IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002056

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Philip Riley
Date of birth:	30 October 1964
Date of death:	17 April 2025
Cause of death:	1a : Aspiration pneumonia complicating down syndrome
Place of death:	Royal Melbourne Hospital 300 Grattan Street Victoria 3050
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 17 April 2025, Philip Riley (**Mr Riley**) was 60 years old when he died due to aspiration pneumonia while in hospital.

2. At the time of his death, Mr Riley resided at Aruma in Glenroy, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Mr Riley received funded daily independent living support due to his concurrent medical conditions including Down Syndrome, hip dysplasia, epilepsy, gout, bronchiectasis, dysphagia and a history of recurrent chest infections and pneumonia.

3. In 2022, Mr Riley was also diagnosed with Alzheimer's disease which marked the beginning of his declining health and mobility. In the year prior to his death, Mr Riley underwent frequent medical reviews relating to follow ups after discharge from hospital, assessments for chest infections, pressure wounds and a COVID-19 infection.

4. In October 2024, Mr Riley underwent a palliative care assessment due to his deteriorating health and was admitted to Royal Melbourne Hospital several times between March and December 2024 due to recurrent chest infections.

5. In early 2025, Mr Riley contracted a chest infection which was managed by his GP, but which, according to Aruma, *'left him increasingly frail'*.

THE CORONIAL INVESTIGATION

6. Mr Riley's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he 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 his death.[1] 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.

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

[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).

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. This finding draws on the totality of the coronial investigation into the death of Philip Riley. 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

Circumstances in which the death occurred

10. Between 1 and 4 April 2025, Aruma staff observed that Mr Riley became increasingly unwell; he had a worsening cough and shortness of breath. On 4 April 2025, Mr Riley had increased difficulty breathing and staff contacted emergency services. He was transported to the Royal Melbourne Hospital, diagnosed with pneumonia and treated with intravenous antibiotics.

11. Mr Riley's condition initially improved, he became medically stable, and clinicians prepared him for discharge. However, on 15 April 2025, he experienced a febrile episode and due to his general health decline and recurrent chest infections over the preceding months, clinicians decided to manage his symptoms only. He was transitioned to palliative care the same day.

12. On 17 April 2025, clinicians declared Mr Riley deceased.

Identity of the deceased

13. On 17 April 2025, Philip Riley, born 30 October 1964, was visually identified by his carer, Alan Somerville.

[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.

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

Medical cause of death

15. Forensic Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 18 April 2025 and provided a written report of his findings dated 21 May 2025.

16. The post-mortem computed tomography (**CT**) showed severe widespread bilateral lung changes consistent with pneumonia.

17. Dr Burke provided an opinion that the medical cause of death was 1(a) *Aspiration pneumonia complicating down syndrome.*

18. Dr Burke's provided an opinion that the cause of death was due to natural causes.

19. I accept Dr Burke's opinion as to cause of death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Philip Riley, born 30 October 1964;

    b) the death occurred on 17 April 2025 at Royal Melbourne Hospital 300 Grattan Street Victoria 3050 from *1a : Aspiration pneumonia complicating down syndrome*; and

    c) the death occurred in the circumstances described above.

21. 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 Royal Melbourne Hospital that caused or contributed to Mr Riley's death.

22. Having considered all the available evidence, I find that Mr Riley'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 his death and to finalise the investigation of Mr Riley's death in chambers.

I convey my sincere condolences to Mr Riley's family, friends and carers for their loss.

Pursuant to section 73(1B) of the Act, this finding is to 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:

Aruma

Royal Melbourne Hospital

First Constable Ebony Reinsma, Reporting member, Victoria Police

Signature:

Coroner Leveasque Peterson

Date: 08 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.