IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2025 001211**

# 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: | Barbara Grace Bright |
| Date of birth: | 19 October 1951 |
| Date of death: | 4 March 2025 |
| Cause of death: | 1a : Pneumonia (palliated) |
| Place of death: | Frankston Hospital<br>2 Hastings Road<br>Frankston Victoria 3199 |
| Keywords: | Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes |

## INTRODUCTION

1. On 4 March 2025, Barbara Grace Bright was 73 years old when she passed away at Frankston Hospital.

2. At the time of her death, Ms Bright resided at 82 McLeod Road, Carrum, a Specialist Disability Accommodation (**SDA**) dwelling[1] enrolled under the National Disability Insurance Scheme (**NDIS**). Ms Bright received funded daily independent living support due to her medical conditions, which was provided by disability service provider, Scope (Aust) Limited (**Scope**).

### Background

3. Ms Bright was born with cerebral palsy and provided a life expectancy of 10 years. Through her parents' dedication, she learned to walk and talk, living with them until moving into permanent care at the Carrum SDA home. She had been a resident there since August 1998.

4. Ms Bright's niece, Sharon Anketell, who was also her medical guardian, described her as the "miracle auntie", who outlived her treating clinicians' prognosis.

5. After suffering a fall and breaking her leg in the late 1990s, Ms Bright became permanently wheelchair bound. Her other medical conditions included intellectual disability, dysphagia, epilepsy, osteoporosis, and lymphoedema. She was non-verbal.

## THE CORONIAL INVESTIGATION

6. Ms Bright's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a *person placed in custody or care* within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Rayner's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is a NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

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.

7. 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.

8. 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.

9. Victoria Police assigned Leading Senior Constable Jade Fitzsimmons to be the Coronial Investigator for the investigation of Barbara Grace Bright's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Barbara Grace Bright including evidence contained in the Coronial Brief and medical records from Peninsula Health. 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

11. On 4 March 2025, Barbara Grace Bright, born 19 October 1951, was visually identified by her carer, Hayley Watson.

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

[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.

**Medical cause of death**

13. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine conducted an external examination on 6 March 2025 and provided a written report of his findings dated 17 April 2025.

14. The post-mortem CT scan showed evidence of bilateral pneumonia, hyperostosis frontalis, marked scoliosis, metal rod and dynamic hip screw left hip, osteoporosis, moderate rectal faecal burden, kidney cysts, cholelithiasis, and splenomegaly

15. Dr Bouwer provided an opinion that the medical cause of death was *1(a) pneumonia (palliated)*. He opined that the death was due to natural causes.

16. I accept Dr Bouwer's opinion as to the medical cause of death.

**Circumstances in which the death occurred**

17. From around July 2024, Ms Bright experienced increasing fatigue and difficulty maintaining her posture. She also had a decline in her nutritional intake, with support staff noting she was gagging and refusing to eat.

18. Support staff subsequently arranged care input from a speech pathologist. The speech pathologist provided an updated mealtime management plan to assist with swallowing during meals.

19. Ms Bright's geriatrician, Dr Ying Ji Khew noted in his consultation report that the decline was likely due to evolving dementia, in the context of multiple medical conditions. In his opinion, given Ms Bright condition, she was not for resuscitation and hospital transfers should be avoided. He also did not recommend artificial feeding in the setting of severe dysphagia.

20. Evidence indicates that while the Advance Care Plan was intended to be developed in consultation with Ms Anketell. Medical records obtained from Peninsula Health suggest that the plan was not finalised at time of Ms Bright death.

21. On 2 March 2025, Ms Bright appeared to be in pain, grimacing when she was moved by support staff. She consumed only small amounts of food, with staff observing she had difficulty swallowing.

22. On the morning of 3 March 2025, Ms Bright was particularly lethargic and fatigued during her morning personal care routine. The home supervisor called emergency services '000' at approximately 8:00am. After initial triage via the Victorian Virtual Emergency Department, paramedics attended around 12:45pm and transported her to Frankston Hospital Emergency Department.

23. At the hospital, Ms Bright was found significantly dehydrated with hypernatremia and had possible pneumonia with supportive biochemistry and chest X-ray changes.

24. After discussion with Ms Anketell about Ms Bright's clinical condition, recent decline and medical conditions, active care was withdrawn, with comfort care followed.

25. Ms Bright died at approximately 7:05am on 4 March 2025 at Frankston Hospital.

**FINDINGS AND CONCLUSION**

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

    a) the identity of the deceased was Barbara Grace Bright, born 19 October 1951;

    b) the death occurred on 4 March 2025 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199 from pneumonia (palliated);

    c) the death occurred in the circumstances described above.

27. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, Scope, or clinical staff at Frankston Hospital that caused or contributed to Ms Bright's death. I also note Ms Anketell expressed no concerns regarding the decision to transfer her to Frankston Hospital emergency treatment and subsequent comfort care.

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

I convey my sincere condolences to Ms Bright'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:

**Shannon Anketell, Senior Next of Kin**

**Scope (Aust) Limited**

**Leading Senior Constable Jade Fitzsimmons, Coronial Investigator**

Signature:


Judge Liberty Sanger, State Coroner

Date: 11 December 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.