



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 001635

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner David Ryan
Deceased:	Patricia Anne Rickards
Date of birth:	18 July 1956
Date of death:	23 March 2026
Cause of death:	Aspiration pneumonia in the setting of cerebral palsy and peg tube feeding
Place of death:	Sunshine Hospital 176 Furlong Road St Albans Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 23 March 2026, Patricia Anne Rickards was 69 years old when she passed away at Sunshine Hospital. At the time of her death, Ms Rickards lived in a residential care facility in Keilor Downs managed by Scope (Aust) Ltd. Her medical history included asthma, osteoporosis and cerebral palsy and she also had an intellectual disability. She had limited mobility and language and was fed via a PEG¹ tube.

THE CORONIAL INVESTIGATION

2. Ms Rickards' 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. Ms Rickards was a person in care at the time of her death and she 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 Ms Rickards' 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 Ms Rickards' death, including information obtained from her medical records and the National Disability Insurance Agency. While I have reviewed all the material, I will only refer to that which is

¹ Percutaneous endoscopic gastronomy.

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

6. On 14 March 2026, Ms Rickards was admitted to Sunshine Hospital with recurrent aspiration. Her records disclosed that she had been experiencing increased incidents of aspiration pneumonia in the few years before her death. A chest x-ray showed left lower lobe consolidation and she was treated with intravenous antibiotics. She experienced worsening tachypnoea during her admission with increased reliance on oxygen therapy. Given the deterioration of her condition, she was transitioned to end of life care in consultation with her family. She passed away on 23 March 2026.

Identity of the deceased

7. On 23 March 2026, Patricia Anne Rickards, born 18 July 1956, was visually identified by her sister, Barbara Davies.
8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination on 25 March 2026 and provided a written report of his findings dated 26 March 2026.
10. There was no evidence of any injuries which may have caused or contributed to the death. Dr Beer expressed the opinion that the death was due to natural causes.
11. Dr Beer provided an opinion that the medical cause of death was *1(a) Aspiration pneumonia in the setting of cerebral palsy and peg tube feeding*.
12. I accept Dr Beer's opinion.

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.

FINDINGS AND CONCLUSION

13. Pursuant to section 67(1) of the Act, I make the following findings:
 - a) the identity of the deceased was Patricia Anne Rickards, born 18 July 1956;
 - b) the death occurred on 23 March 2026 at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria from aspiration pneumonia in the setting of cerebral palsy and peg tube feeding;
and
 - c) the death occurred in the circumstances described above.

14. As noted above, Ms Rickards' death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she 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 Ms Rickards 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 her death.

I convey my sincere condolences to Ms Rickards' 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:

Barbara Davies, Senior Next of Kin

Scope (Australia) Ltd

Senior Constable Anthony Hassett, Coronial Investigator

Signature:



Coroner David Ryan

Date: 26 May 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.
