



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002358

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended pursuant to section 76 of the **Coroners Act 2008**^{1a}*

Findings of:	Coroner Therese McCarthy
Deceased:	Melissa Anne Wright
Date of birth:	23 April 1972
Date of death:	3 May 2025
Cause of death:	1a: Aspiration pneumonia in a woman with Alzheimer's dementia complicating Trisomy 21.
Place of death:	Caritas Christi Hospice 104 Studley Park Road Kew Victoria 3101
Keywords:	In care – Natural causes – Specialist Disability Accommodation – SDA

^{1a} This finding was amended on 9 October 2026 pursuant to section 76 of the *Coroners Act 2008* (Vic) to correct two minor typographical errors.

INTRODUCTION

1. On 3 May 2025, Melissa Anne Wright¹ was 53 years old when she died at Caritas Christi Palliative Care Unit from aspiration pneumonia.
2. Melissa is survived by her mother, Brenda and sister, Alison. Melissa's mother, Brenda and her sister were involved in Melissa's care throughout her life, and they remained involved as participants in 'family conferences' about her care and decisions affecting her.
3. At the time of her death, Melissa lived in a Specialist Disability Accommodation (SDA) facility operated by Scope Australia. Scope Australia is a registered National Disability Insurance Scheme (NDIS) provider that provides disability support services for people with complex intellectual, physical and multiple disabilities. The organisation provided a wide range of services to Melissa including supported accommodation that promotes independent living.

BACKGROUND

4. Melissa was born with Down Syndrome (Trisomy 21) and intellectual disability. She was supported by an NDIS plan which included funding for access to assistive technology, improved Daily Living Skills, SDA accommodation and her support workers assisted her to participate in the community and to engage in activities such as music therapy.
5. Melissa's needs were significant during her last years as she experienced a range of medical and physical health conditions including depression, dysphagia,² epilepsy, gastro-oesophageal reflux disease, hyperthyroidism, incontinence, iron deficiency, low blood pressure, pressure injuries, and recurrent chest infections.³
6. Melissa was known to be a proficient verbal communicator who was able to articulate her needs and preferences. In 2019, she became confused and aggressive at times and was subsequently diagnosed with Alzheimer's disease. Melissa was living independently with her husband at the time but required a more supported living arrangement to meet her cognitive and physical care needs. That same year, Melissa moved into Park Avenue, where she resided

¹ Referred to throughout this finding as 'Melissa', unless more formality is required.

² Difficulty swallowing, chewing and controlling saliva.

³ Statement of Dr Stephen Bennie dated 13 August 2025.

with four other residents. Melissa's mother and sister continued to provide informal supports and remained engaged in her care.⁴

7. From 2023 onwards, Melissa experienced a rapid decline in her mobility, cognition, communication and independence. She was no longer able to stand unaided and required specialist mobility equipment, a hoist for all transfers, pressure relieving devices, and repositioning every two hours. She was assisted with all activities for daily living by the disability support workers, including mealtime management to reduce the risks associated with her modified meals and thickened fluids. Her GP was involved in her care for the last five years of her life and actively supervised her medication and other health interventions designed to keep her comfortable and maintain her participation in her home to the best of her abilities.
8. On 19 May 2023, a family conference was convened where Melissa's declining health was discussed, and a decision was made that she would not be for active resuscitation. She was prone to chest infections caused by aspiration from progressive difficulty with swallowing.
9. Towards the end of 2023 until her passing, Melissa commenced receiving home-based services from Eastern Palliative Care (**EPC**) who were involved in her clinical care, and in advising her disability support workers. Around this same time, Melissa was no longer able to verbally communicate.

THE CORONIAL INVESTIGATION

10. Melissa's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). The death of a person in care is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Melissa was a '*person placed in custody or care*' within the meaning of the Act, as a person who was an SDA resident living in an SDA enrolled dwelling. The public policy rationale for this mandatory report to the Coroner arises because people residing in SDA dwellings are entirely dependent on the care of those providing services in SDA dwellings and this care needs to be subject to some independent consideration because of this vulnerability and dependence.
11. 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

⁴ Statement of Lisa Evans dated 15 September 2025.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Melissa'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.
13. This finding draws on the totality of the coronial investigation into the death of Melissa Anne Wright 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.⁵

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

Circumstances in which the death occurred

14. In October 2024, Melissa underwent a Comprehensive Health Assessment Program conducted by her general practitioner, Dr Stephen Bennie (**Dr Bennie**). Dr Bennie noted that, at that time, Melissa's life expectancy was thought to be around 12 months.⁶
15. During early April 2025, Melissa experienced a persistent cough and increased sputum. She was prescribed multiple courses of antibiotics, with no improvement in respiratory symptoms, and continued to be monitored at home by EPC.
16. Over the next fortnight, Melissa's swallowing deteriorated significantly. She had a fever, moist cough and began coughing during meals. She was observed by staff to be more drowsy than usual, and she showed signs of respiratory distress. The EPC nurse arranged for a palliative care admission due to Melissa's deteriorating condition and increasing need for symptom management.

⁵ 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.

⁶ Statement of Lisa Evans dated 15 September 2025.

17. On 23 April 2025, Melissa was admitted to St Vincent's Hospital's Caritas Christi Palliative Care Unit in the context of increasing dysphagia and associated aspiration pneumonia. She was noted to have a sacral pressure injury and a suspected deep tissue injury to her right heel.⁷
18. On 29 April 2025, Melissa was drowsy, but rousable, with a weak pulse and her extremities were cool to the touch. Her family were informed that she was transitioning to end of life care and oral intake was ceased. She was provided with palliative medications and comfort care.
19. On Sunday 3 May 2025, at 12:30pm, Melissa passed away with her mother and sister by her side.

Identity of the deceased

20. On 3 May 2025, Melissa Anne Wright, born 23 April 1972, was visually identified by her sister, Alison Wright.
21. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Associate Professor Joanna Glengarry (**A/Prof Glengarry**), a forensic pathologist, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 5 May 2025 and provided a written report of her findings dated 6 May 2025.
23. The post-mortem computed tomography (**CT**) scan showed cerebral atrophy and increased lung markings, at the base of both lungs, in keeping with aspiration.
24. A/Prof Glengarry provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia in a woman with Alzheimer's disease complicating Trisomy 21.
25. I accept A/Prof Glengarry's opinion that the cause of death was due to natural causes.

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 Melissa Anne Wright, born 23 April 1972;

⁷ Statement of Dr Sarah Leung dated 14 August 2025.

- b) Melissa's death occurred on 3 May 2025 at Caritas Christi Palliative Care Unit, 104 Studley Park Road, Kew Victoria from 1a: Aspiration pneumonia in a woman with Alzheimer's disease complicating Trisomy 21; and
 - c) her death occurred in the circumstances described above.
27. Having considered all the available evidence, I find that Melissa'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 Melissa's death and to finalise the investigation in chambers.
28. I note that Melissa's care at the end of life was provided pursuant to an NDIS package and she was cared for by SCOPE carers. I have considered the nature and range of supports available to Melissa and the quality of her care including her care at the end of her life. I am satisfied that the quality of her care was of a high standard and that to the extent of her challenges, Melissa was assisted to live independently and participate in the Park Avenue community with the support of her family.

I convey my sincere condolences to Melissa'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:

Brenda Wright, Senior Next of Kin

Scope

National Disability Insurance Agency

St Vincent's Hospital Melbourne

Senior Constable Harriette Lukaitis, Victoria Police, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 06 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.
