IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 007447

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:	Helena Krystofowicz
Date of birth:	18 August 1961
Date of death:	25 December 2024
Cause of death:	1(a) Left lower lobe pneumonia and bronchopneumonia Contributing factors Trisomy 21 with dementia, asthma
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria
Key words:	In care, pneumonia, bronchopneumonia, palliative care, SDA resident

INTRODUCTION

1. On 25 December 2024, Helena Krystofowicz was 63 years old when she died at Box Hill Hospital. At the time, Ms Krystofowicz lived in specialist disability accommodation (**SDA**), provided by Alkira Disability Services (**Alkira**), in Nunawading.

2. Ms Krystofowicz was diagnosed with trisomy 21 at birth and was minimally verbal. At the time of her death, she was receiving funding through the National Disability Insurance Scheme (**NDIS**).

3. Ms Krystofowicz enjoyed op shopping, watching movies, and doing arts and crafts. She was described by her cousin, Wilhelmina (Wendy) McAdam, as a caring, happy, and loving person. Mrs McAdam would visit Ms Krystofowicz weekly until Mrs McAdam moved to Queensland, her visits then became monthly.

4. In her SDA, Ms Krystofowicz was supported by full-time carers and a housing coordinator, as well as a supervisor from the NDIS who was responsible for her care plan.

5. Ms Krystofowicz's medical history included epilepsy, recurrent aspiration pneumonia, asthma, coeliac disease, gastro-oesophageal disease, hepatitis C, hyperthyroidism, osteoporosis, inflammatory bowel disease, urinary and faecal incontinence, traumatic subarachnoid haemorrhage resulting from a fall, and dementia.

6. According to Mrs McAdam, Ms Krystofowicz's health declined in the 24 months prior to her death. Her dementia was deteriorating, and she had several instances of pneumonia. Between July and December 2024, Ms Krystofowicz was hospitalised on several occasions for falls, aspiration pneumonia, seizures, breathing difficulties, fever, lethargy, weakness, and drowsiness.

7. On 11 August 2024, Alkira staff contacted emergency services as Ms Krystofowicz appeared to be deteriorating. They were advised that she should see her general practitioner (**GP**). Ms Krystofowicz was assessed by a GP from Forest Hill Medical Centre who expressed concern for her lack of improvement and suspected pneumonia, which could lead to chest-related sepsis. On 14 August 2024, Ms Krystofowicz attended Box Hill Hospital for a likely viral chest infection. Whilst waiting for assessment, Ms Krystofowicz fell off a couch whilst sleeping and struck her head. She reportedly experienced a brain bleed as a result of this incident.

8. Ms Krystofowicz's NDIS funding did not increase as her needs increased, and her carers expressed concern that her funding was insufficient to cover her changing needs. Alkira staff considered that Ms Krystofowicz required a move to alternative accommodation to better meet her care needs, but she did not have enough funding to facilitate this move.

THE CORONIAL INVESTIGATION

9. Ms Krystofowicz's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

10. 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.

11. 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.

12. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Krystofowicz'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.

13. This finding draws on the totality of the coronial investigation into Ms Krystofowicz's death, 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.[2]

---

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

[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.

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

Identity of the deceased

14. On 25 December 2024, Helena Krystofowicz, born 18 August 1961, was visually identified by her cousin, Ronald A'speculo, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

16. Forensic Pathologist, Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 27 December 2024 and provided a written report of her findings dated 30 December 2024.

17. The post-mortem examination revealed features as per the clinic history. External examination did not show evidence of an injury of a nature that would likely have caused or contributed to death.

18. A post-mortem computerised tomography (**CT**) scan showed changes of lobar and bronchopneumonia, calcification of the basal ganglia, cerebral atrophy, and bilateral pulmonary consolidation which was patchy in the right lung and accompanied by lobar left lower lobe consolidation.

19. Toxicological analysis of samples was not performed and considered unnecessary for this matter.

20. Dr Glengarry provided an opinion that the medical cause of death was *"1(a) Left lower lobe pneumonia and bronchopneumonia"*. Including "*2 Trisomy 21 with dementia, asthma"* as contributing factors.

21. Dr Glengarry concluded Ms Krystofowicz died from natural causes.

22. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

23. On 3 December 2024, Ms Krystofowicz was admitted to Box Hill Hospital for acute changes in behaviour, including increased drowsiness and confusion, as her GP had concerns of delirium.

24. On 16 December 2024, Ms Krystofowicz was discharged to the NDIS ward at Wantirna Health while she awaited NDIS re-assessment in light of her increased needs. While on the ward, Ms Krystofowicz was initially doing well physically and mentally. Hospital staff were in daily contact with Alkira staff regarding Ms Krystofowicz's condition. On 20 December 2024, Alkira staff were notified that Ms Krystofowicz was doing fine, although she was not mobilising very much.

25. On 23 December 2024, Ms Krystofowicz was transferred back to Box Hill ED for acute deterioration in the setting of sepsis secondary to chest infection. She was treated with Ventolin, intravenous ceftriaxone and azithromycin, hydrocortisone, aramine, and intravenous fluids. Her chest x-ray indicated severe pneumonia. Despite treatment, Ms Krystofowicz still presented with hypotension and treating doctors formed the impression that Ms Krystofowicz was dying.

26. Doctors consulted with Akira staff to determine if Ms Krystofowicz had a medical decision maker in place and/or an end-of-life plan. They were advised to discuss these matters with Mrs McAdam. Hospital staff informed Mrs McAdam of Ms Krystofowicz's deterioration and her transition to palliative care.

27. Later that afternoon, Ms Krystofowicz was transferred to the ward and palliative care was commenced.

28. Ms Krystofowicz was kept comfortable until she passed away on 25 December 2024 at 6.31am.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Helena Krystofowicz, born 18 August 1961;

    (b) the death occurred on 25 December 2024 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria;

(c) the cause of Ms Krystofowicz's death was left lower lobe pneumonia and bronchopneumonia with contributing factors of trisomy 21 with dementia, asthma;

(d) the death occurred in the circumstances described above;

(e) I am satisfied that immediately before her death, Ms Krystofowicz was a *'person placed in custody or care'* as defined in section 3 of the Act and that she died from natural causes; and

(f) I have accordingly exercised the discretion in section 52(3A) of the Act not to hold an inquest in relation to Ms Krystofowicz's death.

I convey my sincere condolences to Ms Krystofowicz'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:

Wilhelmina (Wendy) McAdam, senior next of kin
Eastern Health
Senior Constable Jason Lin, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 08 December 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.