IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003902

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Nikki Maree Francis
Date of birth:	29 December 1984
Date of death:	8 July 2025
Cause of death:	1a: Complications of influenza A infection in a woman with Moebius syndrome (palliated)
Place of death:	University Hospital Geelong Bellerine Street Geelong Victoria 3220
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 8 July 2025, Nikki Maree Francis was 40 years old when she died at University Hospital Geelong of natural causes.

2. At the time of her death, Nikki resided at a Specialist Disability Accommodation (**SDA**) dwelling in Highton enrolled under the National Disability Insurance Scheme (**NDIS**). Nikki received funded daily independent living support due to her diagnoses of Moebius syndrome, cerebral palsy and intellectual disability, which was provided by disability service provider, Scope (Aust) Limited.

3. Nikki had lived at her Highton home since 2002 and had one other person living with her. Six permanent support staff supported Nikki, as well as casual support staff when required. She required assistance for some activities of daily living such as personal care, hygiene and medication administration. She received enteral nutrition via a PEG tube.

4. Nikki had limited verbal communication and used keyword signs, Auslan and pointing. She was independent in her day-to-day decision making and supported by her aunt and uncle, Donna and Bruce, with more complex decision making.

5. Nikki is remembered as a vibrant woman who loved watching wrestling and the AFL, being an avid supporter of the Geelong Cats. She enjoyed watching television and participating in household duties such as meal preparation, taking out the rubbish and gardening. She liked getting out for a drive in the car, particularly to the beach.

THE CORONIAL INVESTIGATION

6. Nikki'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] 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.

[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).

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 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 Nikki Maree Francis including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**). 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. On the afternoon of 3 July 2025, Scope staff saw Nikki trying to cough. She said she was unwell and pointed to her chest. Staff contacted Nikki's aunt Donna to inform her that Nikki was feeling unwell. Donna told them that Nikki was known to display behaviour to access an ambulance and hospital visit and advised against calling an ambulance.

11. Nikki slept between 5 and 7pm, when she was woken for her regular medication and personal care. She then watched television until 8pm, when she asked staff to turn off the television so she could settle in for the night.

12. Scope staff noticed Nikki was quieter than usual on the morning of 4 July 2025. They asked if she was okay, and she responded by pointing to her throat and chest. She appeared to be out of breath. Shortly after 8:15am Nikki vomited and an ambulance was called.

[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.

13. Nikki was conveyed to University Hospital Geelong where the plan was for admission, bloods, chest x-ray, intravenous antibiotics and to commence her on the sepsis pathway.

14. Despite interventions, Nikki's condition did not improve. At around 11:30pm on 7 July 2025, a MET call was activated for reduced oxygen saturations of 80%. A chest and abdomen x-ray showed patchy airspace consolidation in both lungs. It was considered that Nikki had likely suffered an aspiration event.

15. Nikki died on the morning of 8 July 2025.

Identity of the deceased

16. On 8 July 2025, Nikki Maree Francis, born 29 December 1984, was visually identified by her uncle, Bruce Francis, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Nikki Francis on 10 July 2025. Dr Bouwer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan and E-Medical Deposition Form from Barwon Health and provided a written report of his findings dated 17 July 2025.

19. The findings at external examination were in keeping with the history. The post mortem CT scan showed bilateral lung consolidation, small pleural and pericardial effusions.

20. Dr Bouwer provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) COMPLICATIONS OF INFLUENZA A INFECTION IN A WOMAN WITH MOEBIUS SYNDROME (PALLIATED).

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Nikki Maree Francis, born 29/12/1984;

   b) the death occurred on 8 July 2025 at University Hospital Geelong, Bellerine Street, Geelong, Victoria 3220;

c) I accept and adopt the medical cause of death ascribed by Dr Heinrich Bouwer and I find that Nikki Maree Francis, a woman with Moebius syndrome, died from complications of influenza A infection;

2. The available evidence does not support a finding that there was any want of clinical management or care on the part of Scope (Aust) Limited, or clinical staff at University Hospital Geelong, that caused or contributed to Nikki Maree Francis' death.

3. Having considered all the available evidence, I find that Nikki Maree Francis' 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 in chambers.

I convey my sincere condolences to Nikki'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:

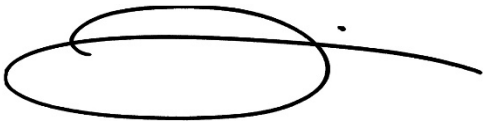
Bruce Francis, Senior Next of Kin

Scope (Aust) Limited

Barwon Health

Senior Constable Hayley Bloor, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 13 April 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.