IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003574

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Christine Klofa
Date of birth:	17 June 1977
Date of death:	22 June 2024
Cause of death:	1(a) Mycoplasma pneumonia 1(b) Rhinovirus infection Contributing factors Down syndrome
Place of death:	Frankston Hospital 2 Hastings Road Frankston Victoria 3199
Keywords:	In care, natural causes, disability care, aspiration pneumonia, Down syndrome

INTRODUCTION

1. On 22 June 2024, Christine Klofa was 47 years old when she died in hospital. At the time, Ms Klofa lived in Moorabbin, Victoria.

2. For over 15 years, Ms Klofa lived in supported accommodation provided by Able Australia. She had diagnoses of Down syndrome, congenital heart disease with surgical repair, cardiac failure with fluid retention, deafness, and obesity.

3. Ms Klofa attended day programs five days a week and received 24-hour care. She had limited mobility, often using a wheelchair. Nonetheless she exercised independence in her daily living but still required assistance and prompting for some tasks.

4. Ms Klofa enjoyed being creative, including baking and crafts. She enjoyed being pampered, getting her nails painted and having a long evening bath. She liked dancing and music, particularly Disney musicals and movies.

5. Ms Klofa's parents, Sadia and Stan, and brother, Greg, had passed away in 2022 and 2023, respectively. She was in contact with her sister-in-law, Sarah Klofa (**Ms Sarah Klofa**), who liaised with Able Australia and would often visit her.

THE CORONIAL INVESTIGATION

6. Although Ms Klofa died on 22 June 2024, her death was not reported to the Coroners Court of Victoria until 26 June 2024. On that date, staff from Peninsula Health notified the Court that Ms Klofa's death may have been a reportable death pursuant to the Coroners Act 2008 (**the Act**).

7. Generally, reportable deaths are those deaths which are unexpected, unnatural or violent or result from accident or injury. However, in the case of a person such as Ms Klofa who was placed in care immediately before death, the death is reportable irrespective of the cause of death, even if it appears to have been from natural causes.[2]

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 Ms Klofa'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 Ms Klofa 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.[1]

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

Identity of the deceased

12. Ms Klofa's identity is not in dispute and requires no investigation.

Medical cause of death

13. On 22 June 2024, Dr Evan Mylonas of Peninsula Health completed a Medical Certificate of Cause of Death (**MCCD**) specifying that Ms Klofa had died of mycoplasma pneumonia with rhinovirus infection listed as an antecedent cause of death and Down syndrome as a significant condition contributing to the death.

14. As Ms Klofa's death was not reported to the Court until four days after her death by which time she had been cremated. Thus a post-mortem CT examination of her body, external examination or autopsy of her body and/or toxicology analysis could not be undertaken as would generally occur.

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

15. I note that Dr Melanie Archer of Victorian Institute of Forensic Medicine, reviewed the MCCD and Ms Klofa's medical records and advised the cause of death was reasonable and appropriate and did not require any changes to be made.

16. I accept Dr Archer's opinion.

17. Based on the above information, I am satisfied that Ms Klofa's cause of death was *"1(a) Mycoplasma pneumonia*" secondary to *"1(b) Rhinovirus infection"* with *2 Down syndrome* noted as a contributing factor.

Circumstances in which the death occurred

18. On 2 June 2024, Mr Klofa's carer noticed she was coughing and had a runny nose. The carer organised a general practitioner (**GP**) appointment for the following days.

19. On 6 June 2024, the GP reviewed Ms Klofa and determined she was not systemically unwell, with normal oxygen saturation, heart rate and temperature. The GP prescribed a course of antibiotics, amoxicillin, to treat a *'possible emerging lower respiratory tract infection'.*

20. On 12 June 2024, Ms Klofa re-visited the GP to discuss recent chest x-ray results, which demonstrated pneumonia. Since Ms Klofa was increasingly unwell – including fatigue, shortness of breath, coughing and wheezing – the GP referred her to the emergency department of Monash Medical Centre.

21. Upon arrival at Monash Medial Centre emergency department, Ms Klofa was short of breath, had an oxygen saturation of 91% and an elevated heart rate of 107 beats per minute. She was admitted under the Respiratory Medicine team and over the next hour, deteriorated with laboured breathing and declining oxygen levels despite high flow oxygen. Ms Klofa became agitated which prevented clinicians from gaining intravenous access.

22. Clinicians sedated Ms Klofa in order to insert a cannula and intubate her. She received ongoing treatment including intravenous antibiotics and fluids. Blood tests revealed she had mild anaemia, mild renal (kidney) impairment and a very elevated c-reactive protein (**CRP**, a marker of infection or inflammation.

23. At this time, there were no beds available in the Intensive Care Unit and alternatives were sought. The Intensive Care Unit at Frankston Hospital accepted Ms Klofa with arrangements made for her transfer early on the morning of 13 June 2024, via Adult Retrieval Victoria.

24. Frankston Hospital clinicians spoke with Ms Sarah Klofa who explained that Ms Klofa's health had been declining in the preceding months. Ms Klofa previously expressed to her brother that she would not want to be supported with mechanical ventilation for a prolonged period of time in the interest of preserving her quality of life.

25. It was evident to clinicians that Ms Klofa's pneumonia was very severe and required a high level of ventilatory support. On 21 June 2024, together with Ms Klofa, clinicians decided to extubate Ms Klofa with the understanding that if she deteriorated, care would be redirected to comfort focused therapies.

26. Following extubation, Ms Klofa's condition further declined and on 22 June 2024, she died with Ms Sarah Klofa nearby.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Christine Klofa, born 17 June 1977;

    b) the death occurred on 22 June 2024 at Frankston Hospital 2 Hastings Road, Frankston Victoria 3199;

    c) the cause of Ms Klofa's death was mycoplasma pneumonia secondary to rhinovirus infection, with a significant contributing condition of Down syndrome; and

    d) the death occurred in the circumstances described above.

28. On the basis that Ms Klofa's death was due to natural causes, and that the care provided to her was reasonable and appropriate, I have determined that it is appropriate to finalise this investigation without an inquest pursuant to section 52(3A) of the Act.

I convey my sincere condolences to Ms Klofa'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:

Sarah Klofa

Peninsula Health

Senior Constable Rachel Clark, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 20 August 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.