



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

COR 2026 001030

## **FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

1. I, Coroner Sarah Gebert, having investigated the death of Gregory Charles Shufflebotham and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:
  - a) the identity of the deceased was Gregory Charles Shufflebotham, born 17 February 1957;
  - b) the death occurred on 21 February 2026 at 6 Heritage Court, Werribee, Victoria from *pneumonia complicating end stage liver cancer*; and
  - c) the death occurred in the circumstances described below.
2. Gregory was 69 years old at the time of his death and resided in a supported independent living residence in Werribee with three other residents.
3. Gregory enjoyed playing cricket, watching AFL, engaging in musical theatre productions, listening to the music, going to the pub, and engaging in conversation.
4. Gregory's medical history included epilepsy, dysphagia, Raynaud's Syndrome, reflux, hernia, liver nodule, and vitamin deficiencies. He had a moderate intellectual disability and required varying levels of support for all activities of daily living.
5. In the months leading up to his death, Gregory attended appointments with a dietician due to concerns about ongoing weight loss. On 15 December 2025, he was assessed as having a

severe swallowing disorder with high risk of choking, pneumonia, and dysphagia, and commenced on a diet of moderately thick fluids.

6. On 19 December 2025, Gregory was admitted to Werribee Mercy Hospital with concerns for an infection. During an extended admission, he was treated for hypoactive delirium secondary to aspirational pneumonia and underwent inpatient rehabilitation before being discharged on 6 February 2026.

### **Circumstances of death**

7. On 15 February 2026, Gregory's support workers observed that he appeared pale, lethargic, and unable to tolerate any foods. Staff called emergency services, and Ambulance Victoria attended. Following their assessment of Gregory, paramedics discussed Gregory's condition with his next of kin, who decided Gregory should remain at his home and be made comfortable.
8. Over the coming days, Gregory was supported at home and cared for by his support workers. By 19 February 2026, he could no longer tolerate oral intake. On 20 February 2026, Gregory's nurse practitioner assisted in preparing an advanced care plan.
9. At about 11.39am on the morning of 21 February 2026, support workers discovered Gregory not breathing on his bedroom floor and commenced cardiopulmonary resuscitation (CPR). Ambulance Victoria attended and verified death shortly after.

### **Medical cause of death**

10. Forensic Pathologist, Dr Michael Burke, from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination on 23 February 2026 and provided a written report of his findings dated 5 May 2026.
11. The findings of the post-mortem examination were consistent with reported circumstances. A post-mortem computed tomography (CT) scan showed a liver mass, marked increase in lung markings, coronary artery calcification, right sided rib fractures, and no hip or pelvic fracture. There was no evidence of an acute head injury from a fall which would have led to death.
12. Dr Burke provided an opinion that the medical cause of death was "*1(a) Pneumonia complicating end stage liver cancer*" due to natural causes.
13. I accept Dr Burke's opinion.

I convey my sincere condolences to Gregory's family and friends 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:

Joanne Wain, senior next of kin

Mercy Health

First Constable Yi Huang, Victoria Police, Coroner's Investigator

Signature:



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Coroner Sarah Gebert

Date: 23 October 2026

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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.

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