IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 008484

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Graham Peter Moore
Date of birth:	19 May 1964
Date of death:	8 December 2025
Cause of death:	Pneumonia complicating trisomy 21
Place of death:	335 Clarendon Street Thornbury Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 8 December 2025, Graham Peter Moore was 61 years old when he passed away at his home. At the time of his death, Mr Moore lived in a residential care facility in Thornbury managed by Yooralla. His medical history included Down syndrome (Trisomy 21), epilepsy and early onset dementia.

THE CORONIAL INVESTIGATION

2. Mr Moore's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. Mr Moore was a person in care at the time of his death and he was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to s52(3A) of the Act given that Mr Moore's death was from natural causes.

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. 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.

5. This finding draws on the totality of the coronial investigation into Mr Moore's death, including information obtained from his health records and the National Disability Insurance Agency. While 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.[1]

[1] 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

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

Circumstances in which the death occurred

6. Staff had observed a decline in Mr Moore's condition in the three months before his death. In late November 2025, Mr Moore developed community acquired pneumonia and he was transported to the Austin Hospital on 24 November 2025. He was treated with intravenous antibiotics but his condition did not improve. He returned home on 2 December 2025 and was transitioned to comfort care which was being managed through the Melbourne City Mission. He passed away on 8 December 2025.

Identity of the deceased

7. On 8 December 2025, Graham Moore, born 19 May 1964, was visually identified by one of his carers, Anthony Hutchins

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

Medical cause of death

9. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine, conducted an examination on 15 December 2025 and provided a written report of her findings dated 9 January 2026.

10. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Archer expressed the opinion that the death was due to natural causes.

11. Dr Archer provided an opinion that the medical cause of death was: 1*(a) Pneumonia complicating Trisomy 21*.

12. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Graham Moore, born 19 May 1964;

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

b) the death occurred on 8 December 2025 at 355 Clarendon Street, Thornbury, Victoria from pneumonia complicating Trisomy 21; and

c) the death occurred in the circumstances described above.

14. As noted above, Mr Moore's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Moore died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr Moore's family 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:

Philip Hammond, Senior Next of Kin

Senior Constable Ashlea Atkins, Coronial Investigator

Signature:

Coroner David Ryan

Date: 28 April 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.