IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2025 006388**

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*

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

**Inquest into the Death of Diane Robyn Hartney**

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| Delivered on: | 12 November 2026 |
| Delivered at: | Coroners Court of Victoria<br>65 Kavanagh Street<br>Southbank Victoria 3006 |
| Hearing dates: | 12 November 2026 |
| Findings of: | Coroner Sara Dennis |
| Representation: | No appearances |
| Counsel Assisting the Coroner: | Anna Pejnovic |
| Keywords | In care, Temporary Treatment Order, *Mental Health and Wellbeing Act*, aspiration pneumonia, starvation |

## INTRODUCTION

1. On 4 September 2025, Diane Robyn Hartney was 73 years old when she died at Dandenong Hospital, where she was an inpatient and subject to a Temporary Treatment Order (**TTO**). At the time of her death, Diane lived at TLC Noble Gardens Residential Aged Care (**Noble Gardens**) in Noble Park.

2. Diane is survived by her four children, Kristy, Nicole, Becky and Aaron, and nine grandchildren.

3. Diane had lived at Noble Gardens since June 2023 and, prior to that, had lived in a Supported Residential Service (**SRS**)[1] in Noble Park. She had limited mobility, used a 4-wheel frame walker, and required assistance with showering, dressing and personal activities.

### Mental health history

4. Diane's mental health began to deteriorate in her forties, following a cholecystectomy. She had received diagnoses of adjustment disorder and major depressive disorder with psychotic features and underlying dependent personality traits. She had several episodes of care with public mental health services.

5. In June 2023, Diane had a voluntary inpatient admission at Dandenong Hospital associated with adjustment difficulties on a background of depressive disorder. It was during this admission that it was determined that her SRS no longer met her needs and accordingly she was discharged to Noble Gardens. Not long after discharge, Diane's mental state deteriorated; she withdrew socially, began refusing meals and did not engage in reviews, stating *"nobody cares"* and *"what's the point?"*

6. In August 2023, Diane was returned to hospital on an Assessment Order (**AO**) under the *Mental Health Act 2014.* She initially engaged in care and the AO was revoked. However, despite modifications to her medications, there was limited improvement in her mental

[1] Supported Residential Services are privately operated, state regulated accommodation for people that require support for daily living, but not at an intensive level.

state and her oral intake remained poor with intermittent refusal of medications. She was placed back on a compulsory order, and an application was made to the Mental Health Tribunal for electroconvulsive therapy (**ECT**)[2]. Despite a course of ECT, her oral intake remained poor, and she became septic and was transferred to the Intensive Care Unit (**ICU**). Her condition gradually improved and she was discharged.

7. In October 2023, Diane was referred to the Residential Support Program (**RSP**), part of the Monash Health Older Adult Mental Health and Wellbeing Service, for ongoing management. She was reviewed weekly.

8. In February 2024, Diane's mental state again deteriorated and, despite modification to her medications, she refused to eat, drink and take medications. She was admitted to Dandenong Hospital and managed under a compulsory order, initially on a medical ward due to starvation ketoacidosis[3] and risk of refeeding syndrome[4]. When her physical condition improved, she was transferred to the inpatient psychiatric unit and engaged well with treatment. The compulsory order was revoked, and she was discharged back to Noble Gardens on 25 March 2024, supported by community-based intensive care.

9. Diane was transferred to the care of the RSP team on 9 April 2024 and she was seen by them weekly to fortnightly until her death.

10. In January 2025, Diane was diagnosed with rectal carcinoma. She completed radiotherapy in March 2025 and remained stable in her mental state throughout her treatment course, with some minor fluctuations in her mood.

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[2] ECT is a safe and effective treatment for some mental illness, particularly severe depression and other mood disorders. ECT is a medical procedure in which a person's brain is stimulated with a brief, controlled series of electrical pulses using electrodes placed at precise locations on the person's head. This stimulus causes a seizure within the brain. For patients who do not have capacity to consent to ECT, the authorised psychiatrist must apply to the Mental Health Tribunal to approve the ECT.

[3] Starvation ketoacidosis is a potentially dangerous metabolic state associated with high blood levels of ketones that can occur after several days of fasting or malnutrition; blood glucose levels typically remain low or normal in starvation ketoacidosis. It differs from diabetic ketoacidosis which is more commonly associated with Type 1 diabetes as a result of the body lacking insulin, resulting in a rise in blood glucose levels.

[4] Refeeding syndrome refers to the potentially fatal shifts in fluids and electrolytes that may occur in malnourished patients receiving artificial refeeding. These shifts result from hormonal and metabolic changes and may cause serious clinical complications.

## THE CORONIAL INVESTIGATION AND INQUEST

### Jurisdiction

11. Diane'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. In addition, Diane's death was reportable as she was a 'person placed in custody or care' within the meaning of the Act as, at the time of her death, she was subject to a Temporary Treatment Order pursuant to the *Mental Health and Wellbeing Act 2022*.[5]

12. The death of a person in care is a mandatory report to the coroner, even if the death appears to have been from natural causes. This category of death is reportable to ensure independent scrutiny of the circumstances leading to the death, given the vulnerability of this cohort.

13. Section 52(2)(b) of the Act requires that I must hold an Inquest into the death of a person placed in custody or care, unless that death is due to natural causes.

14. Having considered the available evidence, which could be regarded as complete and uncontentious, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 Finding into Death with Inquest. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 12 November 2026.

### Purpose of a coronial investigation

15. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[6]

16. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the

[5] Section 4(2)(d) of the Act.

[6] Section 67(1) of the Act.

context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[7]

17. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[8]

18. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9] These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.[10]

19. The Coroners Court of Victoria is an inquisitorial jurisdiction.[11] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[12]

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[7] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[8] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".

[9] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.

[10] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[11] Section 89(4) of the Act.

[12] Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

## Sources of evidence

20. Victoria Police assigned First Constable Joshua Dolan-Hansen to be the Coronial Investigator for the investigation of Diane's death. FC Joshua Dolan-Hansen 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.

21. This finding draws on the totality of the coronial investigation into the death of Diane Robyn Hartney 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.[13]

## Standard of proof

22. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*[14]. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;

[13] 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] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

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

### Circumstances in which the death occurred

Events prior to Dandenong Hospital admission

23. Diane was seen by her regular RSP case manager, Registered Psychiatric Nurse (**RPN**) Rob Fryer, on 8 August 2025. She had been made aware that she had a residual cancerous tumour in her rectum and was due for further review to discuss treatment options. She had been to visit her mother in aged care after she had a fall. Diane's mood was stable, she demonstrated good insight and was eating well. There was no evidence of psychotic symptoms.

24. On 10 August 2025, Diane's mother died at the age of 97.

25. On 21 August 2025, Diane's daughter Kristy phoned RPN Fryer concerned that Diane may be becoming unwell again, as she had refused to attend her mother's funeral scheduled for the following day.

26. RPN Fryer reviewed Diane that day. He obtained additional information from Noble Gardens staff, who reported she had been well until that day, when she refused medication and was teary and reported struggling to think. The identified likely psychosocial triggers were complex family dynamics in the context of her mother's death, and uncertainty about her cancer prognosis. On assessment, Diane's mood was low with no overt psychotic symptoms, but she expressed low self-worth and reduced interest in her usual activities. She denied suicidal ideation. RPN Fryer noted some similarity to her previous signs of relapse and urged Noble Gardens staff to encourage socialisation. He planned to check in the next day and increase the frequency of reviews, if required.

27. RPN Fryer phoned Noble Gardens on 22 August 2025. He spoke to Registered Nurse (**RN**) Hope, who informed him that Diane had refused her medication the previous night and that day, but was eating and drinking regularly. RPN Fryer advised RN Hope that Diane's condition could rapidly deteriorate. He advised her to encourage Diane's oral intake and medications and, should she cease eating and drinking over the weekend, to transfer her to the Emergency Department (**ED**). The plan was for Noble Gardens to commence food and fluid charting.

28. RPN Fryer again contacted Noble Gardens on 25 August 2025. Staff reported that, despite encouragement from Kristy, Diane had declined all medications over the weekend, including her insulin, and had declined blood glucose monitoring. RPN Fryer requested that Noble Gardens obtain a medical review from a general practitioner (**GP**). RPN Fryer arranged a psychiatric review for later that day.

29. Monash Health Consultant Psychiatrist Dr Jo Ravi reviewed Diane on the afternoon of 25 August 2025, as planned. Diane was slow to engage, and her affect was flat and restricted. She blamed herself for her mother's death, and voiced themes of hopelessness and worthlessness. Dr Ravi considered that Diane's presentation was consistent with a rapid decline in the context of grief following her mother's death, and that she was at high risk of further relapse of psychotic depression and physical decline due to starvation.

30. Dr Ravi encouraged Diane to allow staff to measure her blood glucose level, to which she agreed. The level was 5.6 mmol/L.[15] The plan was for staff to continue encouraging oral intake and medications, a GP review of her physical health, daily mental health review, and to waitlist her for admission to the inpatient unit with a low threshold if she continued to refuse meals and medications.

31. RPN Fryer spoke to RN Hope again on the morning of 26 August 2025 and was informed that Diane was still not eating or drinking and was refusing medication. RN Hope agreed to ask a GP to prioritise reviewing Diane that morning, and to provide the GP with a copy of Dr Ravi's mental health assessment from the previous day.

[15] Normal fasting levels are 3.9 – 5.5 mmol/L.

32. Diane was reviewed by a GP later that day. The physical examination was unremarkable, and the GP was supportive of mental health assessment in ED.

33. RPN Fryer conducted a comprehensive review of Diane on the afternoon of 26 August 2025. Diane engaged in the review, but her affect was restricted and flat with themes of hopelessness. There was no evidence of psychotic symptoms, she denied suicidal ideation and did not want to go to hospital. The plan was to update Dr Ravi and to consider if Diane could be managed at Noble Gardens or whether she required an inpatient bed.

34. RPN Fryer spoke with RN Hope on the morning of 27 August 2025, who reported that Diane had declined dinner and breakfast and all medications. RPN Fryer consulted Dr Ravi with plan for admission under an AO. When reviewed face-to-face by RPN Fryer, Diane was slow to engage, denied her mother had died, and declined voluntary hospitalisation as she believed no one would be there to care for her.

Admission to Dandenong Hospital

35. Diane was placed on an AO under the *Mental Health and Wellbeing Act 2022* and transferred to Dandenong Hospital ED where she was seen by Consultant Psychiatrist Dr Pinto. The AO was converted to a TTO. Because no beds were available in the inpatient mental health ward, Diane was admitted to a General Medical Acute ward under the General Medicine team, with mental health care provided by the Consultation Liaison (**CL**) psychiatry team.

36. Diane's blood glucose level was normal on admission, but her ketone level was elevated (6.9 mmol/L), indicative of starvation ketosis. She was initially treated with intravenous (**IV**) glucose and subcutaneous insulin to reduce her ketone levels. She was subsequently seen by a dietitian, but her oral intake did not improve, and the dietitian recommended enteral feeding.

37. Several unsuccessful attempts were made to place a nasogastric tube (**NGT**) over the course of 29 and 30 August 2025, each leading to either an aspiration event or incorrect positioning in the right main bronchus or segmental branch. The process was made challenging by anatomical challenges and by Diane being *"uncooperative"*. It was requested that no further attempts at insertion be made over the weekend, with continuation of IV glucose

until fluoroscopic insertion[16] was available. An NGT was successfully inserted with fluoroscopic guidance on 1 September 2025, and enteral feeding commenced. [17]

38. Diane was reviewed on the morning of 2 September 2025 and was noted to be tolerating feeds. She was for ongoing monitoring given risk of refeeding syndrome.

39. At around 2pm that day, Diane's oxygen saturation level dropped. She became tachycardic, with cough, shortness of breath and pleuritic chest pain. A Code Blue[18] was called and Computed Tomography Pulmonary Angiogram (**CTPA**) and chest x-ray were ordered to eliminate pulmonary embolism and aspiration pneumonia. The NGT was confirmed to be in the correct position.

40. When reviewed on the morning of 3 September 2025, Diane's increased need for oxygen and tachycardia were noted but results of the CTPA were inconclusive – they suggested airway inflammation but no pulmonary embolism or overt pneumonia. Diane reported no difficulty in breathing and denied a cough or chest pain. She was febrile with an increased temperature of 37.7 degrees, so her condition was treated as aspiration pneumonia and antibiotics were commenced.

41. Around 5.30am on 4 September 2025, Diane was found to be coughing and producing copious mucous, followed by sudden onset of unresponsiveness. A Code Blue was initiated, but cardiopulmonary resuscitation was not commenced in line with her documented goals of care on admission. She was declared deceased at 6am.

42. After Diane's death, a respiratory swab returned positive for influenza A.

**Identity of the deceased**

43. On 4 September 2025, Diane Robyn Hartney, born 30 March 1952, was visually identified by her daughter, Kristy Hartney, who completed a Statement of Identification.

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[16] Insertion of the nasogastric tube using x-ray.

[17] This was likely to have been about 7 days since Diane first began refusing food.

[18] An emergency call for assistance in the management of patients who are having or are anticipated to have a cardiorespiratory arrest. A Code Blue facilitates near immediate review by senior medical and intensive care doctors and nurses with the intention of attempting to resuscitate the patient.

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

**Medical cause of death**

45. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Diane Hartney on 8 September 2025 and provided a written report of his findings dated 16 September 2025.

46. The findings at external examination were in keeping with the clinical history. A post-mortem CT scan showed marked kyphosis, bilateral lung markings suggestive of consolidation and focal coronary artery calcification.

47. Dr Beer provided an opinion that the medical cause of death was *1(a) aspiration pneumonia on a background of starvation ketosis, 2 depression with psychotic features.*

48. I accept Dr Beer's opinion as to the cause of death.

**REVIEW OF CARE**

49. Having regard to the circumstances of Diane's death, I checked her medical records to see when she had last received a vaccination for influenza. This vaccination was administered on 8 April 2025.

50. I also requested that the Coroners Prevention Unit (**CPU**) [19] advise me on two issues:

    a) Was it reasonable for Noble Gardens to wait five days to have Diane examined by a doctor and then transfer her to hospital?

    b) Was the position of the NGT inserted at hospital checked, and was it appropriate given her starvation state to attempt nasogastric feeding?

[19] 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.

51. In addition to addressing my two queries, the CPU advised that the overall quality of care provided to Diane by clinicians from the RSP at Monash Health Older Adult Mental Health and Wellbeing Service was of a high level.

**Was there a missed opportunity for earlier admission to hospital?**

52. A review of the evidence indicated that concern regarding Diane's condition was evident and appropriately escalated as soon as Kristy raised concerns with RPN Fryer on 21 August 2025. There was near daily communication about Diane between Noble Gardens, RPN Fryer, Dr Ravi and the GP between 21 and 27 August 2025, when Diane was transferred to hospital. The CPU noted that Noble Gardens had appropriately withheld Diane's insulin in response to her food refusal, to ensure she did not suffer hypoglycaemia.

53. On Diane's arrival at hospital there was evidence of ketosis consistent with a lack of food intake, but her vital signs were otherwise stable. The CPU advised that earlier admission to hospital would not have been indicated; rather, it was appropriate to exhaust all reasonable efforts to avoid placing Diane on a compulsory order and transferring her to hospital.

**Was nasogastric feeding appropriate?**

54. Diane's primary risks were related to refeeding syndrome, traumatic or misplaced NGT placement, and aspiration of nasogastric contents. The CPU was satisfied that these risks were considered and appropriately managed. A dietician provided initial dietary supplementation and monitoring for refeeding syndrome and appropriately recommended to progress to short-term nasogastric supplementation when it became evident that she was not meeting her requirements through oral supplementation. The difficulties in the placement of Diane's NGT were well documented, and the appropriate procedures for ensuring its correct placement were followed.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Diane Robyn Hartney, born 30 March 1952;

    b) the death occurred on 4 September 2025 at Dandenong Hospital, 135 David Street, Dandenong, Victoria 3175;

    c) Diane, a woman with depression with psychotic features, died from aspiration pneumonia on a background of starvation ketosis; and

    d) the death occurred in the circumstances described above.

56. Having considered the available evidence, I am satisfied that Diane began refusing oral intake following the death of her mother and on the background of longstanding, diagnosed mental ill-health which was being appropriately treated.

57. I am satisfied that Diane's care at Noble Gardens and by Monash Health was reasonable and appropriate and I have not identified any prevention opportunities.

I convey my sincere condolences to Diane's family for their loss.

Pursuant to section 73(1) 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:

Kristy Hartney, Senior Next of Kin

Monash Health

First Constable Joshua Dolan-Hansen, Coronial Investigator

Signature:






Coroner Sara Dennis

Date: 12 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 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.