IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000106

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Dorothy Boag
Date of birth:	20/01/1933
Date of death:	5/01/2025
Cause of death:	1a : ASPIRATION PNEUMONIA IN A WOMAN WITH MULTIPLE CO-MORBIDITIES
Place of death:	Western Health, Footscray Hospital 160 Gordon Street, Footscray, Victoria, 3011
Keywords:	In care, SDA resident, aspiration pneumonia, natural causes death

INTRODUCTION

1. On 5 January 2025, Ms Dorothy Boag **(Dorothy)** was 91 years old when she died at Footscray Hospital, (Western Health). She is survived by her niece, Ms Helen Cherry **(Helen)**.

2. Dorothy's medical history included stroke, moderate intellectual disability, hydrocephalus, chronic obstructive pulmonary disease, congestive cardiac failure and schizophrenia.

3. At the time of her death, Dorothy was a Specialist Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 5 Batusrol Close, Sunbury. She received daily independent living support from disability service provider, Possability Victoria.

4. Dorothy required varying levels of support for all her activities of daily living. Possability Operations Manager Jacqueline McSparron **(Ms McSparron)** noted that Dorothy enjoyed watching television, listening to music and generally engaging in conversations with those around her.

5. Dorothy's general health was monitored by her General Practitioner Dr Himani Abeyratne. She was seen by the GP approximately fortnightly, or more as required. Ms McSparron noted that a swallow assessment and mealtime review were undertaken by a speech pathologist on 28 May 2024. The results of the assessment indicated ongoing moderate oropharyngeal dysphagia. It was recommended that Dorothy continue a puree diet (Level 4) and thick fluids (Level 3) as per the International Dysphagia Diet Standardisation Initiative guidelines.

THE CORONIAL INVESTIGATION

6. Dorothy'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.

[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).

7. 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.

8. 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.

9. This finding draws on the totality of the coronial investigation into the death of Dorothy Boag 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]

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

Circumstances in which the death occurred

10. On the evening of 29 December 2024, Dorothy was observed to be struggling to breathe, coughing and gasping for air. A GP had attended the day prior and commenced Dorothy on treatment for a suspected chest infection. An ambulance was called, and Dorothy was subsequently admitted to Footscray Hospital.

11. Upon assessment, it was determined that Dorothy had aspiration pneumonia. Her symptoms included a three-day productive cough and shortness of breath. It was also noted that Dorothy had a slow decline in her swallowing and speech over the past few weeks to months.

12. Western Health Consultant Geriatrician Dr Nicholas Sze Ee Voon provided a statement to the Court and noted that Dorothy was commenced on intravenous antibiotics and reviewed by a speech pathologist. The speech pathologist could not recommend any safe diet or fluids as Dorothy was aphagic and not managing secretions.

[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.

13. Following discussions with Helen, it was indicated that Dorothy had at least a six-month decline with progression of her dysphagia and dysarthria evident. Despite the appropriate medical therapy, Dorothy continued to deteriorate in hospital.

14. Following discussions between the treating team and Helen, it was determined to transition Dorthy to comfort case. Dorothy passed away peacefully on 5 January at 10.02pm.

15. A Medical Certificate Cause of Death was provided, with the cause of death being aspiration pneumonia with antecedent causes of cerebrovascular accident and emphysema.

Identity of the deceased

16. On 6 January 2025, Dorothy Boag, born 20 January 1933, was visually identified by her niece, Helen Cherry.

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

Medical cause of death

18. Forensic Pathologist Dr Gergory Young from the Victorian Institute of Forensic Medicine conducted an external examination on 8 January 2025 and provided a written report of his findings dated 31 March 2025.

19. The post-mortem examination revealed no *unexpected* signs of trauma. A post-mortem CT scan showed patchy lung changes, coronary artery calcification and dilated ventricles in brain. No other significant pathology was identified. Toxicological analysis of blood was not performed

20. Dr Young provided an opinion that the medical cause of death was *1(a) Aspiration pneumonia in a woman with multiple co-morbidities.*

21. Aspiration pneumonia is infection of the lungs that occurs after inhaling (aspirating) foreign material, such as food or vomitus. Dorothy had multiple risk factors for the development of aspiration pneumonia, based on her pre-existing disease processes including stroke, chronic obstructive pulmonary disease and schizophrenia. Dr Young provided an opinion that the cause of death was due to natural causes.

22. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dorothy Boag, born 20 January1933;

    b) the death occurred on 5 January 2025 at Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011, from aspiration pneumonia in a woman with multiple co-morbidities; and;

    c) the death occurred in the circumstances described above.

24. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Dorothy died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

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:

Helen Cherry, Senior Next of Kin

Jacqueline McSparron, Possability Victoria

Georgia Astrand-Ferris, Western Health (Footscray Hospital)

National Disability Insurance Agency

First Constable Kristie-Lee Drake, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 20 August 2026

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.