



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2025 006606**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner David Ryan
Deceased:	Carol Rae Street
Date of birth:	11 June 1976
Date of death:	13 September 2025
Cause of death:	Coronary artery atherosclerosis in the setting of pulmonary valve replacement for management of complications of tetralogy of fallot
Place of death:	The Royal Melbourne Hospital 300 Grattan Street Parkville Victoria
Keywords:	In care – natural causes

## INTRODUCTION

1. On 13 September 2025, Carol Rae Street was 49 years old when she passed away at the Royal Melbourne Hospital. At the time of her death, Carol lived in a residential care facility in Werribee managed by Independent Australia. Her medical history included schizophrenia, epilepsy, depression, obsessive compulsive disorder and tetralogy of fallot.<sup>1</sup> She also had an intellectual disability. In 1980, she underwent surgery to repair her tetralogy of fallot.

## THE CORONIAL INVESTIGATION

2. Carol'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. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. Carol was a person in care at the time of her death and she was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to s52(3A) of the Act given that Carol's death was from natural causes.
3. 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.
4. 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.
5. This finding draws on the totality of the coronial investigation into Carol's death, including information obtained from her health records and the National Disability Insurance Agency. While I have reviewed all the material, I will only refer to that which is directly relevant to

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<sup>1</sup> Tetralogy of fallot is a combination of four congenital heart defects that affect infants and children.

my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>2</sup>

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

### **Circumstances in which the death occurred**

6. On 10 September 2025, Carol was admitted to the Royal Melbourne Hospital to undergo a percutaneous pulmonary valve insertion to treat pulmonary regurgitation. The Office of the Public Advocate consented to the procedure following extensive multidiscipline team discussion. Following the successful surgery, Carol was admitted to the Intensive Care Unit and then the Coronary Care Unit.
7. On 11 September 2025 at around 11.20am, Carol was found unresponsive by staff. She was found to have sustained a severe hypoxic brain injury and passed away on 13 September 2025 at 1.09pm.

### **Identity of the deceased**

8. On 13 September 2025, Carol Rae Street, born 11 June 1976, was visually identified by her carer, Marie Yuon-Pierre.
9. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

10. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine, performed an autopsy on 18 September 2025 and provided a written report of his findings dated 5 March 2026.
11. There was no evidence of any injuries which may have caused or contributed to the death. Dr Lynch expressed the opinion that the death was due to natural causes.
12. Dr Lynch noted evidence of significant coronary artery atherosclerosis and cardiomegaly (enlargement of the heart). The postmortem computed tomography (CT) scan also showed cerebral oedema.

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<sup>2</sup> 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. Dr Lynch provided an opinion that the medical cause of death was: *1(a) Coronary artery atherosclerosis in the setting of pulmonary valve replacement for treatment of tetralogy of fallot.*
14. I accept Dr Lynch's opinion.

## **FINDINGS AND CONCLUSION**

15. Pursuant to section 67(1) of the Act, I make the following findings:
  - a) the identity of the deceased was Carol Rae Street, born 11 June 1976;
  - b) the death occurred on 13 September 2025 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from coronary artery atherosclerosis in the setting of pulmonary valve replacement for treatment of tetralogy of fallot; and
  - c) the death occurred in the circumstances described above.
16. As noted above, Carol's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Carol died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into her death.

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

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:

Anthony Street, Senior Next of Kin

DonateLife Victoria

Royal Melbourne Hospital

Constable Brandon I, Coronial Investigator

Signature:



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Coroner David Ryan

Date: 27 April 2026

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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.

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