IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007352

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Annette Kelly
Date of birth:	25 September 1951
Date of death:	18 October 2025
Cause of death:	1a : Aspiration pneumonia
Place of death:	Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 18 October 2025, Annette Kelly, affectionately known as Annie, was 74 years old when she died at Wantirna Palliative Care due following hospitalisation due to aspiration pneumonia.

2. At the time of her death, Annette resided at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Annette received funded daily independent living support from the Disability Support for Older Australians Program[1] due to her extensive medical conditions, which was provided by disability service provider, Scope (Aust) Limited (**Scope**).

3. Annette's niece, Lydia Clinnick (**Lydia**) reported that Annette experienced oxygen deprivation in utero. Throughout her life, Annette was diagnosed was several conditions including an intellectual disability, profound learning disability, anxiety, autism, mood disorder, epilepsy and vision disorder. She also had dysphagia (difficulty swallowing) and experienced recurrent aspiration pneumonia, with four episodes in 2024.

4. In her early childhood, at around four years of age, Annette moved to the Kew Cottages and in 2001, began living at a facility in Mitcham operated by Scope. She attended Scope's Social Connections programs five days a week. Annette did not have any contact with her two sisters; she received family support only from Lydia.

5. Given that Annette was non-verbal, she communicated through vocalisations, gestured, facial expressions, touch and behaviour. She was required assistance for all movements including hoist transfers, for personal care including continence management and mealtimes. She enjoyed excursions to shopping centres, going to the cinema, listening to music and receiving hand massages.

THE CORONIAL INVESTIGATION

6. Annette Kelly'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] This category of death is

[1] Administered by the Australian Government Department of Health, Disability and Ageing.
[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).

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.

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

9. This finding draws on the totality of the coronial investigation into the death of Annette Kelly. 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]

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

Circumstances in which the death occurred

10. On 12 June 2025, Annette's general medical practitioner (**GP**) completed her Comprehensive Health Assessment Program. The GP documented that they *'would be surprised'* if Annette died within the next 12 months.

11. The same month, Annette experienced a COVID-19 infection but recovered with anti-viral medication. Between July and September 2025, Annette continued attending her day program and maintained good sleep and eating routines.

12. On 16 September 2025, Scope workers noticed that Annette appeared unwell – she was sweating and had a chesty cough. Her urine catheter was not draining properly, and her

[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.

incontinence aid had become wet overnight. Staff contacted Bolton Clarke nursing services who replaced the catheter. A GP appointment was booked to review Annette's cough and order a urine screen. Staff redeemed a prescription for antibiotics.

13. On 19 September 2025, a GP reviewed Annette at the Mitcham facility and noted her chest was clear and directed that she continue to take the antibiotics. Annette completed the five-day course and returned to her normal activities.

14. On 30 September 2025, Scope staff organised another GP appointment due to Annette's nasal discharge and moist cough. The GP diagnosed her with a lower respiratory tract infection and prescribed antibiotics. They noted nil concerns with Annette's recent urine screen. The following day, Annette declined food and drink and *'did not appear to be her usual self'*. Staff contacted emergency services and she was transported to Box Hill Hospital due to aspiration pneumonia.

15. Clinicians administered intravenous antibiotics however, Annette continued to decline clinically. Scope staff regularly visited Annette and provided her with emotional support and aided her communication with medical staff. Clinicians informed Scope that Annette continued to refuse oral intake and exhibited shallow breathing.

16. Clinicians discussed Annette's status with Lydia, including that she was not for resuscitation. In mid-October 2025, a decision was made to commence Annette on palliative care, and she was transferred to Wantirna Palliative Care operated by Eastern Health.

17. On 18 October 2025, at 7:20am, Annette was declared deceased.

Identity of the deceased

18. On18 October 2025, Annette Kelly, born 25 September 1951, was visually identified by her support worker, Martin Dignam.

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

Medical cause of death

20. Forensic Pathologist Dr Judith Fronczek of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an inspection on 20 October 2025 and provided a written report of her findings dated 5 November 2025.

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

22. A computed tomography (**CT**) scan showed of the brain; atrophy and left parietal lobe. In the lungs there was left loculated pleural effusion and left lower lobe consolidation. Affecting the heart were coronary artery calcifications and aortic valve and mitral valve calcifications. There was also subcutaneous gas in the right upper arm.

23. Dr Fronczek provided an opinion that the medical cause of death was 1(a) *Aspiration pneumonia*. Dr Fronczek provided an opinion that the cause of death was due to natural causes.

24. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Annette Kelly, born 25 September 1951;

    b) the death occurred on 18 October 2025 at Wantirna Palliative Care, 251 Mountain Highway, Wantirna Victoria from 1a: *Aspiration pneumonia*; and,

    c) the death occurred in the circumstances described above.

26. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at of Scope or Eastern Health that caused or contributed to Annette's death.

27. Having considered all the available evidence, I find that Annette'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 Annette Kelly's death in chambers.

Pursuant to section 72(2) of the Act, I make the following recommendations:

I convey my sincere condolences to Annette Kelly'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:

Kathy Kelly, Senior Next of Kin

Scope (Aust) Limited

Eastern Health

Leading Senior Constable Joseph Leavy, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 19 June 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.