IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007834

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Mary Louise Bleeser
Date of birth:	4 February 1968
Date of death:	9 November 2025
Cause of death:	1a: Aspiration pneumonia complicating status epilepticus in a woman with trisomy 21, epilepsy and Alzheimer's dementia
Place of death:	Wonthaggi Hospital 235 Graham Street Wonthaggi Victoria 3995
Keywords:	In care death, aspiration pneumonia, epilepsy, Alzheimer's dementia, natural causes

INTRODUCTION

1. On 9 November 2025, Mary Louise Bleeser was 57 years old when she died at Wonthaggi Hospital. At the time of her death, Mary lived in specialist disability accommodation (**SDA**) in Wonthaggi, managed by Melba Support Services.

2. Ms Bleeser was born with Trisomy 21 (Down Syndrome). She resided with her parents until they passed away in 2002, before moving into SDA in Wonthaggi. Ms Bleeser was largely independent until she was diagnosed with Alzheimer's dementia in 2021. Ms Bleeser's level of care increased after she suffered multiple falls and developed issues swallowing. In January 2025, Ms Bleeser was diagnosed with epilepsy.

THE CORONIAL INVESTIGATION

3. Ms Bleeser's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] The sole reason for the report was that Ms Bleeser was a person placed in custody or care pursuant to the definition in section 4 of the Act, as she was a prescribed person or a person belonging to a prescribed class of person due to her status as an SDA resident residing in an SDA enrolled dwelling.[2]

4. 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.

5. 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.

[1] Section 4(1), (2)(c) of the Act.
[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a *prescribed person or a prescribed class of person* includes a person in Victoria who is an *SDA resident residing in an SDA enrolled dwelling*, as defined in Reg 5. I have received information that Ms Bleeser resided at an address where the residents meet these criteria.

6. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Bleeser's death. The Coronial Investigator conducted inquiries and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Mary Louise Bleeser 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]

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

Circumstances in which the death occurred

8. Ms Bleeser's health and mobility declined after her epilepsy diagnosis, resulting in multiple hospital inpatient admissions in 2025. Following her second admission in September 2025, discussions occurred between Ms Bleeser's treating clinicians and her family regarding goals of care. A referral was made to a community palliative care team.

9. On 25 October 2025, Ms Bleeser suffered a seizure at home. Carers followed her epilepsy plan and administered Clonazepam. Ambulance Victoria attended and were satisfied that Ms Bleeser could remain at home under her carers' continued management.

10. On 26 October 2025, Ms Bleeser's carer found her unresponsive at home. Ambulance Victoria paramedics attended and took Ms Bleeser to Wonthaggi Hospital. The treating team suspected community acquired pneumonia and prescribed antibiotics. Ms Bleeser was discharged and returned home the same day.

11. At approximately 5:20 pm on 5 November 2025, Ms Bleeser suffered a further seizure at home. After failing to respond to medication, Ambulance Victoria paramedics attended and took Ms Bleeser to Wonthaggi Hospital.

12. Ms Bleeser presented to the Emergency Department and was admitted to the short stay unit. She was seen by the General Medicine Admitting Registrar, who found her unresponsive, with abnormal involuntary movements and increased tone. It was documented that Ms Bleeser had

[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.

nonconvulsive status epilepticus, with type 1 (hypoxic) respiratory failure, on a background of Trisomy 21, Alzheimer's-type dementia, a seizure disorder, and progressive functional decline. Ms Bleeser was treated acutely for the status epilepticus but she remained unresponsive.

13. On 6 November 2025 the General Medicine Admitting Registrar consulted with Ms Bleeser's consultant geriatrician who advised the context of her declining health and that she was known to the community palliative care team. It was agreed that there would be a Goals of Care C approach, and that if Ms Bleeser entered the terminal phase, she would be transitioned to Goals of Care D, comfort care.

14. Ms Bleeser remained non-responsive to treatment with a poor prognosis. Discussion occurred between her family and the treating medical team. A decision was made to progress Ms Bleeser to Goals of Care D, comfort care with no active medical treatment. Ms Bleeser was admitted to the medical ward and Ms Bleeser received palliative care with involvement by the palliative care team.

15. At approximately 8:20 am on 9 November 2025, Ms Bleeser was found unresponsive in her hospital bed on the medical ward. She was pronounced deceased at 8:24 am.

Identity of the deceased

16. On 10 November 2025, Mary Louise Bleeser, born 4 February 1968, was visually identified by her sister, Anne Bleeser.

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

Medical cause of death

18. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of Ms Bleeser's body on 11 November 2025 and provided a written report of his findings dated 21 November 2025.

19. The external examination revealed no unexpected signs of trauma. Examination of a post-mortem CT scan showed dilated cerebral ventricles, no intracranial haemorrhage, and increased lung markings. Toxicological analysis was not performed.

20. Dr Young was satisfied that based on the information available, Ms Bleeser's death was due to natural causes.

21. Dr Young provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia complicating status epilepticus in a woman with Trisomy 21, epilepsy and Alzheimer's dementia.

22. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) The identity of the deceased was Mary Louise Bleeser, born 4 February 1968.

    b) The death occurred on 9 November 2025 at Wonthaggi Hospital, 235 Graham Street, Wonthaggi, Victoria, 3995 from 1(a) Aspiration pneumonia complicating status epilepticus in a woman with trisomy 21, epilepsy and Alzheimer's dementia.

    c) The death occurred in the circumstances described above.

24. Having considered all the available evidence, I find that Ms Bleeser's death was from natural causes. No concerns have been raised regarding the disability or medical care provided to Ms Bleeser, and there are no issues which require further investigation. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to Ms Bleeser's family 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:

Anne Bleeser, Senior Next of Kin

Bass Coast Health

First Constable Liam Hendricks, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 01 September 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.