



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2026 000084**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

|                 |                                                                                |
|-----------------|--------------------------------------------------------------------------------|
| Findings of:    | Coroner Simon McGregor                                                         |
| Deceased:       | Mary Kuliveovski                                                               |
| Date of birth:  | 4 October 1960                                                                 |
| Date of death:  | 5 January 2026                                                                 |
| Cause of death: | 1a : DECOMPENSATED HEART FAILURE<br>AND PNEUMONIA<br>2 : WHO CLASS III OBESITY |
| Place of death: | Casey Hospital<br>62-70 Kangan Drive<br>Berwick Victoria 3806                  |
| Keywords:       | In care; Specialist Disability Accommodation;<br>SDA resident; Natural causes  |

## INTRODUCTION

1. On 5 January 2026, Mary Kuliveovski was 65 years old when she passed away at Casey Hospital. At the time of her death, Mary lived alone at 9 Curzon Street, Clyde North, Victoria, 3978.
2. Mary grew up in the eastern suburbs of Melbourne with her brother, Victor. After completing her schooling, she did some administrative work for the family business and mainly worked from home.<sup>1</sup> Mary had had significant weight management issues since childhood and later developed chronic Lymphedema and Lipedema.
3. In 2021, Mary moved into residential care following a fall at home and suffering from a broken bones in her leg.<sup>2</sup>
4. In the period leading up to her death, Mary was relocated to an SDA dwelling operated by Magical Care. While in care, she received support services through the National Disability Insurance Scheme (**NDIS**) for all personal activities and daily living until her passing.

## THE CORONIAL INVESTIGATION

5. Mary'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 Mary was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling<sup>3</sup> at the time of her death, her passing was determined to be 'in care' 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

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<sup>1</sup> *Coronial Brief*, Statements of Victor Kuliveovski and Leanne Vassallo.

<sup>2</sup> *Ibid.*

<sup>3</sup> See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

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 Stuart Tweddle to be the Coronial Investigator for the investigation of Mary'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 Mary Kuliveovski 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>4</sup>
11. In considering the issues associated with this finding, I have been mindful of Mary'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.

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

### **Circumstances in which the death occurred**

12. On 4 January 2026, Mary experienced a collapse at her residential home in North Clyde and was transported to the Casey Hospital Emergency Department at 9:32 pm. Mary was diagnosed with respiratory failure due to chest sepsis and was treated with antibiotics. Mary was placed on non-invasive ventilation to assist with her oxygen levels but developed severe coagulopathy and acute renal failure from sepsis.

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<sup>4</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.

13. Mary's treating medical team confirmed that she had respiratory failure from a presumed infection and had pre-existing heart failure.<sup>5</sup>
14. On 5 January 2026, Mary condition deteriorated and it was determined that she would not survive, she was transitioned to palliative care and passed at 2:10 am.<sup>6</sup>

### **Identity of the deceased**

15. On 13 January 2026, Mary Kuliveovski, born 4 October 1960, was visually identified by their sibling, Victor Kuliveovski.
16. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

17. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 7 January 2026 and provided a written report of his findings dated 15 January 2026.
18. There were no remarkable findings noted from the external examination.
19. Dr Beer provided an opinion that the medical cause of death was 1(a) DECOMPENSATED HEART FAILURE AND PNEUMONIA in the setting of 2 WHO CLASS III OBESITY and I accept his opinion.

### **FINDINGS AND CONCLUSION**

20. 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>7</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.

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<sup>5</sup> *Coronial Brief*, Statement of Dr Nathan Bushby.

<sup>6</sup> *Ibid.*

<sup>7</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

21. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Mary Kuliveovski, born 4 October 1960;
  - b) the death occurred on 5 January 2026 at Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria, 3806, from 1(a) DECOMPENSATED HEART FAILURE AND PNEUMONIA secondary to 2 WHO CLASS III OBESITY; and
  - c) the death occurred in the circumstances described above.
22. Having considered all of the circumstances, I am satisfied that Mary’s care was reasonable and appropriate at all material times.
23. As Mary 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>8</sup> I am satisfied by the available evidence that Mary’s death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Mary’s family for their loss.

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reasonable satisfaction of the tribunal. In such matters “reasonable satisfaction” should not be produced by inexact proofs, indefinite testimony, or indirect inferences...’.

<sup>8</sup> Section 52(2) of the Act.

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:

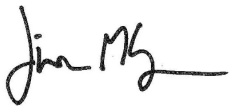
Victor Kuliveovski, Senior Next of Kin

Anand Ponniraivan, Monash Health

Dr Chin Wei Ch'ng, Casey Hospital

Senior Constable Stuart Tweddle, Coronial Investigator

Signature:



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Coroner Simon McGregor

Date: 02 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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