IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 004435

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:	Kerrie Terese Berlowitz
Date of birth:	27 April 1947
Date of death:	31 July 2025
Cause of death:	1(a) Hypernatraemia in the setting of lowered oral intake Contributing factors: Cerebral palsy, intellectual disability
Place of death:	Frankston Hospital, 2 Hastings Road, Frankston, Victoria
Key words:	In care, supported disability accommodation, SDA, hypernatraemia, cerebral palsy

INTRODUCTION

1. On 31 July 2025, Kerrie Terese Berlowitz was 78 years old when she died at Frankston Hospital. At the time, Ms Berlowitz lived in Carrum at a supported disability accommodation (**SDA**) owned by the Victorian State Government, with supported living services provided by Scope (Aust) (**Scope**).

2. Ms Berlowitz's medical history included an intellectual disability, cerebral palsy, schizophrenia, dyspnoea, aspiration pneumonia, and dysphagia. In 2007, Ms Berlowitz moved into her SDA, having previously lived with her mother.

3. Ms Berlowitz had five permanent staff who supported her, in addition to casual or agency staff as required. Ms Berlowitz required support for all activities of daily living, including meal preparation, personal care, medication administration (as prescribed and directed by her health practitioners), and continence management (both bladder and bowel). She was unable to stand independently and required full assistance for all transfers, including a ceiling hoist for transfers into her wheelchair.

4. Ms Berlowitz's family was not actively engaged in her care, and had a medical guardian appointed by the Victorian Civil and Administrative Tribunal.

THE CORONIAL INVESTIGATION

5. Ms Berlowitz's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, 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]

6. 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.

[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.

7. 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.

8. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Berlowitz'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.

9. This finding draws on the totality of the coronial investigation into Ms Berlowitz'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.[2]

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

Identity of the deceased

10. On 1 August 2025, Kerrie Terese Berlowitz, born 27 April 1947, was visually identified by her carer, Patricia Dunn, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Forensic Pathologist, Adjunct Associate Professor Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 4 August 2025 and provided a written report of his findings dated 15 September 2025.

13. The post-mortem examination and computed tomography (CT) scan revealed atrophic brain with remote subdural collection of the right convexity, and patchy consolidation in the lower lobe of the right lung.

[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.

14. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Hypernatraemia in the setting of lowered oral intake"* with contributing factors of *"Cerebral palsy, intellectual disability"*.

15. I accept Dr de Boer's opinion.

Circumstances in which the death occurred

16. Prior to January 2025, Ms Berlowitz was in good spirits. She engaged with her co-residents and daily activities with Scope staff, and she was eating as usual. From January 2025 onwards, staff noted that Ms Berlowitz began refusing to eat and appeared to lose her appetite. Additionally, staff observed changes in her mood, including withdrawal from activities, frustration, and not engaging with other residents.

17. On 26 March 2025, Ms Berlowitz's dietitian recommended a change of diet to include more fat and vitamin rich foods due to Ms Berlowitz's recent weight loss. A follow-up visit was scheduled for 2 July 2025.

18. Through May and June 2025, Scope staff did not observe any deterioration of Ms Berlowitz's health. Staff complied with Ms Berlowitz's Mealtime Management Plan, recorded her daily bowel movements, and administered 'as needed' medication as prescribed.

19. On 2 July 2025, Ms Berlowitz's dietitian recommended adjustments to her diet, as she had refused, or was unable, to eat her meals according to her Mealtime Management Plan. From 7 July to 22 July 2025, Ms Berlowitz continued to refuse meals, spat her food at staff during meal assistance, and lost more weight.

20. On 11 July 2025, Scope staff notified Ms Berlowitz's general practitioner (**GP**) about her deterioration. Ms Berlowitz was reviewed by her GP and found to be tired, pale, and seemed aggressive with staff who attempted to assist her with meals. Ms Berlowitz's GP recommended she undergo blood testing.

21. On 22 July 2025, a nurse attended Ms Berlowitz's SDA to complete a blood test. Due to Ms Berlowitz's behaviour, the nurse was unable to do the blood test and returned the following morning to try again.

22. On 23 July 2025, at about 5.00pm, Ms Berlowitz was observed choking while eating. She kept food in her mouth, and was unable, or refused, or to swallow the food. Ms Berlowitz did not

respond to staff's prompts to avoid choking and did not accept their assistance. Staff then contacted emergency services.

23. Ambulance Victoria Paramedics arrived at the scene and transported Ms Berlowitz to Frankston Hospital via ambulance.

24. Upon arrival to the Frankston Hospital, Ms Berlowitz presented with significant hypernatraemia (high sodium) due to severe dehydration, an upper gastrointestinal bleed with melaena,[3] a drop in haemoglobin, and possible aspiration pneumonia. On admission, Ms Berlowitz was non-verbal and appeared frail, with drowsiness and an altered conscious state.

25. Ms Berlowitz was managed with anti-acid medication for the upper gastrointestinal bleed, and two units of blood to correct the anaemia. She was also commenced on intravenous antibiotics to treat the possible aspiration pneumonia, and a dextrose infusion for her dehydration and hypernatraemia.

26. On 24 July 2025, Ms Berlowitz was reviewed by the endocrinology team, which resulted in alterations to her fluid rates. The gastroenterology team also discussed Ms Berlowitz's care and recommended to continue her anti-acid infusion.

27. On 25 July 2025, at 8.21am, the general medicine team reviewed Ms Berlowitz and found her conscious state was significantly altered, and she appeared unwell and frail. There were concerns that her condition had not improved despite active treatment.

28. She was reviewed again at 12.30pm and her condition was unchanged. Given Ms Berlowitz's decreased conscious state, her condition was thought to be irreversible. Active treatment was withdrawn, and comfort measures were implemented.

29. On 31 July 2025, Ms Berlowitz passed away at 3.00am.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Kerrie Terese Berlowitz, born 27 April 1947;

[3] Melaena describes black, tarry stools.

(b) the death occurred on 31 July 2025 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria;

(c) the cause of Ms Berlowitz's death was hypernatraemia in the setting of lowered oral intake with contributing factors of cerebral palsy, intellectual disability; and

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

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

31. The available evidence supports a finding that Ms Berlowitz's death occurred in the context of her rapid decline in the two months prior to her passing. This is consistent with the natural progression of multiple disease processes, particularly her deceased oral intake and difficulties swallowing.

32. I convey my sincere condolences to Ms Berlowitz's family, friends and carers for their loss.

PUBLICATION

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.

DISTRIBUTION

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

Denise Moran, senior next of kin

Scope (Aust)

Senior Constable Brendan Kugler, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 26 June 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.