



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 002015

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Heather Rose Martin
Date of birth:	7 June 1958
Date of death:	9 April 2026
Cause of death:	Complications of metastatic caecal carcinoma
Place of death:	Beechworth Health Service 52 Sydney Road Beechworth Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 9 April 2026, Heather Rose Martin was 67 years old when she passed away at the Beechworth Health Service. At the time of her death, Ms Martin lived in a residential care facility in Beechworth managed by Scope Australia. Her medical history included absence seizures, diverticular disease, recurrent urinary tract infections and osteoporosis. She also had an intellectual disability.

THE CORONIAL INVESTIGATION

2. Ms Martin'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. Ms Martin 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 Martin'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 Ms Martin's death including information obtained from her 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. In the 12 months before her death, staff observed that Ms Martin had experienced a functional decline with associated weight loss and reduced mobility. After being reviewed by a geriatrician on 23 January 2026, she was placed on a palliative care pathway and admitted to Beechworth Health Service on 2 April 2026. On 9 April 2026, Ms Martin passed away.

Identity of the deceased

7. On 9 April 2026, Heather Rose Martin, born 7 June 1958, was visually identified by Shaun Wilhelm, a clinician at Beechworth Health Service.
8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an examination on 13 April 2026 and provided a written report of his findings dated 17 June 2026.
10. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Lynch expressed the opinion that the death was due to natural causes.
11. Dr Lynch provided an opinion that the medical cause of death was *1(a) Complications of metastatic caecal carcinoma*.
12. I accept Dr Lynch'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 Heather Rose Martin, born 7 June 1958;
 - b) the death occurred on 9 April 2026 at Beechworth Health Service, 52 Sydney Road, Beechworth, Victoria, from complications of metastatic caecal carcinoma; and

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

c) the death occurred in the circumstances described above.

14. As noted above, Ms Martin's 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 Martin 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 Martin'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:

Coral Martin, Senior Next of Kin

Scope (Aust) Ltd

Senior Constable Joshua Barnes, Coronial Investigator

Signature:



Coroner David Ryan

Date: 25 September 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.
