IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002947

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Shane Michael Kelly
Date of birth:	28 September 1958
Date of death:	27 May 2024
Cause of death:	1a : ASPIRATION PNEUMONIA COMPLICATING UROSEPSIS IN SETTING OF NEPHROLITHIASIS AND CEREBRAL PALSY
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004
Keywords:	Disability; In care death; Natural causes

INTRODUCTION

1. On 27 May 2024, Shane Michael Kelly was 65 years old when he passed from natural causes in the Alfred Hospital. Shane was living in care prior to his hospitalisation at 184 Grange Road, Carnegie, Victoria, 3163.

2. Although Shane had suffered from Cerebral Palsy since birth, requiring full time care provided most recently by Yooralla at Grange Road, he lived as full a life as his disability allowed, both founding and working tirelessly as an advocate for people with disabilities, and being awarded the Australian Distinguished Service medal.[1]

3. He had been under the care of Dr Mehandran since 9 August 2001. His recent medical history involved episodes of pneumonia in 2021 and 2022, then he suffered from urine retention and urinary tract infections arising from his use of a catheter during 2023.[2]

4. In April 2024, he started a six week trial without a catheter to reassess his bladder function.[3]

5. As a further part of his care programme he had completed a "making choices at meal times consent form" back on 25 July 2023 in which he chose not to adhere to the recommendations of his speech pathologist regarding a modified diet, and this choice was appropriately respected by his carers.[4]

THE CORONIAL INVESTIGATION

6. Shane'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.

7. 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. Because Shane was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling at the time of his death, her passing was determined to be 'in care'[5] and, as such, is subject to a mandatory inquest, pursuant to section 52(2) of the Act.

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[1] Statement of Roger Kelly, Coronial Brief.
[2] Statement of Dr Mehandran, Coronial Brief.
[3] Statement of Dr Hancock, Coronial Brief.
[4] Statement of Wilhelmina de la Ferte and Attachment 3, Coronial Brief.
[5] Regulation 7(d) of the *Coroners Regulations 2019* (Vic).

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Shane'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.

11. This finding draws on the totality of the coronial investigation into the death of Shane Michael Kelly 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.[6]

12. In considering the issues associated with this finding, I have been mindful of Shane'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.

[6] 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

13. On the morning of 20 May 2024, staff noticed that Shane looked unwell and the decision was made to transfer him to the Alfred Hospital.[7]

14. Shane's long subsequent period of hospitalisation shows that the significant delay in arranging transport that Ambulance Victoria experienced due to other operational constraints did not contribute to the death in any way.[8] He was promptly diagnosed on arrival with an infected kidney stone which, despite the best efforts of the medical staff, became septic and aspirated into his lungs. These were known risks of his medical conditions.[9]

15. Across the next few days, no improvements were noted after the administration of both oxygen and intravenous antibiotics, so after discussions with Shane's brother,[10] he was managed into palliative care and passed at 12.40 am on 27 May 2024.

Identity of the deceased

16. On 29 May 2024, Shane Michael Kelly, born 28 September 1958, was visually identified by his brother, Roger Kelly. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 3 June 2024 and provided a written report of his findings dated that same day.

18. The post-mortem CT scan confirmed cerebral atrophy, bilateral pneumonic change and a left ureteric stent, and no other findings that were inconsistent with his medical history.

19. In light of this level of certainty, I did not order toxicological analysis.

20. Dr Lynch provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA COMPLICATING UROSEPSIS IN SETTING OF NEPHROLITHIASIS AND CEREBRAL PALSY, and I accept his opinion.

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[7] Statement of Wilhelmina de la Ferte, Coronial Brief.
[8] Grange Road Incident Report dated 20/5/2024, Coronial Brief.
[9] Statement of Dr Hancock, Coronial Brief.
[10] Statement of Roger Kelly, Coronial Brief.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Shane Michael Kelly, born 28 September 1958;

    b) the death occurred on 27 May 2024 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from 1(a) ASPIRATION PNEUMONIA COMPLICATING UROSEPSIS IN SETTING OF NEPHROLITHIASIS AND CEREBRAL PALSY; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Shane'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.

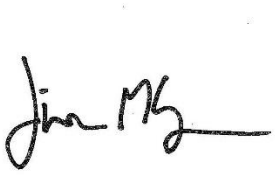
I direct that a copy of this finding be provided to the following:

Roger Kelly, Senior Next of Kin

Paige Edwards & Mitsi Blazos, Alfred Hospital

Senior Constable Dean Herskope, Coronial Investigator

Signature:



Date: 24 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.