IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002585

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	SJI
Date of birth:	1969
Date of death:	13 May 2025
Cause of death:	1a: Complications arising from down's syndrome and dementia (bronchopneumonia).
Place of death:	Maryborough District Health Service 75/87 Clarendon Street, Maryborough, Victoria 3465
Keywords:	In care, SDA resident, Down's Syndrome, natural causes death

INTRODUCTION

1. On 13 May 2025, SJI was 55 years old when she died at the Maryborough District Health Service. SJI is survived by her mother, VOM and brother, RLY.

2. SJI's medical history included Down's Syndrome and dementia. She was a Specialist Disability Accommodation (**SDA**) resident in an SDA enrolled dwelling at 1/47 Laidman Street, Maryborough, Victoria 3465. SJI received funding from the National Disability Insurance Agency.

THE CORONIAL INVESTIGATION

3. SJI'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**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody[1] is a mandatory report to the coroner, even if the death appears to have been from natural causes. SJI was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as she was *"a prescribed person or a person belonging to a prescribed class of person"* due to her status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

4. 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.

5. This finding draws on the totality of the coronial investigation into the death of SJI including evidence provided to and obtained by the Court. 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]

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[1] See the definition of 'reportable death' in section 4 of Act, especially section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5.

[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.

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

Circumstances in which the death occurred

6. In the six months prior to her death, SJI had progressive cognitive and functional decline along with frequent falls. She developed pressure ulcers on her sacrum and heel and was admitted to the Maryborough District Health Service on 11 April 2025 for treatment and care.

7. Although SJI's pressure ulcers were treated and improved incrementally, medical notes indicated that she gradually declined in terms of her cognitive function and mobility. She started refusing to eat despite interventions from a dietician and speech pathologist. Her mobility gradually worsened despite input from an occupational therapist and physiotherapist, and she appeared to not recognise or respond to family members and people known to her.

8. Following discussions with SJI's family, end of life care was commenced. SJI passed away on 13 May 2025 at 1.45am.

Identity of the deceased

9. On 13 May 2025, SJI, born 1969, was visually identified by her cousin.

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

Medical cause of death

11. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an external examination on 19 May 2025 and provided a written report of his findings dated 22 May 2025.

12. The post-mortem CT scan revealed patchy lung consolidation. There were no fractures, intracranial haemorrhage or cerebral atrophy present.

13. Dr Beer provided an opinion that the medical cause of death was 1(a) Complications arising from Down's Syndrome and dementia (bronchopneumonia). He considered that the death was due to natural causes.

14. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is SJI, born 1969;

    b) her death occurred on 13 May 2025 at Maryborough District Health Service, 75/87 Clarendon Street, Maryborough, Victoria 3465 from natural causes, namely, complications arising from Down's Syndrome and dementia (bronchopneumonia); and

    c) her death occurred in the circumstances described above.

16. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that SJI died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to SJI's family and loved ones 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:

VOM, Senior Next of Kin

National Disability Insurance Agency

Signature:

CORONER KATE DESPOT
Date: 11 August 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.