IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 008247

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Tracy Louise Walford
Date of birth:	27/07/1972
Date of death:	28/11/2025
Cause of death:	1a : Respiratory failure due to community acquired pneumonia and acute pulmonary oedema in a woman with down syndrome, dementia and epilepsy
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 28 November 2025, Tracy Louise Walford **(Ms Walford)** was 53 years old when she died at Austin Hospital, 145 Studley Road Heidelberg, Victoria from 1a : Respiratory failure due to community acquired pneumonia and acute pulmonary oedema in a woman with down syndrome, dementia and epilepsy.

THE CORONIAL INVESTIGATION

2. Ms Walford'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.[1]

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. This finding draws on the totality of the coronial investigation into the death of Tracy Louise Walford. 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

Circumstances in which the death occurred

5. Ms Walford had a relevant past medical history which included down syndrome, intellectual disability, epilepsy, early onset Alzheimer's disease and hypothyroidism. Ms Walford was able to communicate her needs clearly and required assistance with activities that she was

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

[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.

unable to complete independently. Ms Walford reportedly enjoyed having her nails done, and was rarely without her hairbrush, which she liked to keep close by.

6. Ms Walford had resided at SL Coburg for more than 25 years and was deeply loved by her family and those in her life.

7. In the six to seven weeks prior to her passing, carers observed a change in Ms Walford's behaviour and appropriate medical treatment was enaged. On 27 November 2025, Ms Walford declined to get out of bed, having experienced a restless night, though she was accepting of her medications. This prompted the concern of her carers who contacted 'Nurse-on-Call' and were advised to call an ambulance.

8. Ms Walford was transferred to Austin Health Emergency Department via ambulance. She was found to be in significant respiratory distress with oxygen saturations of 40%. Clinicians considered that sadly Ms Walford was critically unwell with a respiratory illness causing significant hypoxia and was likely a terminal event.

9. In consultation with family Ms Walford was transferred to end of life comfort care and she passed away peacefully on 28 November 2025.

Identity of the deceased

10. Ms Tracy Louise Walford, born 27/07/1972, was visually identified by her niece.

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

Medical cause of death

12. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 1 December 2025 and provided a written report of her findings.

13. Dr Ho provided an opinion that the medical cause of death was 1(a) respiratory failure due to community acquired pneumonia and acute pulmonary oedema in a woman with down syndrome, dementia and epilepsy.

14. Dr Ho provided an opinion that the cause of death was due to natural causes.

15. I accept Dr Ho's opinion.

FINDINGS

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

    a) the identity of the deceased is Tracy Louise Walford, born 27/07/1972;

    b) her death occurred on 28/11/2025 at Austin Hospital 145 Studley Road Heidelberg Victoria 3084 from 1a : Respiratory failure due to community acquired pneumonia and acute pulmonary oedema in a woman with down syndrome, dementia and epilepsy; and

    c) her death occurred in the circumstances described above.

17. Having considered all the available evidence, I find that Ms Walford'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 Ms Walford's death.

I convey my sincere condolences to Ms Walford's family, loved ones 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:

Jim Walford, Senior Next of Kin

Klara Pauls, Austin Health

First Constable Andrew Corker, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 03 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.