



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2025 003021**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Simon McGregor
Deceased:	Nicole Jennifer Kateiva
Date of birth:	30 July 1985
Date of death:	31 May 2025
Cause of death:	1a : RESPIRATORY FAILURE IN THE SETTING OF ASPIRATION PNEUMONIA IN A WOMAN WITH ARTHROGRYPOSIS MULTIPLEX CONGENITA, INTELLECTUAL IMPAIRMENT AND EPILEPSY
Place of death:	Barwon Health Bellerine Street Geelong Victoria 3220
Keywords:	In care; Natural causes

## INTRODUCTION

1. On 31 May 2025, Nicole Jennifer Kateiva was 39 years old when she passed away at Barwon Health. At the time of her death, Nicole lived in Specialist Disability Accommodation (SDA) at 88 Vines Road, Hamlyn Heights, Victoria, 3215.
2. Nicole was born to parents, Leah and Algirdas Kateiva and is the youngest of two siblings. Nicole was born with physical deformities to her arms, knees, fingers, feet and hands as a result of arthrogryposis. Nicole had difficulty meeting significant growth milestones and was non-verbal with limited movement.
3. Nicole received support through the National Disability Insurance Scheme (NDIS) commencing in 2018 and was able to secure accommodation at a managed SDA dwelling in Belmont before moving to a new SDA dwelling at 88 Vines Road in February 2025.
4. In the 12 months leading up to Nicole's passing, she had been treated at Barwon Health for the following:
  - a) Admitted between 17 March 2025 to 26 March 2025 under the care of the General Medicine team for poor oral intake leading to dehydration; and
  - b) Admitted between 16 April 2025 to 21 May 2025 under the care of the General Medicine team for stercoral colitis, pneumonia, hypernatremia, hypotension and refractor seizures. Nicole was managed in the Intensive Care Unit between 16-22 April 2025 and again from the 25-30 April 2025. Nicole's care was transferred to the Neurology team after she developed refractory seizures.

## THE CORONIAL INVESTIGATION

5. Nicole'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.
6. Because Nicole was a Specialist Disability Accommodation (SDA) resident residing in an SDA enrolled dwelling<sup>1</sup> at the time of his death, her passing was determined to be 'in care'

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<sup>1</sup> See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

and, as such, is subject to a mandatory further investigation, pursuant to section 52(3A) of the Act. These findings are the result of that investigation.

7. 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.
8. 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.
9. Victoria Police assigned Senior Constable Cassandra D'Alessandro to be the Coronial Investigator for the investigation of Nicole's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
10. This finding draws on the totality of the coronial investigation into the death of Nicole Jennifer Kateiva including evidence contained in the coronial brief. Whilst 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.<sup>2</sup>
11. In considering the issues associated with this finding, I have been mindful of Nicole's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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<sup>2</sup> 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.

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

### Circumstances in which the death occurred

12. On 29 May 2025, an ambulance was called for Nicole as her carers at the 88 Vines Road facility had concerns for her health. Nicole was brought to the Barwon Health Emergency Department (ED) via ambulance with ongoing shortness of breath and hypoxia on arrival. A history was reported of two days of a cough and shortness of breath. A chest x-ray revealed '*subtle patchy airspace opacities project over the right lower zone, possibly reflecting evolving consolidative change*' indicating potential chest sepsis.<sup>3</sup>
13. Nicole was commenced on antibiotics (Ceftriaxone and Azithromycin), with the first dose given at 11:20 pm and treated with supplemental oxygen and intravenous fluids.<sup>4</sup>
14. Over the course of the morning of 30 May 2025, Nicole remained in the ED. The amount of oxygen required to keep her oxygen saturations above 90% steadily increased and by 5:00 am she was requiring 50% oxygen with high flow nasal prongs.
15. Nicole was reviewed by the Intensive Care Registrar at 5:50 am and given the overall trajectory, treatment decisions were rediscussed with her parents. It was noted that Nicole's parents did not wish to subject her to invasive therapy, such as an ICU admission, as they were concerned that this would cause her discomfort and distress. There was shared decision for a trial of ward-based care for the next 24 to 48 hours to assess Nicole's response before considering a transition to comfort care.<sup>5</sup>
16. Later that same morning at 9:50 am, Nicole was seen by the General Medical Consultant. The impression was of 'chest sepsis in setting of likely aspiration' with a 'guarded prognosis'. It was documented that if there was ongoing deterioration, specifically worsening hypoxia despite maximal oxygen therapy that could be delivered on the ward, then there would be a transition to comfort care as per the wishes of the family. It was felt to be appropriate to admit to the Rapid Access and Planning Medical Unit.<sup>6</sup>
17. At 1:55 pm, a Medical Emergency Team (MET) call was activated for worsening hypoxia, tachycardia and respiratory distress. This was suspected to be either from her aspiration

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<sup>3</sup> Statement of Dr Peter Iser dated 5 November 2025; Medical records from Barwon Health.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

pneumonia process or mucous plugging. Nicole's oxygen levels improved with repositioning in bed and nebulised salbutamol. A further discussion was held with her mother, who agreed to the provision of palliative comfort care in the event Nicole continued to deteriorate further.

18. On 31 May 2025 at around 8:24 am, a second MET call was made for worsening hypoxia and reduced conscious state. The medical registrar noted that the family were keen to keep Nicole comfortable and that, given there had been a further deterioration, further resuscitation attempts would be futile. A plan was made to commence palliative care and Nicole subsequently passed away at 10:30 am.<sup>7</sup>

### **Identity of the deceased**

19. On 2 June 2025, Nicole Jennifer Kateiva, born 30 July 1985, was visually identified by her father, Algirdas Kateiva.
20. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

21. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 4 June 2025 and provided a written report of her findings dated 5 June 2025.
22. The post-mortem external examination and CT scan were consistent with the clinical history provided from Barwon Health and consistent with a natural causes death.
23. Dr Ho provided an opinion that the medical cause of death was 1(a) RESPIRATORY FAILURE IN THE SETTING OF ASPIRATION PNEUMONIA IN A WOMAN WITH ARTHROGRYPOSIS MULTIPLEX CONGENITA, INTELLECTUAL IMPAIRMENT AND EPILEPSY and I accept her opinion.

### **FAMILY CONCERNS**

24. In their a prepared statement to the Court dated 24 July 2025, Nicole's mother, Leah Kateiva, expressed concern about the following:

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<sup>7</sup> Ibid.

- a) The organisation of medical tests and examinations without consulting Nicole's mother;
- b) Difficulties inserting cannula's where a cannula was required and difficulties arranging CAT scans when required;
- c) Nicole having difficulty eating and vomiting as well as difficulties with a nasal tube;
- d) Nicole experiencing seizures during her admission and the use of Valium;
- e) Barwon Health not having facilities to shower Nicole during her admission; and
- f) A constant rotation of medical practitioners treating Nicole.

## **FURTHER INVESTIGATIONS**

25. As a result of being appraised of Leah's concerns, I directed the independent practitioners in the Health and Medical Investigation Team of the Coroners Prevention Unit (CPU) to review the medical care Neil received in the days leading up to his passing.
26. The CPU<sup>8</sup> is a team made up of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.
27. A review of the available evidence indicates that Nicole's disease was progressive and non-preventable. Many of the issues identified by Nicole's mother including difficulties with cannulation, cannula's becoming non-functional and Nicole being distressed with treatment, are a reflection of the underlying pathology, rather than poor treatment. With respect to other concerns noted including staff changeover and the use of multidisciplinary teams, these are a function of hospital administration and operations.
28. Dr Peter Iser (Barwon Health) provided a statement to which detailed the efforts that Barwon Health undertook to treat the issues that Nicole was diagnosed with.<sup>9</sup> In relation to the concerns about the cessation of the diazepam and seizures, while diazepam 5mg was stopped

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<sup>8</sup> The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

<sup>9</sup> Statement of Dr Peter Iser dated 5 November 2025.

another benzodiazepine (clonazepam 0.5mg - which is as potent as diazepam 5mg) twice a day was commenced as was another antiepileptic - all under the care of the neurology team. This was noted as being successful by the treatment team.<sup>10</sup>

29. Ultimately, the CPU formed the view that there was no misdiagnosis or mistreatment that caused this death.

## FINDINGS AND CONCLUSION

30. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.<sup>11</sup> Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
31. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Nicole Jennifer Kateiva, born 30 July 1985;
  - b) the death occurred on 31 May 2025 at Barwon Health, Bellerine Street, Geelong, Victoria 3220, from 1(a) RESPIRATORY FAILURE IN THE SETTING OF ASPIRATION PNEUMONIA IN A WOMAN WITH ARTHROGRYPOSIS MULTIPLEX CONGENITA, INTELLECTUAL IMPAIRMENT AND EPILEPSY; and
  - c) the death occurred in the circumstances described above.
32. Having considered all of the circumstances, I am satisfied that Nicole's care was reasonable and appropriate at all material times.
33. As Nicole was residing in Specialist Disability Accommodation at the time of her passing, her death is considered to be '*in care*' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.<sup>12</sup> I am satisfied by the available evidence that Nicole's

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<sup>10</sup> Ibid.

<sup>11</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'

<sup>12</sup> Section 52(2) of the Act.

death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

34. I convey my sincere condolences to Nicole's family for their loss.

35. 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:

Leah Kateiva & Mr Algirdas Kateiva, Senior Next of Kin

Barwon Health

Kate Cooch, Moray & Agnew Lawyers

Daniel Maroske, Gadens Lawyers

Senior Constable Cassandra D'Alessandro, Coronial Investigator

Signature:



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Coroner Simon McGregor

Date: 12 March 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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