IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004577

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Anne Margaret Chase

Delivered On:	15 September 2026
Delivered At:	Southbank, Victoria
Hearing Dates:	15 September 2026
Findings of:	Coroner Paul Lawrie
Representation:	No appearances
Counsel Assisting the Coroner	Bemani Abeysinghe, Coroner's Solicitor
Keywords	In care, Specialist Disability Accommodation, SDA

1. I, Coroner Paul Lawrie, having investigated the death of Anne Margaret Chase, and having held an inquest in relation to this death on 15 September 2026 at Southbank, Victoria, I find that:

    a. the identity of the deceased was Anne Margaret Chase born on 15 September 1965;

    b. the death occurred on 5 August 2025 at West Gippsland Hospital, 41 Landsborough Street, Warragul Victoria 3820; and

    c. the cause of death was**:**

    1(a): COMPLICATIONS FOLLOWING A RIGHT TOTAL HIP REPLACEMENT FOR SEVERE OSTEOARTHRITIS IN A WOMAN WITH MULTIPLE COMORBIDITIES (PALLIATED).

2. I find, under section 67(1) (c) of the *Coroners Act 2008* (Vic) that the death occurred in the following circumstances:

INTRODUCTION AND PERSONAL BACKGROUND

3. On 5 August 2025, Anne Margaret Chase was 59 years old when she died at West Gippsland Hospital in Warragul, Victoria. Ms Chase is survived by her siblings, Elizabeth and William Chase.

4. Ms Chase was born with Down syndrome and was diagnosed with dementia later in life. Her medical history included an intellectual disability, anxiety, depression, hearing loss, osteoarthritis, diverticular disease, urinary incontinence, hypothyroidism and hypercholesterolaemia.

5. At the time of her death, Ms Chase resided in Warragul, Victoria, at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**) where she received full time care. The SDA was operated by Good Housing Pty Ltd, a registered NDIS provider and had resided at the SDA[1] since 2024. Ms Chase received Supported Independent Living (**SIL**) assistance through Scope (Aust) Ltd (**Scope**). Ms Chase enjoyed going to cafes, swimming, and talking to people during her daily outings. More recently, she was confined to a wheelchair and had stopped swimming.

6. In 2010, Ms Chase underwent a left hip replacement due to severe osteoarthritis. In 2022, her osteoarthritis worsened in her right hip. At the time, her family sought medical advice for another hip replacement surgery but was advised against it due to potential risks associated with the surgery and dementia.

CORONIAL INVESTIGATION

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

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1 Ms Chase resided at the original Scope facility in Warragul from 2006 to 2024. From 2024, Ms Chase resided at a purpose-built share house facility in Warragul, Victoria.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Pursuant to section 4(2)(c) of the *Coroners Act 2008* (**the Act**), the death of a person who immediately before their death was 'a person placed in custody or care', falls within the definition of a reportable death. A person in Victoria who is an SDA resident[2] residing in an SDA enrolled dwelling'[3] is a person 'in care' within the meaning of the Act.[4] The death of a person in care is a mandatory report to the Coroner, regardless of the apparent cause of death.

10. I am satisfied that Ms Chase was an SDA resident residing in an SDA enrolled dwelling, and therefore she was a person 'in care' for the purposes of the Act. Accordingly, pursuant to section 52(2)(b) of the Act, an inquest is mandatory where the apparent cause of death is not wholly attributable to natural causes.

11. I determined that the inquest should proceed in a summary manner as the evidence may be regarded as complete and uncontentious, and it is appropriate for the evidence to be admitted in a summary form without the need to examine witnesses. The inquest took place on 15 September 2026.

12. First Constable (FC) Andrew Wilson of Victoria Police acted as the Coronial Investigator for the investigation of Ms Chase's death. FC Wilson conducted inquiries on my behalf, including taking statements from family, treating medical practitioners, clinicians and care support workers, and submitted a coronial brief of evidence.

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[2] 'SDA resident' means a person with a disability – (a) who receives, or is eligible to receive, funded daily independent living support; and (b) who is residing, or proposes to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement, *Residential Tenancies Act 1997* – s.3(1).
[3] *Residential Tenancies Act 1997* – s.3(1) (definition of 'SDA enrolled dwelling').
[4] *Coroners Regulations 2019* – r.7(1)(d)

13. This finding draws on the totality of the coronial investigation into the death of Anne Margaret Chase including the 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.[5]

IDENTITY OF THE DECEASED

14. On 5 August 2025, Anne Margaret Chase, born 15 September 1965, was visually identified by her brother, William George Chase.

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

MEDICAL CAUSE OF DEATH

16. Forensic pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine conducted an external examination on 7 August 2025 and provided a written report of findings dated 8 August 2025.

17. The external examination did not reveal any significant injuries that may have caused or contributed to the death.

18. The post-mortem computed tomography scan confirmed a right hip replacement (on the background of a previous left hip replacement) and revealed increased lung markings within the lower lobes of both lungs. No skeletal injuries were observed.

[5] 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.

19. Dr Zhou provided an opinion that the medical cause of death as, '1(a) Complications following a right total hip replacement for severe osteoarthritis in a woman with multiple comorbidities (palliated)'.

20. I accept Dr Zhou's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

21. In early June 2025, Ms Chase was suffering increasing loss of mobility due to severe osteoarthritis in her hip, and progressive functional decline. Ms Chase started using an electric wheelchair and depended on a sling or hoist for transfer in and out of bed.

22. Ms Chase's sister, Elizabeth Chase stated that, in addition to the general pain and discomfort related to her osteoarthritis, Ms Chase had also developed a fear of falling and anxiety associated with her worsening dementia. This made it difficult for her carers to transfer her during her day-to-day activities. Scope implemented patient specific training for its staff at the SDA to ensure appropriate care was provided to Ms Chase.

23. On 13 June 2025, Ms Chase was admitted to West Gippsland Hospital with severe pain associated with her osteoarthritis, and an inability to weight bear that did not improve with analgesics.

24. On 24 June 2025, Elizabeth Chase organised for her sister to be transferred from the West Gippsland Hospital to the Mulgrave Private Hospital, for a surgery consultation regarding her right hip replacement.

25. On 7 July 2025, Ms Chase underwent a total hip replacement at the Mulgrave Private Hospital. The surgery was completed without any complications.

26. Elizabeth Chase stated that her sister refused to stand following the surgery and would only eat and drink after a great deal of effort and encouragement.

27. Ms Chase had an indwelling urinary catheter (**IDC**) from 30 June 2025 until 10 July 2025.

28. On 11 July 2025, Ms Chase was discharged back to the care of the SDA.

29. On 13 July 2025, pathology results confirmed that Ms Chase had developed a post-operative urinary tract infection (**UTI**). She was treated with antibiotics (cefalexin) commencing the following day.

30. On 17 July 2025, Ms Chase visited Dr Priscilla Stephen, her regular General Practitioner (**GP**) at the Central Clinic in Warragul for a review. Dr Stephen stated that Ms Chase did not allow for her to take her vitals or examine her right hip. This was not unusual as Ms Chase was usually uncomfortable with clinicians. Ms Chase appeared calm, settled and was comfortable in her wheelchair. Dr Stephen did not identify any concerns that warranted further investigation. At the request of Ms Chase's carer, Dr Stephen provided a referral to a physiotherapist and a follow up appointment was arranged for 21 July 2025.

31. On 19 July 2025, Ms Chase tested positive to influenza following a routine nasopharyngeal swab and was treated with antiviral medication (oseltamivir).

32. In the afternoon, carers observed Ms Chase was difficult to rouse and so they called Triple Zero. Ambulance Victoria paramedics attended and assessed Ms Chase. Her vital signs appeared normal. Paramedics deemed her suitable to remain at the SDA while noting that she had a GP appointment scheduled two days later.

33. Later that evening Ms Chase refused to take her medication.

34. On 20 July 2025, Ms Chase's condition improved marginally. She had ample fluids and a small amount of food. Carers noted that, although she appeared tired, she enjoyed time in the sensory room and watched television.

35. On 21 July 2025 at approximately 6.45am, carers observed Ms Chase to be unwell and confused. She did not recognise those around her and refused food and drinks. Ambulance Victoria paramedics attended and transferred Ms Chase to West Gippsland Hospital where she was treated with intravenous fluids and analgesia.

36. Ms Chase continued to decline during her hospital admission. She became increasingly drowsy, persistently refusing oral intake, nursing care and physiotherapy. She declined to be examined by the medical team on number of occasions.

37. On 30 July 2025, following discussions with Ms Chase's family, a decision was made to transition Ms Chase to palliative care.

38. At 7.48pm on 5 August 2025, Ms Chase passed away at the West Gippsland Hospital.

FAMILY CONCERNS

39. Elizabeth Chase provided a written statement dated 25 October 2025 in which she expressed concerns regarding the care received by her sister. In particular, the concerns related to:

    a) the length of time Ms Chase's IDC was in place during her admission at the Mulgrave Private Hospital; and

    b) a contention that the SDA put obstacles in place which prevented Ms Chase's early discharge from Mulgrave Private Hospital.

40. With respect to the second concern, I consider that it is not useful or appropriate to gainsay the SDA's assessment that Ms Chase's care requirements had increased to a level where they could no longer provide the proper care.

FURTHER INVESTIGATIONS AND CPU REVIEW

41. As part of my investigation, I obtained further material including Ms Chase's medical records from Mulgrave Private Hospital.

42. I also referred this matter to the Court's Coroners Prevention Unit (the **CPU**)[6] for an independent review of all relevant material including the medical records and to advise in respect of Ms Chase's IDC management at Mulgrave Private Hospital.

43. The CPU considered that there was no evidence that the UTI contributed to the death. It was noted that Ms Chase did not have a fever, and the suspected UTI had been treated with antibiotics.

44. The CPU also explained that it is routine practice to have a catheter in place when a patient is due to undergo surgery, and for it to remain in place until such time the patient recovers mobility. Ms Chase did not walk following her surgery and it was appropriate for her IDC to remain in place because of her immobility.

45. The CPU observed that where a patient such as Ms Chase has only a limited physical reserve, any physiological challenge, such as a surgery, can overwhelm the patient's reserves even without any additional factors being present. In this context the CPU noted that Ms Chase

[6] 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.

began refusing allied health interventions before her surgery, and refused food and drink afterwards, which are signs of failing reserve.

46. The CPU concluded that the medical care provided to Ms Chase was reasonable. I accept this opinion.

CONCLUSION

47. Having considered all of the circumstances, I am satisfied that the care provided to Ms Chase at the SDA and by the SIL provider was appropriate and reasonable. I reach the same conclusion regarding the medical care provided to Ms Chase at the Mulgrave Private Hospital and West Gippsland Hospital.

ACKNOWLEDGEMENTS

48. I extend my sincere condolences to Ms Chase's family for their loss.

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

DIRECTIONS

50. Pursuant to section 73(1) of the Act, I direct that this finding be published on the Coroners Court website in accordance with the Rules.

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

    Elizabeth Chase, Senior Next of Kin

    Good Housing Pty Ltd

    Scope (Aust) Ltd

    Mulgrave Private Hospital

West Gippsland Hospital

National Disability Insurance Agency

First Constable Andrew Wilson, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 15 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 inquest. 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.