



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001496

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sara Dennis
Deceased:	Lisa Jane Gladman
Date of birth:	26 June 1972
Date of death:	16 March 2025
Cause of death:	1a: Large bowel obstruction 1b: Sigmoid volvulus <u>Contributing Factors:</u> Congenital encephalopathy
Place of death:	South Eastern Private Hospital Corner Princes Highway and Heatherton Road Noble Park Victoria 3174
Keywords:	In care, Specialist Disability Accommodation, SDA, natural causes

INTRODUCTION

1. On 16 March 2025, Lisa Jane Gladman was 52 years old when she died at South Eastern Private Hospital. At the time of her death, Lisa resided at a Specialist Disability Accommodation (**SDA**) dwelling in Carrum enrolled under the National Disability Insurance Scheme (**NDIS**). Lisa received funded daily independent living support which was provided by disability service provider Scope (Aust) Limited (**Scope**).
2. At birth, Lisa's right leg was several inches shorter than her left, and she had congenital hydrocephalus.¹ At 20 months of age, Lisa underwent amputation of her right leg below the knee. Her right leg was missing a bone, which caused the difference in length. She was later fitted for a prosthesis that she became accustomed to fairly quickly.
3. When Lisa started kindergarten, it became apparent that she was developing at a slower rate than other kids in the class. The following year her family noticed her speech was slower and she appeared to be developmentally behind where her older brothers were at her age. At around this time, Lisa was diagnosed with an intellectual disability. She attended a school for children with disabilities and settled in well. At school, she enjoyed excursions such as visiting farm animals. Lisa began falling behind at school and transferred to a special development school. While at this school, Lisa enjoyed arts and crafts, and jigsaw puzzles.
4. At 21 years of age, Lisa gained employment at the workshop neighbouring her school. She lived at home but had weekly visits from a carer. The carer took Lisa out on Saturdays to do activities like dancing, bowling, shopping or watching movies.
5. Lisa's health progressively declined and her hospital admissions increased. From 30 years of age, she began experiencing seizures which required medication. From around 35 years of age, she experienced chest infections that developed into pneumonia and occasionally caused hallucinations.
6. At 45 years of age, Lisa was able to move into her SDA and was provided with two carers during the day and one at night. She was also able to gain employment closer to her new home. As part of Lisa's transition out of home and into care, her parents sought Guardianship – which was granted by the Victorian Civil and Administrative Tribunal in 2018. Due to her disability, Lisa was unable to sign a Power of Attorney.

¹ Congenital hydrocephalus occurs when a child is born with, or shortly after birth develops, hydrocephalus – an abnormal buildup of cerebrospinal fluid in the brain.

7. In 2021, a consultant psychiatrist diagnosed Lisa with major depression and anxiety disorder which was managed with medication. The psychiatrist noted that, due to Lisa's intellectual disability and her limited ability to express information, symptoms of mental ill health were incorrectly understood to be physical health ailments. Lisa's mental health history also included schizophrenia and psychosis.

THE CORONIAL INVESTIGATION

8. Lisa'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 with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.² 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.
9. 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.
10. 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.
11. Coroner Audrey Jamieson (as her Honour then was) originally held carriage of this investigation prior to her retirement in April 2026. I assumed carriage of this investigation on 27 April 2026 for the purposes of finalising the investigation and making findings.
12. Victoria Police assigned Leading Senior Constable Jonathan Weisshardt to be the Coronial Investigator for the investigation of Lisa's death. Leading Senior Constable Jonathan Weisshardt conducted inquiries on my behalf, including taking statements from witnesses –

² This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Lisa Jane Gladman 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.³

BACKGROUND

14. In 2022, Lisa was admitted to hospital as her stomach appeared bloated and was firm. She underwent a colonoscopy and they identified polyps in the transverse colon and the sigmoid, and haemorrhoids.
15. In 2023, Lisa fractured her back following a fall in her bedroom and was wheelchair bound from this point onwards.
16. On 19 June 2024, Lisa saw her general practitioner to complete her Comprehensive Health Assessment Program. In a section of the assessment regarding future planning, her general practitioner noted that he would not be surprised if Lisa passed away within 12 months.
17. Between late 2024 and early 2025, Lisa's health deteriorated further, and she experienced periods of delirium and confusion (noting staff did not think this was unusual given her mental health issues and known behaviours), she was quiet and tired, and was inconsistent with eating and drinking (and more particular about what she would or would not eat).
18. In September 2024 Lisa was notified by the National Bowel Cancer Screening Program that her test kit result was positive and it was recommended she have a colonoscopy. Her parents were notified but decided not to agree to this.
19. On 8 February 2025, Scope staff assisted Lisa with her morning personal care routine, when they noticed her stomach was protruding. Staff contacted emergency services and Lisa was

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.

transported to Mulgrave Private Hospital. Upon assessment, Lisa was found to have a large bowel obstruction due to sigmoid colon volvulus.

20. Attempts to treat the volvulus non-surgically were not successful. The surgical team opined that she would need a stoma following surgery. Hospital staff discussed this with Lisa's parents who decided to manage her palliatively and not surgically, as they did not think Lisa would cope with the stoma in the context of her intellectual disability.
21. A second opinion was sought regarding surgery that would not result in a stoma. It was determined this would be a large operation with a prolonged and potentially difficult recovery. There was also a low chance that Lisa would return to her previous level of functioning and be able to return to her SDA. Lisa's parents decided that the isolation associated with entering residential care would not be in the best interest of Lisa and her quality of life. Ultimately, Lisa's parents decided to manage her palliatively.

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

Circumstances in which the death occurred

22. On 5 March 2025, Lisa was transferred from Mulgrave Private Hospital to South Eastern Private Hospital for palliative care and symptom management due to a large bowel obstruction secondary to sigmoid volvulus.
23. Lisa was reviewed by respiratory specialists, infectious disease specialists and palliative care physicians throughout her admission.
24. On 16 March 2025, at 8.15pm, Lisa passed away.

Identity of the deceased

25. On 21 March 2025, Lisa Jane Gladman, born 26 June 1972, was visually identified by her father, Stanley Gladman.
26. Identity is not in dispute and requires no further investigation.

Medical cause of death

27. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (VIFM) conducted an examination on 26 March 2025 and provided a written report of her findings dated 31 March 2025.

28. The post-mortem examination was unremarkable.
29. Dr Ho provided an opinion that the medical cause of death was *1(a) Large bowel obstruction* secondary to *1(b) Sigmoid volvulus*, with a contributing factor of *Congenital encephalopathy*.
30. Dr Ho stated that death was due to natural causes.
31. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

32. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was Lisa Jane Gladman, born 26 June 1972;
 - b) the death occurred on 16 March 2025 at South Eastern Private Hospital, Corner Princes Highway and Heatherton Road, Noble Park, Victoria 3174 from large bowel obstruction secondary to sigmoid volvulus with a contributing factor of congenital encephalopathy; and
 - c) the death occurred in the circumstances described above.
33. 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 South Eastern Private Hospital, that caused or contributed to Lisa's death.
34. Having considered all the available evidence, I find that Lisa'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 Lisa's death in chambers.

I convey my sincere condolences to Lisa'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:

Stanley and Alison Gladman, Senior Next of Kin

Scope (Aust) Limited

Leading Senior Constable Jonathan Weisshardt, Coronial Investigator

Signature:



Coroner Sara Dennis

Date: 14 October 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.
