IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004345

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Maree Joan Bermingham
Date of birth:	28 August 1958
Date of death:	27 July 2025
Cause of death:	Complications of reduced oral intake in setting of cerebral palsy
Place of death:	Sale Hospital, Central Gippsland Health, Sale, Victoria
Keywords:	In care, Specialist Disability Accommodation, natural causes

INTRODUCTION

1. On 27 July 2025, Maree Joan Bermingham was 66 years old when she passed away at Sale Hospital, Central Gippsland Health, Sale, Victoria, following complications of reduced oral intake in the setting of cerebral palsy.

2. Ms Bermingham grew up on a rural farming property in Nambrok in central Gippsland, Victoria. At six months of age Ms Bermingham was diagnosed with cerebral palsy. She also had a mild intellectual disability, and medical conditions including hypertension, hypercholesterolaemia, gastro-oesophageal reflux disease, hiatus hernia, constipation, anxiety, scoliosis, chronic hyponatraemia, dysphagia, and osteoporosis.

3. At the time of her death, Ms Bermingham resided at a Specialist Disability Accommodation (**SDA**) dwelling at Cunninghame Street, Sale. The facility is enrolled under the National Disability Insurance Scheme (**NDIS**) and operated by Melba Support Services. Ms Bermingham received NDIS funded daily independent living support. Ms Bermingham had resided in SDA care since 2010 and continued to receive family support, including visits and social outings with her siblings.

THE CORONIAL INVESTIGATION

4. Ms Bermingham'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.

5. Senior Constable Lachlan Adams acted as the Coronial Investigator for the investigation of Ms Bermingham's death. Senior Constable Adams conducted inquiries on my behalf and compiled a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Maree Joan Bermingham including evidence contained in the coronial brief. Whilst I have reviewed all

[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).

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

7. On 1 July 2025, Ms Bermingham tested positive for COVID-19 and was treated with a five-day course of antiviral medication.

8. Following Ms Bermingham's COVID-19 illness, her oral intake declined markedly, and she experienced vomiting and nausea. Ms Bermingham was taken to the Sale Hospital Emergency Department on two occasions, 5 July and 9 July 2025.

9. On 10 July 2025, Ms Bermingham was admitted at Sale Hospital where the clinical staff managed conditions including severe faecal loading, post-prandial vomiting, and possible gastroparesis.

10. Despite treatment with enemas, motility agents, anti-nausea medications, and intermittent intravenous fluids, Ms Bermingham's oral intake did not improve. Multiple attempts at a nasogastric tube insertion, with pre-procedure medications and sedation, were unsuccessful. Due to the distress that this procedure caused Ms Bermingham, a decision was made to not to pursue nasogastric feeding.

11. On 22 July 2025, a gastroscopy identified only a small hiatus hernia with no other gastric issue identified. Ultimately, the treating team were unable to find a cause for Ms Bermingham's continued refusal to eat and discussions with her family focused on a transition to palliative care.

12. On 24 July 2025, the medical team and Ms Bermingham's family reached a decision to transition to end-of-life care. She was commenced on a syringe driver delivering morphine and midazolam for symptom relief.

[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. On 27 July 2025 at 4:45 pm, Ms Bermingham passed away surrounded by her siblings and a support worker.

Identity of the deceased

14. On 29 July 2025, Maree Joan Bermingham, born 28 August 1958, was visually identified by her brother, John Bermingham.

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

Medical cause of death

16. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an external examination on 30 July 2025 and provided a written report of his findings dated 4 August 2025.

17. The post-mortem examination revealed findings consistent with the clinical history.

18. Dr Lynch provided an opinion that the death was due to natural causes, and the medical cause of death was '*1(a) complications of reduced oral intake in setting of cerebral palsy.'*

19. I accept Dr Lynch's opinion.

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 Maree Joan Bermingham, born 28/08/1958;

    b) Ms Bermingham's death occurred on 27/07/2025 at Sale Hospital, Central Gippsland Health, 155 Guthridge Parade, Sale, Victoria from complications of reduced oral intake in the setting of cerebral palsy; and

    c) her death occurred in the circumstances described above.

21. There is nothing to suggest that the care provided to Ms Bermingham by her disability service provider, or the medical care provided to her at Sale Hospital was anything other than appropriate.

ACKNOWLEDGEMENTS

I extend my sincere condolences to Ms Bermingham's family, friends and carers for their loss.

I thank the Coronial Investigator and those assisting for their work in this investigation.

DIRECTIONS

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:

Janet Munckton, Senior Next of Kin

Melba Support Services

Sale Hospital

Senior Constable Lachlan Adams, Victoria Police, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 24 September 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.