IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005697

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended on 28 July 2025 pursuant to section 76 of the **Coroners Act 2008** **

Findings of:	Coroner Simon McGregor
Deceased:	Ann Williams
Date of birth:	14 November 1952
Date of death:	28 September 2024
Cause of death:	1a : ASPIRATION PNEUMONIA COMPLICATING DYSPHAGIA AND STATUS EPILEPTICUS
Place of death:	Frankston Hospital 2 Hastings Road Frankston Victoria 3199
Keywords:	SDA resident; Death in care; Disability

* Paragraph 16 was amended to correct the stated familial relationship.

INTRODUCTION

1. On 28 September 2024, Ann Williams was 71 years old when she died of natural causes whilst living in care at 242 Jetty Road, Rosebud, Victoria, 3939.

2. Ann suffered from multiple medical issues since her earliest days. In particular, her inability to speak coherently meant she could not attend primary school, nor mix with other children. She attended a special school in Frankston in the 1960s, and moved into full time care during her teenage years as her parents aged.[1]

3. In 1996, she moved into her current accommodation, and when her father died in 1998, her first cousin, Mr Robert Parker, oversaw her welfare and maintained his visiting programme. Mr. Parker observed that although she missed both her parents, Ann's quality of life otherwise drastically improved at this facility.[2]

4. From time to time she was admitted to both Rosebud and Frankston hospitals for various documented medical conditions, including a history of multiple chest infections over the last seven years. Ann also had a medical history of severe intellectual disability, anxiety, lymphoedema, Milroy's disease, severe bilateral osteoarthritis, atrial fibrillation, aspirational pneumonia, Coeliac's disease, a total hip replacement in 2011 and a sigmoidoscopy.[3]

5. Under the supervision of Melbourne Support Services Area General Manager, Mr Kelvin Kamara, Ann was receiving appropriate speech pathology, meal time assistance, dysphagia management, falls management and miscellaneous other interventions, care and activity routines. [4]

THE CORONIAL INVESTIGATION

6. Ann'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.

[1] Statement of Robert Parker, *Coronial Brief.*
[2] Ibid.
[3] Statement of Dr John Liu, *Coronial Brief.*
[4] Statement of Kelvin Kamara and Exhibit 1, *Coronial Brief.*

7. Because Ann resided in a Specialist Disability Accommodation enrolled dwelling at the time of her death, her passing was deemed to be 'in care'[5] and, as such, is subject to a mandatory inquest, pursuant to section 52(2) of the Act.

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 Ann's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinician 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 Ann Williams 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 Ann'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.

[5] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

[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. Ann's carers noted that she was unusually sleepy on the 21 September 2024 whereupon her GP prescribed her with antibiotics and recommended close monitoring.[7] By the 24 September 2024, at 8:41 pm, Ann had showed no improvements so was presented by staff to Frankston Hospital's emergency department with progressive acute respiratory symptoms in the setting of chronic dysphagia. She was treated for pneumonia, but experienced atrial flutter complications and seizures. A subsequent CT scan showed that she had suffered a stroke with the possibility of cancer behind both her eyes.[8]

14. When she continued to deteriorate, she was transitioned to end of life care after consultation with Mr. Parker and passed peacefully at 4:30 am on the 28 September 2024. [9]

15. More than twenty past and present carers attended Ann's funeral.[10]

Identity of the deceased

16. On 29 September 2024, Ann Williams, born 14 November 1952, was visually identified by her counsin Robert Parker. 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 examination on 1 October 2024 and provided a written report of his/her/their findings dated 7 October 2024.

18. Both the examination and the postmortem CT scan were consistent with the history and treatment described in the medical deposition of Dr Thomas Saxton dated 29 September 2024.

19. In these circumstances, toxicological analysis of post-mortem samples was not required.

20. Dr Lynch provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA COMPLICATING DYSPHAGIA AND STATUS EPILEPTICUS, and I accept his opinion.

---

[7] Statement of Kelvin Kamara, *Coronial Brief.*
[8] Medical Deposition of Dr Thomas Saxton, Statement of Kelvin Kamara and Patient Health Summary, *Coronial Brief.*
[9] Ibid.
[10] Ibid.

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 Ann Williams, born 14 November 1952;

    b) the death occurred on 28 September 2024 at Frankston Hospital, 2 Hastings Road Frankston, Victoria, 3199, from 1(a) ASPIRATION PNEUMONIA COMPLICATING DYSPHAGIA AND STATUS EPILEPTICUS; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ann'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.

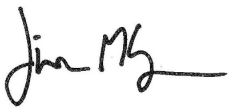
I direct that a copy of this finding be provided to the following:

Robert Parker, Senior Next of Kin

Kathleen Jansen, Peninsula Health

Senior Constable Timothy Taylor, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 28 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.