IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 001103

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 Melissa Grace Yelland and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (**the Act**):

   a) the identity of the deceased was Melissa Grace Yelland, born 9 October 1971;

   b) the death occurred on 25 February 2026 at [redacted], Mentone, Victoria from unascertained causes; and

   c) the death occurred in the circumstances described below.

2. Melissa was 54 years old when she was found deceased at her home in Mentone.

3. Immediately before her death, Melissa lived in a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Deaths which occur in these circumstances, fall within the definition of a reportable death in the Act, which includes the death of a person *in care or custody*, even if the death appears to have been from natural causes.

4. Melissa received support with activities of daily living, health management and behavioural support provided by disability service provider Aruma.

5. Victoria Police assigned Senior Constable Sam Bardoel to be the Coroner's Investigator for the investigation of Melissa's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statement from Aruma about the support provided to Melissa. All the

material will remain on the coronial file and comprises my investigation into Melissa's death. In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted in the circumstances of this case.

6. Melissa's medical history included medicinal lithium-induced toxicity, post-traumatic stress disorder (**PTSD**), bipolar disorder, anxiety, diabetes insipidus, ulcerative colitis, chronic kidney disease and dysphagia. She was supported by a multidisciplinary team including her general practitioner, medical specialists and allied health professionals.

7. Melissa's mother reported she did not have any concerns about the support services Aruma provided and described Melissa's support workers as 'wonderful'.

Circumstances of death

8. On 24 February 2026, Melissa engaged in an in-home activity in the morning before attending a Move Ability class in the afternoon. Staff noted she appeared to enjoy the class, engaging well and expressing a desire to attend on a weekly basis.

9. That evening, Melissa's support worker assisted her with her evening routine, which included meal preparation and administering her regular medications. The support worker stated she did not observe anything out of the ordinary and reported that Melissa appeared relaxed throughout the evening.

10. At about 8.00pm, Melissa asked to go to bed and was supported to do so.

11. At about 10.00pm, the support worker checked on Melissa and observed she appeared to be asleep.

12. At about 6.30am on 25 February 2026, Melissa's support worker entered her bedroom to wake her up in accordance with her usual routine. The support worker discovered Melissa unresponsive and called emergency services. She administered cardiopulmonary resuscitation (**CPR**) until Ambulance Victoria arrived and took over care. Paramedics were unable to revive Melissa.

13. Victoria Police also responded. Following their investigation, police found no evidence of any suspicious circumstances.

Medical cause of death

14. Forensic Pathologist, Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 2 March 2026 and provided a written report of her findings dated 13 May 2026.

15. The post-mortem examination revealed focal inflammation in the heart muscle without damage to the heart muscle cells. Dr Fronczek advised that this was insufficient to explain death. The examination also revealed follicular cystitis, a chronic inflammatory disorder of the urinary bladder. Dr Fronczek noted this was also not sufficient to explain death.

16. A bladder swab detected the bacterium *klebsiella pneumoniae*, which Dr Fronczek advised was likely to be the result of post-mortem contamination or colonisation. She noted histological examination showed no active inflammation in the bladder wall. The inflammatory marker c-reactive protein was not elevated.

17. The examination also revealed polycystic kidneys, which Dr Fronczek considered raised the possibility of an underlying genetic disorder. Vitreous humour biochemistry was non-contributory, and there was no evidence of renal impairment.

18. Toxicological analysis of post-mortem samples detected an elevated concentration of antipsychotic olanzapine. Dr Fronczek clarified that this may be partly related to post-mortem changes and was not contributory to death.

19. There was no post-mortem evidence of any traumatic injuries which may have caused or contributed to death.

20. Dr Fronczek advised that causes of death in the absence of significant autopsy findings include cardiac arrythmias, metabolic derangement and seizure disorders. She noted that Melissa had an extensive history of endocrine illnesses and electrolyte disturbances.

21. Despite an autopsy with ancillary investigations having been conducted, Dr Fronczek provided an opinion that the medical cause of death remained *1(a) Unascertained* but was considered to be due to *natural causes*.

22. I accept Dr Fronczek's opinion.

I convey my sincere condolences to Melissa's family and friends for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published (in redacted form) 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:

Carolyn Yelland, senior next of kin

Senior Constable Sam Bardoel, Victoria Police, Coroner's Investigator

Signature:





Coroner Sarah Gebert

Date: 10 November 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.