IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 002789

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Sarah Gebert
Deceased:	Lynn Maree Sturgess
Date of birth:	15 March 1960
Date of death:	22 May 2025
Cause of death:	1(a) Bronchopneumonia and rhinovirus infection in a woman with cerebral palsy and epilepsy (palliated)
Place of death:	Bendigo Health 100 Barnard Street Bendigo, Victoria
Key words:	*In care, SDA resident, bronchopneumonia, rhinovirus*

INTRODUCTION

1. On 22 May 2025, Lynn Maree Sturgess was 65 years old when she died in hospital following an illness.

2. At the time of her death, Lynn lived in supported disability accommodation in Bendigo with four other residents.

THE CORONIAL INVESTIGATION

3. Lynns'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.

4. 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.

5. 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.

6. Victoria Police assigned First Constable Michael Barry to be the Coroner's Investigator for the investigation of Lynn's death. The Coroner's 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.

7. In addition, I asked the Coroners Prevention Unit (**CPU**)[1] to investigate whether the medical care Lynn received in the lead up to her death was reasonable.

[1] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

8. This finding draws on the totality of the coronial investigation into Lynn'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]

Background

9. Lynn grew up in Castlemaine with her parents and four siblings. At 18 months old, she was diagnosed with cerebral palsy. Lynn's brother said she was very energetic growing up and developed her own shorthand and nicknames to communicate with her family. According to her brother, the limitations of Lynn's condition never affected her mood, and she was always involved in family functions.

10. Lynn mobilised using a manual wheelchair and required support for all daily living activities. She had epilepsy which was well managed with medication for over 30 years.

11. Lynn lived in the family home until she was about 30 years old, at which point she moved into supported disability accommodation operated by Scope (Aust) Limited. Lynn attended a social program, also run by Scope, where she participated in art and craft, swimming and shopping. She enjoyed going on day trips and meeting new people.

12. Lynn was a patient of Golden City Medical Clinic, where she was under the care of the same general practitioner for about 27 years. In her later years Lynn developed arthritis in her knees and hips, which led to increased falls and contributed to her physical decline.

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

Circumstances in which the death occurred

13. On 6 May 2025, Lynn was taken to Bendigo Hospital with right arm weakness and decreased responsiveness. She was assessed for stroke, which was negative, and sent home the same day with an assessment of possible progression of cerebral palsy.

14. On 7 May 2025, support staff observed Lynn to have general weakness, increased temperature a high heart rate. Lynn was transported by ambulance to Bendigo Hospital., where she was

[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.

admitted for treatment and monitoring. She was diagnosed with rhinovirus and hyponatremia, and the cause of her febrile illness was presumed to be bacterial bronchopneumonia. Over the coming days, Lynn was drowsy and did not take oral feeds.

15. On 11 May 2025, Lynn experienced increasing seizures and was admitted to the intensive care unit. Her treating team formed the impression that her seizures were a result of her febrile illness and missed anti-epileptic medication doses causing a low seizure threshold.

16. On 12 May 2026, following discussions with her family, Lynn was transitioned to comfort measures. On 16 May 2026, she was transferred to hospice.

17. Lynn's family visited her frequently throughout her admission. She passed away peacefully on 22 May 2025.

Identity of the deceased

18. On 22 May 2025, Lynn Maree Sturgess, born 15 March 1960, was visually identified by her sister, Julie Elliott.

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

Medical cause of death

20. Forensic Pathologist, Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 26 May 2025 and provided a written report of her findings dated 27 May 2025.

21. The post-mortem examination and computed tomography (**CT**) scan did not show any significant injuries that may have caused or contributed to death.

22. The post-mortem CT scan showed findings in keeping with bronchopneumonia.

23. Dr Zhou explained that viral infections, such as rhinovirus, increase the risk the risk of developing secondary bacterial infections.

24. Dr Zhou noted the clinical impression was that Lynn's seizures were subsequent to her febrile illness and missed anti-epileptic medication doses causing a lowered seizure threshold. Based on the information available to Dr Zhou, it was unclear why doses of Lynn's anti-epileptic medications were missed, or whether this was medically withheld.

25. Dr Zhou provided an opinion that the medical cause of death was *"1(a) Bronchopneumonia and rhinovirus infection in a woman with cerebral palsy and epilepsy (palliated)"*.

26. I accept Dr Zhou's opinion.

FURTHER INVESTIGATION

Coroners Prevention Unit review

27. In light of Dr Zhou's observations regarding Lynn's anti-epileptic medication, I obtained a statement from Bendigo Health regarding the treatment she received in the weeks leading up to her death. I referred this statement and Lynn's medical records to the CPU for review of how Lynn's anti-epileptic medication was managed.

28. The CPU explained that the medical records indicated that, on multiple previous hospital presentations, Lynn was known to decline oral medication due to experiencing drowsiness while she had an infection. On her final admission, the drowsiness continued longer than usual and Lynn started having seizures. The hospital commenced intravenous alternatives, but these were unsuccessful. Consistent with the wishes of Lynn's family, palliation was commenced.

29. As this approach had been successful in the past, and considering the family's wishes, the CPU concluded the care Lynn received was reasonable.

30. Following the CPU's review, VIFM Forensic Pathologist Dr Joanna Glengarry provided an opinion that Lynn's death was due to *natural causes*.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Lynn Maree Sturgess, born 15 March 1960;

    (b) the death occurred on 22 May 2025 at Bendigo Health, 100 Barnard Street, Bendigo, Victoria, from bronchopneumonia and rhinovirus infection in a woman with cerebral palsy and epilepsy (palliated); and

    (c) the death occurred in the circumstances described above.

I convey my sincere condolences to Lynn'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:

Terrence Sturgess, senior next of kin

Naomi Baquing, Scope (Aust) Ltd

Stacy Thackray, Bendigo Health

First Constable Michael Barry, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 25 June 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.