IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 004291

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	VKO
Date of birth:	1983
Date of death:	25 July 2025
Cause of death:	1(a) Complications of primary central nervous system lymphoma
Place of death:	Dandenong Hospital, 135 David Street, Dandenong, Victoria
Key words:	In care, primary central nervous system lymphoma, natural causes

INTRODUCTION

1. On 25 July 2025, VKO was 42 years old when she died in hospital following a deterioration in health. At the time, VKO resided in Dandenong with her husband.

2. VKO grew up and attended school in Somerville. After high school, and pursuing her passion for drama, she obtained a Diploma in Stage Production from TAFE and worked in theatre.

3. VKO had close relationships with her mother and sister.

4. According to her sister, UXM, VKO participated in at least four medical drug trials for new medicines in her 20s. VKO was otherwise in good health.

5. In 2019, VKO married her long-term partner, JNG. JNG stated they had a very happy relationship.

6. In about 2021, VKO began to complain of whole-body pain and lethargy. She sought medical assistance and was subsequently diagnosed with spinal diffuse large B-cell lymphoma (stage four). She underwent treatment, including a 16-month admission to Monash Health.

7. UXM stated that due to her illness, VKO lost a lot of her body function and strength, which required her to spend time in rehabilitation in an attempt to get herself walking again. However, VKO subsequently became paralysed from the chest down and became confined to a wheelchair.

8. In about 2022, VKO transitioned to palliative care as all treatment options had been exhausted. However, her condition subsequently stabilised and she moved to a care facility in Cranbourne.

9. Toward the end of 2024, VKO moved to another care facility in Dandenong where her husband could also reside. VKO chose her own care service provider (Magical Care Pty Ltd) who provided disability support workers to assist VKO with her daily needs, transfers, and access to the community.

10. JNG stated that VKO *"still lived her life and was very resistant and determined and wouldn't let her disability get in the way of living her life".*

THE CORONIAL INVESTIGATION

11. VKO's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1] [2]

12. 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.

13. 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.

14. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of VKO's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. This finding draws on the totality of the coronial investigation into VKO's death, 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.[3]

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[1] See the definition of *"reportable death"* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act.

[2] Pursuant to section 52(2)(b) of the Act, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care. However, sub-section (3A) provides that a coroner is not required to hold an inquest if the coroner considers that the death was due to natural causes.

[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

Identity of the deceased

16. On 25 July 2025, VKO born 1983, was visually identified by her husband, JNG, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

18. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 28 July 2025 and provided a written report of her findings dated 1 September 2025.

19. The post-mortem examination revealed atypical lymphoid infiltrates within the subarachnoid space, cortex, subcortex, cerebellum, and brainstem. Given VKO's known history of treated primary central nervous system lymphoma, these findings would favour a relapse of this.

20. There were also bilateral convexity and base of skull chronic subdural membranes and marked spinal cord atrophy with near complete obliteration of the thoracic cord.

21. Dr Ho provided an opinion that the medical cause of death was *"1(a) Complications of primary central nervous system lymphoma"*. She opined that this was a natural causes death.

22. I accept Dr Ho's opinion.

Circumstances in which the death occurred

23. According to Yingying Wang, General Manager of Magical Care Pty Ltd, from about 7 July 2025, support workers observed VKO exhibiting acute cognitive and behavioural changes. Due to unavailability of her general practitioner, she was reviewed by the Victoria Virtual Emergency Department and advised that VKO should be medically reviewed.

24. That day, VKO attended an Urgent Care Clinic in Dandenong where it was reported she had been displaying confused and delusion behaviour over the preceding days. A urine sample was taken, and the clinical impression was urinary tract infection. Antibiotics were prescribed and VKO was advised to follow up with her general practitioner in 24 hours.

25. On 10 July 2025, VKO had a telehealth consultation with Dr Sugunendra Thevasagayam at Casey Medical Centre. It was noted there was recent concern VKO had a urinary tract infection and had been started on antibiotics. However, her confusion had persisted with no fever, nausea, or vomiting. Dr Thevasagayam queried whether she had sepsis and advised that VKO should present to hospital for further assessment.

26. Dandenong Hospital records indicate VKO presented later that day with a three-day history of worsening confusion due to presumed urinary tract infection. She was investigated for relapse of lymphoma. A urine MCS (microscopy, culture, and sensitivity) test returned a negative result.

27. Multiple investigations demonstrated possible progressive multifocal leukoencephalopathy (**PML**) or primary central nervous system relapse of lymphoma. Testing of cerebrospinal fluid was negative for John Cunningham virus, and therefore inconclusive for PML. It was noted that if VKO did have relapse of primary central nervous system lymphoma, the imaging appearance was very atypical.

28. VKO also experienced seizures during her admission.

29. On 17 July 2025, VKO was moved to the Intensive Care Unit.

30. Multiple family discussions were held where the clinical impression of atypical infection was explained, including VKO's prognosis remained poor. Once weaned off sedation, VKO remained minimally responsive.

31. VKO was subsequently transitioned to palliative care. She was extubated on 24 July 2025 and subsequently passed away at 11.07am on 25 July 2025.

FAMILY CONCERNS

32. While VKO's family did not submit written concerns about the care she received, they each referred to suboptimal care (such as uneducated staff, language barriers, staff being more interested in their mobile phones) provided by disability support staff prior to her hospitalisation.

33. I note the role of the coroner is limited. I can only examine matters that are significantly proximate and causative, or contributory, to a death. Many family complaints are best directed to the service provider or the NDIS Quality and Safeguards Commission and Safety

Commission. For example, coroners do not investigate issues of poor communication or suboptimal care that has not contributed to death.

34. Following review of the medical care provided to VKO (see further below), I am comfortably satisfied that the care she received from disability support carers and providers did not cause or contribute to her death.

REVIEW OF CARE

35. As part of my investigation, and in light of the concerns raised by VKO's family, I obtained advice from the Coroners Prevention Unit[4] (**CPU**) about the clinical management and care provided to her in the 12 months preceding her death.

36. The CPU noted the post-mortem examination confirmed what VKO's treating team suspected – a recurrence of her lymphoma.

37. While the medical staff wondered whether she had PML (a side effect of previous treatment), post-mortem examination confirmed this was not the case.

38. The CPU considered medical care provided to VKO was reasonable and appropriate.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was VKO, born 1983;

    (b) the death occurred on 25 July 2025 at Dandenong Hospital, 135 David Street, Dandenong, Victoria;

    (c) the cause of VKO's death was complications of primary central nervous system lymphoma; and

    (d) immediately before death, VKO was a *"person placed in custody or care"* as defined in section 4 of the Act;

[4] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

(e) VKO's resulted from the complications of primary central nervous system lymphoma which I consider to be a death from natural causes for the purposes of section 52(3A) of the Act; and

(f) the death occurred in the circumstances described above.

40. The available evidence does not support a finding that there was any want of clinical management or care on the part of the clinical staff at Monash Health or her disability support carers that caused or contributed to VKO's death.

41. I convey my condolences to VKO's family and friends for their loss.

PUBLICATION OF FINDING

Pursuant to section 73(1B) of the Act, I order that a de-identified version of this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

I direct that a copy of this finding be provided to the following:

Senior next of kin

Monash Health

Magical Care Pty Ltd

Senior Constable Dulanjith Kulasuriya, Victoria Police, Coronial Investigator

Signature:





Deputy State Coroner Paresa Antoniadis Spanos

Date: 06 November 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.