IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 006673

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Marina Victoria Radovan
Date of birth:	13 February 1971
Date of death:	15 September 2025
Cause of death:	1a: ASPIRATION PNEUMONIA 2: MULTIPLE SCLEROSIS
Place of death:	Cabrini Malvern 181/183 Wattletree Road Malvern Victoria 3144
Keywords:	In care, Specialist Disability Accommodation, SDA, supported independent living, disability support, natural causes

INTRODUCTION

1. On 15 September 2025, Marina Victoria Radovan[1] was 54 years old when she died at Cabrini Malvern after a short period of palliative care.

2. At the time of her death, Marina resided at a Specialist Disability Accommodation (**SDA**) dwelling in Carnegie, enrolled under the National Disability Insurance Scheme (**NDIS**). Marina received funded daily independent living support, which was provided by disability service provider Yooralla.

3. Marina's medical history included Multiple Sclerosis (**MS**), which she was diagnosed with when she was around 20 years old. She required the use of a wheelchair for mobility. Yooralla staff supported Marina in most activities of daily living.

4. Marina frequently attended her local Catholic Church and liked going to cafes. She enjoyed a loving and supportive relationship with her brother, Michael Radovan (**Michael**).

5. On 15 September 2024, Marina was admitted to Monash Hospital by ambulance after experiencing difficulty breathing. She was placed on oxygen and was diagnosed with aspiration pneumonia. At around this time, Marina's health began to rapidly deteriorate, and she required more intensive support. Her ability to swallow also declined.

6. Marina was first assessed by the Calvary Community Palliative Care Unit in November 2024. As she was not presenting with acute symptoms, it was determined that she did not require their support at that time.

7. In 2025, Marina had a number of hospitalisations due to aspiration pneumonia, as a result of her impaired swallowing in the context of her progressing MS. After a hospitalisation in March 2025, a meeting was held with Marina's speech pathologist, in consultation with her General Practioner, to discuss Marina's plans for eating. On 24 March 2025, a Making Choices at Mealtimes Consent Declaration was signed to document that Marina would eat and drink at risk, in order to maintain her quality of life.

8. In March 2025, the Calvary Community Palliative Care Unit was contacted to provide in-home supports for Marina, due to her increased symptoms. It was recommended that if Marina's health continued deteriorating that she be admitted to a palliative care unit.

[1] Referred to throughout my finding as 'Marina' unless more formality is required.

THE CORONIAL INVESTIGATION

9. Marina'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.[2]

10. 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.

11. 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.

12. 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.

13. This finding draws on the totality of the coronial investigation into the death of Marina Victoria Radovan 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.[3]

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[2] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

[3] 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.

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

Circumstances in which the death occurred

14. On 1 September 2025, Marina experienced difficulty breathing after drinking a smoothie. Yooralla staff contacted emergency services and Marina was admitted to Cabrini Hospital by ambulance. Marina was assessed and transferred to the Intensive Care Unit at Cabrini for management and treatment. She was treated with antibiotics and placed on oxygen.

15. Marina's condition progressively deteriorated. She stopped responding to antibiotics, and she experienced continued difficulty breathing. Scans showed that her pneumonia had progressed and she became unable to eat or drink.

16. On 8 September 2025, Michael and Marina's treating clinicians had a discussion regarding Marina's ongoing care. Given her further decline, the progression of her pneumonia and that she had not responded to antibiotics, a decision was made to commence end-of life care. On 14 September 2025, Marina was transferred to a palliative care ward and placed on end-of-life care.

17. On 15 September 2025, Marina died peacefully in hospital.

Identity of the deceased

18. On 15 September 2025, Marina Victoria Radovan, born 13 February 1971, was visually identified by her brother.

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

Medical cause of death

20. Forensic Pathologist Dr Judith Fronczek (**Dr Fronczek**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 18 September 2025 and reviewed a post-mortem computed tomography (**CT**) scan and other relevant materials. Dr Fronczek provided a written report of her findings dated 6 October 2025.

21. The post-mortem examination was consistent with the reported history.

22. Toxicological analysis of ante-mortem or post-mortem samples was not indicated and was therefore not performed.

23. Dr Fronczek provided an opinion that the medical cause of death was '*1(a) aspiration pneumonia; 2 multiple sclerosis.'*

24. Dr Fronczek provided an opinion that the cause of death was due to natural causes.

25. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Marina Victoria Radovan, born 13 February 1971;

    b) the death occurred on 15 September 2025 at Cabrini Malvern, 181/183 Wattletree Road Malvern Victoria 3144 from aspiration pneumonia and multiple sclerosis; and

    c) the death occurred in the circumstances described above.

27. Having considered all the available evidence, I find that Marina's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Marina's death 'on the papers' by way of written finding.

I convey my sincere condolences to Marina's family, friends and carers 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:

Michael Radovan, Senior Next of Kin

Cabrini Health

Senior Constable Andrew Warburton, Coronial Investigator

Signature:



INGRID GILES

CORONER

Date: 20 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 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.