



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001871

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Therese McCarthy
Deceased:	Loretta Therese Ward
Date of birth:	20 July 1960
Date of death:	8 April 2025
Cause of death:	1(a) Urosepsis and pneumonia on a background of dementia and cognitive decline
Place of death:	Bendigo Health 100 Barnard Street, Bendigo, Victoria 3550
Keywords:	In care; Natural causes; Specialist Disability Accommodation (SDA); NDIS

INTRODUCTION

1. Loretta Therese Ward was 64 years old when she died at Bendigo Health on 8 April 2025. At the time of her death, Loretta had been living in Specialist Disability Accommodation (SDA) in Wollert, Victoria. She lived independently for most of her life and was still living independently when she received a diagnosis of Lewy Body dementia in 2022 and she later moved into supported accommodation in December 2023.
2. Loretta was described as a strong independent woman, who raised four daughters on her own, easy to talk to and a 'good talker'. She was known as possessing a knack for making friends wherever she went. She was known as a farmer, a school mum, a librarian, and volunteered with online support groups and Vinnies.
3. Loretta and her first husband Terry Ward shared a happy, loving relationship and had three daughters together, Kate, Sarah and Bridget. When they first married, Loretta and Terry were living and working on their sheep station which they later sold to purchase a farm. They were married for seven years when Terry died suddenly, leaving Loretta with three young children. Loretta remained on the farm for two years after Terry's death. She single-handedly ran the farm and raised her daughters on her own.
4. Loretta later re-married and sold her farm to move in with her second husband. Her second marriage was described as difficult for Loretta. She had a fourth daughter, Emma. Soon after, Loretta sought to have the marriage annulled and was a single parent of four daughters from then on.
5. Loretta suffered cognitive deterioration and was diagnosed with Alzheimer's Disease and Lewy Body Dementia. From May 2022, she suffered rapid cognitive decline. She also had a history of Systemic Lupus Erythematosus, epilepsy, irritable bowel syndrome and Meniere's Disease.
6. The SDA in which Loretta resided was enrolled under the National Disability Insurance Scheme (NDIS). She received funded daily independent living support due to her health conditions, provided by disability service provider, Claro Disability Services. Loretta's NDIS Plan included supports to engage in community activities, assistance with both occupational therapy and physiotherapy, and the provision of assistive technology supports, such as an electric bed and a recliner chair. Loretta was supported by her family who were actively involved in her care and decision-making.

7. Loretta enjoyed being active, doing gardening, listening to classical music and going shopping. She was described as a kind and compassionate person with an enduring sense of humour and fun despite the adversity she faced in life. She was a good mother and a good person who was well-loved by her family and friends alike.

THE CORONIAL INVESTIGATION

8. Loretta'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.¹ Loretta's death in a SDA facility is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of people in care and the level of trust the community places in 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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Loretta's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
12. Coroner John Olle originally had carriage of this investigation until he retired in June 2025. In July 2025, I assumed carriage of the matter into Loretta's death for the purpose of finalising the investigation and making findings.

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

13. These findings draw on the totality of the coronial investigation into the death of Loretta Therese Ward including evidence contained in the coronial brief and information from other sources. 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 and findings must be made on various matters.

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

Circumstances in which the death occurred

14. Towards the end of 2024, Loretta's health started to deteriorate significantly with a decrease in her mobility and neurological function. This decline was attributed to progression of her Lewy Body Dementia.
15. On 24 February 2025, Loretta was admitted to the Northern Hospital by her carers due to limited mobility and confusion. She was found to have urosepsis and was treated with intravenous antibiotics.
16. In hospital, Loretta deteriorated further and her prognosis did not improve. In discussion with the medical team and in line with Loretta's advance care directive, which was unsigned, but which referred to the importance of her active relationships with family, the family decided to transition Loretta to comfort care. She was transferred to the Palliative Care Unit at Bendigo Hospital on 1 April 2025 and passed away on 8 April 2025.

Identity of the deceased

17. On 8 April 2025, Loretta Therese Ward, born 20 July 1960, was visually identified by her daughter, Sarah Ward.
18. 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

19. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 9 April 2025 and provided a written report of his findings dated 14 April 2025.
20. Dr Beer provided an opinion that the medical cause of death was “*1(a) Urosepsis and pneumonia on a background of dementia and cognitive decline*” and that the cause of death was due to natural causes.
21. I accept Dr Beer’s opinion.

FINDINGS AND CONCLUSION

22. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was Loretta Therese Ward, born 20 July 1960;
 - b) the death occurred on 8 April 2025 at Bendigo Health, 100 Barnard Street, Bendigo, Victoria 3550 from *urosepsis and pneumonia on a background of dementia and cognitive decline*; and
 - c) the death occurred in the circumstances described above.
23. Loretta’s family did not express any concerns with her care. Sarah observed that the SDA facility provided “*great care*” to her mother Loretta and acted on signs of infection promptly. I note that the ongoing day-to-day care Loretta received from her support workers and medical team was reasonable and appropriate.
24. I note that the provision of NDIS funding to Loretta allowed her the dignity of care which assisted her mobility and her engagement in community activities from her SDA dwelling.
25. Having considered all the available evidence, I find that Loretta’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 Loretta’s death in chambers.

I convey my sincere condolences to Loretta’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:

Sarah Ward, Senior Next of Kin

National Disability Insurance Agency

Bendigo Health

Senior Constable Jack Milligan, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 22 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 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.
