



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2025
001545**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	William Thomas Kerby
Date of birth:	28 December 1944
Date of death:	22 March 2025
Cause of death:	1a: Pneumonia in a man with multiple medical comorbidities
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084

INTRODUCTION

1. On 22 March 2025, William Thomas Kerby was 80 years old when he died at the Austin Hospital.
2. At the time of his death, William lived at a Specialist Disability Accommodation (SDA) dwelling in Reservoir. William received funded daily independent living support due to his intellectual disability, epilepsy and bipolar disorder, which was provided by disability service provider Aruma and funded by the Commonwealth Continuity of Support Programme.
3. William was affectionately known to his family as Bill. He was a much-loved member of the family and is remembered as an intelligent man with a wicked sense of humour.

Background

4. William's mother Kathleen suffered from rubella while pregnant with William, which doctors believed caused his intellectual disability. He was non-verbal and displayed several behavioural issues.
5. At the age of 13, William moved into Kew Cottages as his parents were unable to safely care for him at home. He remained close with his family who visited him regularly.
6. At age 20, William moved to the Sunbury Training Centre, where he lived for 20 years. He was sadly assaulted on multiple occasions while living there. At age 40, he moved back to Kew Cottages.
7. At the age of 54, William moved to a home in Glenroy where he lived with five other residents and a full-time support staff.
8. William moved to his current home in Reservoir at the age of 70. He was initially still able bodied, but within 2-3 years his ability to walk deteriorated significantly and he was at risk of falls. In his later years he used a wheelchair, which frustrated him.
9. William had a regular history of pneumonia resulting in hospitalisation. His health deteriorated rapidly in January 2025. He was hospitalised in both January, for fluid overload, and February, for presumed aspiration pneumonia.

THE CORONIAL INVESTIGATION

10. William's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he 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 his 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.
11. 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.
12. 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.
13. This finding draws on the totality of the coronial investigation into the death of William Thomas Kerby. 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

14. William was well and settled throughout the day on 21 March 2025. He tolerated his food and fluids well and received all medication as charged.

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).

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.

15. At around 7pm evening, while being assisted to bed, William's carers noticed that he was experiencing shortness of breath. They called Triple Zero, and he was conveyed to the Austin Hospital by ambulance.
16. William was found to have community acquired pneumonia complicated by right moderate volume loculated pleural effusion. He was initially commenced on intravenous antibiotics and fluids, however his condition continued to deteriorate with evidence of organ failure.
17. Following discussions with his family, William was transitioned to comfort care and given palliative medications. He died on 23 March 2025.

Identity of the deceased

18. On 22 March 2025, William Thomas Kerby, born 28 December 1944, was visually identified by his sister, Diane Burrows, who completed a Statement of Identification.
19. Identity is not in dispute and requires no further investigation.

Medical cause of death

20. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of the body of William Kerby on 24 March 2025. Dr Fronczek considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan and E-Medical Deposition Form from the Austin Hospital and provided a written report of her findings dated 25 March 2025.
21. The findings at external examination were in keeping with the clinical history.
22. The CT scan showed right loculated pleural effusions, small left pleural effusion, bilateral lung consolidation, coronary artery calcifications and cardiomegaly.
23. Dr Fronczek provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) PNEUMONIA IN A MAN WITH MULTIPLE MEDICAL CO-MORBIDITIES.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was William Thomas Kerby, born 28 December 1944;

- b) the death occurred on 22 March 2025 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084;
 - c) I accept and adopt the medical cause of death ascribed by Dr Judith Fronczek and I find that William Thomas Kerby, a man with multiple comorbidities, died from pneumonia;
2. AND, the available evidence does not support a finding that there was any want of clinical management or care on the part of the Aruma or clinical staff at the Austin Hospital that caused or contributed to William Thomas Kerby's death.
3. AND FURTHER, having considered all the available evidence, I find that William Thomas Kerby's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation in chambers.

I convey my sincere condolences to William's family, friends and carers 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.

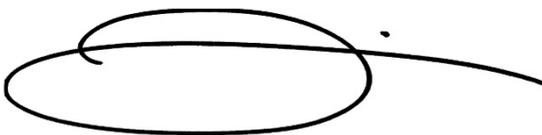
I direct that a copy of this finding be provided to the following:

Diane Burrows, Senior Next of Kin

Austin Health

Constable Ryan Carter, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 23 February 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.
