemorrhage⁵, and ventricular dilatation possibly indicating communicating hydrocephalus⁶, with broad potential differential diagnoses including cerebral relapse of disease as cause for hydrocephalus.
20. Ms Richards was reviewed by the neurosurgery team who determined that she was not for neurosurgical intervention given her frailty and poor overall prognosis.
21. Ms Richards was later transferred to the general ward where her conscious state fluctuated in the context of acute neurological changes from the subarachnoid haemorrhage and hydrocephalus. A magnetic resonance imaging (MRI) scan was planned for further investigations however this was abandoned because of Ms Richards' level of distress and the associated risk of sedation (which would be necessary for the scan in the circumstances).
22. Ms Richards continued to deteriorate, and she was transitioned to end of life care on 18 February 2025 and passed away at 2.35pm on 20 February 2025.

Identity and medical cause of death

23. On 20 February 2025, Robyn Julia Richards, born 21 April 1955, was visually identified by Tracy Lee Hall, support worker at Araluen.
24. Identity is not in dispute and requires no further investigation.
25. On 27 February 2025, Dr Joanna Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of Ms Richards' body which

⁵ Bleeding across the surface of the brain.

⁶ Dilatation of the cerebrospinal fluid spaces in the brain.

included a post-mortem CT scan, and provided a written report of her findings dated 4 March 2025.

26. Dr Glengarry noted that the external examination showed features consistent with the clinical history.
27. Dr Glengarry opined that, though a small volume of subarachnoid haemorrhage (bleeding across the surface of the brain) showed on the post-mortem CT scan, there was no unequivocal trauma. Dr Glengarry further commented that the cause of Ms Richards' new-onset hydrocephalus (dilatation of the cerebrospinal fluid spaces in the brain) is not clear and that it may be due to natural causes (such as infection or relating to her underlying leukaemia), trauma, or a combination of both.
28. An autopsy was originally directed to facilitate examination of the brain and clarify aforementioned matters. However, this direction was revoked after a request for reconsideration was submitted by Ms Richards' senior next of kin, and such request having been granted.
29. Dr Glengarry provided an opinion that the medical cause of death was,
'1(a) HYDROCEPHALUS AND SUBARACHNOID HAEMORRHAGE IN THE
SETTING OF A FALL IN A WOMAN WITH LEUKAEMIA AND CEREBRAL
PALSY'.
30. I accept Dr Glengarry's opinion.

CONCLUSION

31. I am satisfied that the fall sustained by Ms Richards on 1 February 2025 appeared to have resulted in only a minor injury. The fall itself occurred in the context of her mobilising with the assistance of a 4-wheel walker.
32. There is nothing to suggest that the assessment and treatment by paramedics shortly after the fall was inappropriate. I reach the same conclusion regarding the care provided by the staff at Araluen and medical care provided by the clinicians and staff at the Austin Hospital.
33. Pursuant to section 67(1) of the Act I make the following findings:
 - a. the identity of the deceased was Robyn Julia Richards born on 21 April 1955;
 - b. the death occurred on 20 February 2025 at Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084;
 - c. the cause of death was: ‘1(a) HYDROCEPHALUS AND SUBARACHNOID HAEMORRHAGE IN THE SETTING OF A FALL IN A WOMAN WITH LEUKAEMIA AND CEREBRAL PALSY’; and
 - d. the death occurred in the circumstances described above.

ACKNOWLEDGEMENTS

34. I extend my sincere condolences to Ms Richards’ family for their loss.
35. I thank the Coronial Investigator and those assisting for their work in the investigation.

DIRECTIONS

36. Pursuant to section 73(1) of the Act, I direct that this finding be published on the Coroners Court website in accordance with the Rules.
37. I direct that a copy of this finding be provided to the following:

Michelle Edlington, Senior Next of Kin

Austin Health

Araluen

National Disability Insurance Agency

Senior Constable James Doney, Coronial Investigator

Signature:



Coroner Paul Lawrie

Date: 25 May 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 inquest. 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.
