



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001521

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of KATHLEEN SMITH

Findings of: AUDREY JAMIESON, Coroner

Delivered on: 19 February 2026

Delivered at: Coroners Court of Victoria
65 Kavanagh Street, Southbank, Victoria 3006

Hearing dates: 19 February 2026

Representation: None

Counsel assisting the Coroner: Ms Anna Pejnovic of the Coroners Court of Victoria

I, AUDREY JAMIESON, Coroner, having investigated the disappearance of KATHLEEN SMITH

AND having held a Summary Inquest in relation to this suspected death on 19 February 2026

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the person suspected to be deceased was KATHLEEN SMITH

born on 17 March 1971

suspected to have died on 15 July 2024

at Sorrento Back Beach, Sorrento, Victoria, 3942

from:

1a: UNASCERTAINED (PRESUMED DROWNED)

in the following summary of circumstances:

KATHLEEN SMITH (**Kathy**)¹ was 53 years old when she disappeared on 15 July 2024. Prior to her disappearance, Kathy was experiencing deteriorating mental health and significant anxiety related to future surgery on her feet. The circumstances of her disappearance suggested she intended to take her own life.

BACKGROUND CIRCUMSTANCES

1. Kathy grew up in the northern suburbs of Melbourne and was the younger sister to Ruen, whom she was close with. She was a happy child with lots of friends.
2. Kathy attended secondary school in Lalor where she was a dedicated student. She then studied sports medicine for a year at LaTrobe University, before transferring into a podiatry course. Later in life she disclosed to Ruen that she had chosen podiatry due to issues with her own feet.
3. Kathy worked as a podiatrist in private practice her whole life. She was a hard worker and did not leave a role without having another lined up. Darren Tymms, whose practice Kathy

¹ Referred to throughout this finding as Kathy at the request of her family, save for where formality requires that I use her full name.

worked for as a contractor, noted that she never took time off. On the one holiday she took, she returned home after two days.

4. Kathy had a particular passion for fitness. As a child she did ballet and gymnastics, and she later took up running and rowing, attending a development program at the Australian Institute of Sport. She was competitive and trained almost daily. As an adult, Kathy ran morning and night. According to Ruen, *“sport and fitness was her whole world. I think it was her reason for living.”* She told Darren that if she couldn’t exercise, she wouldn’t have a life.
5. Kathy had a determined and strong personality and was described by Ruen as someone that *“always had a pretty good outlook. She wasn’t really doom and gloom.”* Darren described her as *“very set in her ways, very routine focussed”*.
6. Kathy’s medical history included recurrent iron deficiency and fluctuating neutropenia and macrocytosis. According to her general practitioner Dr Rachael Sutherland, Kathy presented on multiple occasions over several years with symptoms of fatigue, reduced power and possible incoordination. These symptoms were extensively investigated by several specialists, but no clear cause was found.
7. In 2020, Kathy was diagnosed with severe osteoarthritis of the feet, with an anticipated requirement for surgery in the future. The symptoms and functional impact of this increased over time.

THE CORONIAL INVESTIGATION

Purpose of a coronial investigation

8. The purpose of a coronial investigation of a reportable death² is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.³ For coronial purposes, death includes a suspected death.⁴

² The term is exhaustively defined in section 4 of the *Coroners Act 2008* (Vic) (“the Act”).

³ Section 67(1) of the Act.

⁴ See section 3 of the Act for the definition of “death”.

9. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.⁵
10. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.⁶
11. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.⁷ These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.⁸
12. The Coroners Court of Victoria is an inquisitorial jurisdiction.⁹ Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.¹⁰

⁵ This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

⁶ The “prevention” role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as “implicit”.

⁷ See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.

⁸ See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

⁹ Section 89(4) of the Act.

¹⁰ Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

Investigation of suspected deaths

13. The coronial investigation of a suspected death differs significantly from most other coronial investigations which commence with the discovery of a deceased person's body or remains. The focus in those cases is on the identification of the body or remains, a forensic pathologist's examination and advice to the coroner about the medical cause of death, and the circumstances in which the death occurred.
14. Absent a body or remains, the coronial investigation focuses on the last sighting of the person suspected to be deceased, any subsequent contact with family or the authorities, and evidence of proof of life since. In such cases, the coronial investigation is essentially an exercise in proof of death through the absence of evidence that a person has been alive.
15. A finding that a person is deceased, absent a body or remains, is a serious matter with significant legal consequence. Such a finding is not made lightly and requires me to reach a comfortable level of satisfaction as to the facts.
16. I considered it appropriate to use my discretion to hold an inquest. Having considered the available evidence, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 19 February 2026.

Sources of evidence

17. This Finding is based on the totality of the material produced by the coronial investigation into the presumed death of Kathleen Smith. That is, the Court File and Coronial Brief of Evidence compiled by Detective Senior Constable Timothy Paltridge. The Coronial Brief will remain on the Court File, together with the Inquest transcript.¹¹

¹¹ From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

18. In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

EVENTS PROXIMATE TO KATHLEEN'S DISAPPEARANCE

19. In early 2024, Kathy told Darren that she was physically unable to run anymore due to issues with her feet. She was also walking with a limp, which he did not believe was related to her feet. He encouraged her to see a specialist that could also assess her hips and knees to determine the cause of her issues.
20. Ruen noticed a change in Kathy around the time of Easter in 2024. She looked as if "*she had the life sucked out of her*" and she sounded defeated whenever they spoke. She told him that she had issues with her feet and was morbidly flat footed, requiring surgery.
21. On 17 May 2024, Kathy saw orthopaedic surgeon Mr Otis Wang, who diagnosed her with "*severe flatfoot deformity with instability of her lateral ligament complex with a peroneal tendon tear as well as medial tibialis posterior insufficiency*" of the right foot, and "*severe left midfoot rocker-bottom collapse with first and second TMT J arthritis as well as a planovalgus hindfoot midfoot deformity and lateral ankle instability with peroneal tendinopathy.*" They discussed surgical and non-surgical treatment options.
22. Kathy returned for a review on 4 June 2024 and reported that over the past two weeks, her left side had deteriorated significantly, and she found it difficult to weight-bear. They discussed her options in detail, and Mr Wang offered a left ankle scope with lateral ligament reconstruction and peroneal repair debridement, and a flatfoot reconstruction and first second corrective midfoot fusion. He explained in detail the surgery and recovery.
23. According to Dr Sutherland, Kathy was anxious about the prospect of surgery and her functional limitations in the post-operative period. She experienced overwhelm, catastrophic thinking and difficulty making a decision about surgery. Dr Sutherland recommended Kathy seek psychological counselling which she initially declined, however subsequently seemed more willing to consider. On the evidence it does not appear that she consulted with a psychologist.

24. Kathy did not contact Mr Wang's rooms to confirm her decision to proceed with surgery, which had been tentatively scheduled for 24 July 2024.
25. Kathy had several conversations with Ruen and others about surgery. Ruen described her as *"sound[ing] like she had lost any hope of having a life after the surgery."* She told her friend Michael that doctors had told her there was a chance she would need one of her feet amputated, and she could not cope with the prospect of losing her mobility.
26. Darren *"could tell that Kath was depressed"*, and she was negative, argumentative and spoke of suicide. Her friend Wayne also noted that *"it was clear she was thinking about suicide more and more"*, and she often told him of ways she had considered ending her life. According to Darren, Kathy had been having similar conversations with others, including receptionists at the clinic, though he was unaware of this until after her disappearance. She had told one receptionist that she wanted to swim out from the Sorrento Back Beach.
27. In the weeks prior to her disappearance, Wayne became aware that Kathy had driven to Sorrento around three or four times. When she told him, he immediately *"thought she was thinking about suicide"*. On one occasion, she disclosed parking the car and walking to a high cliff.
28. On 16 June 2024, Michael tried to call Kathy four times. She did not answer which was unusual as they spoke every Sunday. At around 7pm she called him back and told him *"I can't go on anymore. I don't know how I'm going to get through this. It's all too much."* He could hear waves and wind and knew she was by the ocean. Michael was able to convince her to return to her car and drive home. He met her at home, where he noticed she looked *"terrible"*, *"freezing and covered in sand"*. He stayed with her for around two hours.
29. Kathy called Michael the next morning to thank him for helping her. He told her that she needed to contact Beyond Blue as she needed help and he was not qualified. She told him that she would call them.
30. On 20 June 2024, Kathy attended Dr Sutherland who recommended she commence sertraline for the management of her anxiety. She declined the prescription. Dr Sutherland prescribed short term diazepam for use as needed.

31. Kathy attended Dr Sutherland again on 26 June 2024. She reported having used a single dose of diazepam and told Dr Sutherland that a friend had called the Alfred Health Mental Health Triage out of concern for her mental health. Dr Sutherland noted that Kathy remained very anxious and reported new symptoms including gait disturbance that varied on examination, causing her to suspect a functional element. Dr Sutherland prescribed sertraline 50mg, with a plan for review in two weeks. Dr Sutherland did not consider Kathy to be at risk of self-harm or suicide.
32. Michael and Kathy spoke almost daily over the next month, during which he continued to try and encourage her to make plans for after the surgery, but she *"fobbed him off"* and did not engage. He noted that she did not mention self-harm or suicide. Kathy also regularly spoke to her family, who tried to offer solutions such as her staying with Ruen while she recovered.
33. Ruen spoke to Kathy on the phone on the afternoon of 9 July 2024. It was a short conversation, but he noted that *"it was the best she had sounded in months"*. He thought it was a good sign, and that she was coming to terms with the surgery. He hung up feeling relieved.
34. On the morning of 14 July 2024, Kathy called Wayne while driving home from Sorrento. She told him she had been walking along the beach when she had lost her footing and fallen in the water and had been rescued by two bystanders. She said this was accidental, but Wayne was *"one hundred percent sure"* that it was intentional. He told her that she needed to seek professional help, which she did not take well. They spoke until Kathy returned home to her apartment.
35. Ruen's last contact with Kathy was on 14 July 2024. He sent her a text message asking if she needed any help and requesting if she could call their mother as she was worried. She replied with *"Hi there. No thank you. I'm all good for today but thanks for offering. I'll give you a call a bit later and I'll give mum a call. Everything is okay though my phone got wet and wasn't working for about 12 hours after I dropped it in the bath."*
36. Kathy sent Michael a text message on 15 July 2024 saying *"will call you soon"*, though she did not end up doing so. Michael followed up the following day, but she did not answer.

MISSING PERSONS INVESTIGATION

37. On 16 July 2025, a welfare check was called to police at South Melbourne Police Station. Officers attended at Kathy's home and knocked on the door. They left a message card. At this time, police were not aware of Kathy's recent history.
38. On 17 July 2024, Dr Wang's rooms contacted Darren's practice as they had not heard from Kathy in relation to her surgery. Darren spoke to Julie, a receptionist at the practice, who went to Kathy's home. When she could not get in, she called the police.
39. At 10am, a missing persons report was lodged by Senior Constable Jessica George of the St Kilda Police Station. At 10:46am, police attended at Kathy's apartment, where the message card was still in the door from the previous day. They accessed the apartment with the assistance of a neighbour who had keys and observed several bowls of food left out for Kathy's cats, who were both well.
40. On the same date, enquiries were made into Kathy's vehicle, which revealed that it had that day been reported to the Police Assistance Line by personnel at the Sorrento Life Saving Club.
41. Police attended at Sorrento and conducted a foot patrol of the beach, locating a set of keys belonging to Kathy's car, a black Asics shoe with sock that appeared to have washed up on shore and a discarded bikini. The Victoria Police Airwing also conducted a fly over of the location.
42. Further Airwing and foot patrols continued on 18 July 2024, with Search and Rescue also conducting underwater searches. A further pair of shoes and a sock were located, though neither could be definitively linked to Kathy.
43. On 19 July 2024, Call Charge Records were obtained for two phone numbers belonging to Kathy, her primary phone and her work phone. A review revealed that:
 - Between 4.57am and 6.14am on 14 July 2024, Kathy's phone was connected to a telecommunications tower in the Sorrento area near Ocean Beach Road.

- Between 9.41am and 12.53am, Kathy's phone was connected to a telecommunications tower near St Kilda West, Albert Park, and St Kilda Beach areas.
- Between 4.36pm and 5.23pm Kathy's phone was connected to a telecommunications tower in the Sorrento area near Ocean Beach Road.
- Between 8.34pm until 8.03am on the 15th of July, 2024, Kathy's phone was connected to a telecommunications tower near St Kilda West, Albert Park, and St Kilda Beach areas.
- From 10.55am on 15 July 2024, Kathy's phone was connected to a telecommunications tower in the Sorrento area near Ocean Beach Road. The phones remained in that area until they were located and moved by police

44. Several other proof of life checks were undertaken, revealing the following:

- The last transaction made with Kathy's account was at 8:08am on 15 July 2024, when she made a \$10 purchase at Bibas Hardware in Albert Park. The owner "*slightly recalled*" Kathy but was unable to recall what she purchased.
- Kathy last purchased medication on 12 June 2024 at Cravens Pharmacy in Albert Park, where she filled a prescription for trimethoprim.
- Kathy had not left Australia since 10 September 2009.
- Kathy had not recently travelled with Qantas, Jetstar or Virgin Australia.
- Kathy did not have a registered Myki in her name.
- Kathy was not a patient at major hospitals in Victoria, and she had not contacted the Alfred CATT team.
- The Coroners Court of Victoria confirmed no unidentified persons had been located matching Kathy's description.

45. Kathy's apartment was searched and photographed on 23 July 2024. The property was in a neat and tidy condition, with her medication prescriptions laid out on the kitchen bench. Nothing akin to a "suicide note" was located.
46. Should an investigation into a missing person continue for more than 30 days, it is Victoria Police practice that a Crime Investigation Unit assumes responsibility. Accordingly, on 30 August 2024, Detective Senior Constable Timothy Paltridge formally took carriage of the investigation into Kathy's disappearance. He was also the Coronial Investigator in this matter.
47. Upon assuming carriage of the investigation, DSC Paltridge again conducted the aforementioned proof of life checks. There were no changes.
48. On 20 January 2025, Ruen contacted DSC Paltridge to advise he had located Kathy's journal in her apartment. The entries in the journal were akin to a "suicide note". She wrote "*I cannot endure a life where I have no or very little mobility*".

FINDINGS AND CONCLUSION

The standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explication.¹²

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Kathleen Smith, born 17 March 1971, formerly of 110/315 Beaconsfield Parade, St Kilda, Victoria 3182, died on or soon after 15 July 2024;
2. AND, I find to a comfortable satisfaction that Kathleen Smith died at or near to Sorrento Back Beach, Sorrento, Victoria, 3942;

¹² *Briginshaw v Briginshaw* (1938) 60 CLR 336 esp. at 362-363: "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...*".

3. AND, while in the absence of a body I am unable to make a definitive finding as to Kathleen Smith's cause of death, the evidence available to me suggests that she drowned, in circumstances where she intended to take her own life;
4. AND FURTHER, although the exact precipitating factor/s can never be known, on the evidence available to me I find that Kathleen Smith's anxiety and catastrophic thinking about upcoming surgery influenced the course of action she ultimately chose.

I convey my sincere condolences to Kathy's family and friends for their loss.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008* (Vic), I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

I direct that a copy of this finding be provided to:

Mr Ruen Kruczkowski, Senior Next of Kin

Registrar of Births, Deaths and Marriages

Detective Senior Constable Timothy Paltridge

Signature:



AUDREY JAMIESON
CORONER

Date: 19 February 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.
