IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000291

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Katherina Bitzios
Date of birth:	4/07/1969
Date of death:	14/01/2024
Cause of death:	1(a) Respiratory failure 1(b) Pneumonia 1(c) Multiple sclerosis
Place of death:	Cabrini Malvern, 181/183 Wattletree Road, Malvern Victoria 3144
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 14 January 2024, Katherina Bitzios (**Kathy**) was 54 years old when she died at Cabrini Malvern, 181/183 Wattletree Road, Malvern Victoria 3144.

2. At the time of her death, Kathy resided at McKinnon House, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Kathy received funded daily independent living support due to her diagnosis of multiple sclerosis.

3. Kathy previously lived with her mother, who was her full-time carer, however she passed away in 2016. Kathy's brother, Jim, organised for her to move into McKinnon House, which specialises in care for women with multiple sclerosis. Kathy's other medical conditions included neurogenic bladder, suprapubic catheter, hypertension, recurrent urinary tract infections, heel ulcers, type two diabetes and diabetic neuropathy.

THE CORONIAL INVESTIGATION

4. Kathy's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

5. 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.

6. 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

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. This finding draws on the totality of the coronial investigation into the death of Katherina Bitzios. 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.[2]

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

Circumstances in which the death occurred

8. On 10 January 2024, staff at McKinnon House observed that Kathy was experiencing difficulty breathing and vomited earlier that day, which was unusual. They called an ambulance, and she was transferred to Cabrini Hospital Malvern.

9. Kathy was admitted to a medical ward on 11 January 2024 where she experienced a Medical Emergency Team (**MET**) call due to hypoxia. Investigations confirmed she was not experiencing a pulmonary embolism; however, she was transferred to the intensive care unit to facilitate high flow nasal oxygen.

10. Over the following two days, Kathy's condition showed minimal improvement. Following discussions with Kathy's brother, Jim, she was transitioned to comfort care. Kathy passed away on the evening of 14 January 2024.

Identity of the deceased

11. On 14 January 2024, Katherina Bitzios (also known as Kathy), born 4 July 1969, was visually identified by her brother, Jim Bitzios.

12. Identity is not in dispute and requires no further investigation.

[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.

Medical cause of death

13. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 17 January 2024 and provided a written report of his findings dated 18 January 2024.

14. The post-mortem examination revealed bilateral pleural effusions and increased lung markings.

15. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

16. Dr Burke provided an opinion that the medical cause of death was 1(a) rspiratory failure secondary to 1(b) pneumonia, due to 1(c) multiple sclerosis

17. Dr Burke provided an opinion that the cause of death was due to natural causes.

18. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

19. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:

    a) the identity of the deceased was Katherina Bitzios, born 4/07/1969;

    b) the death occurred on 14 January 2024 at Cabrini Malvern, 181/183 Wattletree Road, Malvern, Victoria 3144 from respiratory failure secondary to pneumonia, due to multiple sclerosis; and

    c) the death occurred in the circumstances described above.

20. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Cabrini Malvern, that caused or contributed to Kathy's death.

21. Having considered all the available evidence, I find that Kathy's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Kathy's death in chambers.

I convey my sincere condolences to Kathy's family, friends and carers 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:

Jim Bitzios, Senior Next of Kin

Cabrini Health

First Constable Abagail Thomas, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 31 July 2025

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.