IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 006853

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:	Allan James Anton
Date of birth:	2 September 1961
Date of death:	24 September 2025
Cause of death:	1(a) Complications of Alzheimer's dementia
Place of death:	19 Weldon Street, Tarneit, Victoria
Keywords:	In care, specialist disability accommodation, supported independent living, natural causes

INTRODUCTION

1. On 24 September 2025, Allan James Anton was 64 years old when he passed away at his specialist disability accommodation (**SDA**). At the time, Mr Anton lived at an SDA in Tarneit managed by disability service provider, Disability Dynamics.

2. Mr Anton was in a relationship with his partner, Eva Jaroszek, on and off since 1993. The couple shared a farm property (**the farm**) together in Avalon. Mr Anton loved the outdoors, was passionate about hunting and enjoyed the extra space at the farm to keep hunting dogs and other animals.

3. When Mr Anton left school at the age of 15, he worked in the mining industry. He then worked in construction for many years. Ms Jaroszek stated that he was always a hard worker. In 2018 or 2019, he left his employment in construction, and while he was determined to get another job, he was unable to.

4. Mr Anton served almost two years in prison for sexual offending and was released in 2008. He had a history of heavy alcohol use, and although he overcame his drinking habit whilst in prison, Ms Jaroszek stated that he resumed drinking heavily upon his release.

5. In October 2021, Ms Jaroszek reported Mr Anton as missing. He was found by police in Colac disorientated and confused, and in November 2021, he was diagnosed with younger onset dementia. At this time, Mr Anton was living with Ms Jaroszek at her home in Sunshine, and she became his full-time carer.

6. Following his diagnosis, Mr Anton's condition rapidly deteriorated, severely impacting his cognitive and functional abilities. He experienced memory loss, confusion and other challenging behaviours.

7. In 2023, Mr Anton's care needs increased, and he was becoming more difficult for Ms Jaroszek to manage. She organised for carers to assist at home, and a respite schedule was also implemented whereby Mr Anton's carers would take him to the farm for a few days each week.

8. In January 2024, Mr Anton entered full-time care at Whitehaven Retirement and Respite Care in Geelong for short-term accommodation. He moved into his SDA facility in Tarneit shortly after. In 2024, he could still walk but was experiencing significant cognitive challenges and

his ability to verbally communicate had decreased. He would rely on non-verbal cues to communicate.

9. The SDA in which Mr Anton resided was enrolled under the National Disability Insurance Scheme (**NDIS**). At his SDA, Mr Anton's carers provided him with Supported Independent Living (**SIL**) services for daily tasks including personal care, meal preparation, medication administration, and mobility. He also received care from his general practitioner (**GP**), an occupational therapist, speech therapist, allied health assistant, and behaviour support practitioner. Additionally, Ms Jaroszek remained involved in his care and would prepare food and visit him regularly.

10. Mr Anton had an extended hospital admission between mid-October and early December 2024 due to hypoactive delirium, fever of unclear origin, prostatomegaly and liver function derangement.

11. By the beginning of 2025, Mr Anton's physical condition and motor function had significantly deteriorated. He was largely bedbound, required a wheelchair and hoist to mobilise, and was dependent for all activities of daily living.

THE CORONIAL INVESTIGATION

12. Mr Anton's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. 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]

13. 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.

14. 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

[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.

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

15. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Anton'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.

16. This finding draws on the totality of the coronial investigation into Mr Anton'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

17. On 24 September 2025, Allan James Anton, born 2 September 1961, was visually identified by his carer, Madhav Bhandari, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

19. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 26 September 2025 and provided a written report of her findings dated 15 October 2025.

20. The post-mortem computed tomography (**CT**) scan revealed an obliquely oriented right parietal linear skull defect with no associated underlying brain injury, dilated lateral ventricles with generalised cerebral atrophy, and patchy lung consolidation suggestive of pneumonia. There was no evidence of any significant injuries.

21. Routine toxicological analysis was not indicated and was therefore not performed.

[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.

22. Dr Archer provided an opinion that the medical cause of death was *"1(a) Complications of Alzheimer's dementia"*.

23. I accept Dr Archer's opinion.

Circumstances in which the death occurred

24. In August 2025, Mr Anton was hospitalised due to a transient neurological episode. During this admission, he was found to have aspiration pneumonia and incidental bilateral neck of femur fractures.

25. Mr Anton had his last face-to-face appointment with his GP on 22 August 2025, during which he was non-verbal, in a wheelchair and demonstrated intermittent grimacing on movement. His carers reported that he had generally been well and the GP stated that he did not appear to be in any significant pain during the appointment.

26. In early September 2025, Mr Anton was hospitalised due to suffering another transient neurological episode.

27. On 24 September 2025, Mr Anton was at his SDA when he finished eating lunch and was in bed watching television. At about 1.05pm, his carers had completed changing his incontinence pad whilst he was lying in bed when they noticed that he was shaking and had laboured breathing. They readjusted the bed to aid his breathing, which appeared to help him briefly, but he quickly returned to heavy breathing and began sweating and changing colour. His carers immediately contacted emergency services. When Ambulance Victoria paramedics arrived at about 1.22pm, they commenced cardiopulmonary resuscitation (**CPR**), but Mr Anton could not be revived and was declared deceased at the scene.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Allan James Anton, born 2 September 1961;

    (b) the death occurred on 24 September 2025 at 19 Weldon Street, Tarneit, Victoria;

    (c) the cause of Mr Anton's death was complications of Alzheimer's dementia;

    (d) immediately before his death, Mr Anton was a *"person placed in custody or care"* as defined in section 4 of the Act; and

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

29. I convey my sincere condolences to Mr Anton's family and friends 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:

Eva Jaroszek, senior next of kin

Senior Constable Rory Hynan, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 27 August 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.