IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003153

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Melanie Ranken
Date of birth:	27 April 1992
Date of death:	28 May 2025
Cause of death:	Respiratory sepsis in a woman with an acquired brain injury
Place of death:	Grampians Health Ballarat 1 Drummond Street North Ballarat Central, Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 28 May 2025, Melanie Ranken was 33 years old when she passed away at Ballarat Base Hospital. At the time of her death, Ms Ranken lived in supported disability accommodation in Sebastopol. Her medical history included a traumatic brain injury sustained in a motor vehicle accident in 2017 and post-traumatic epilepsy.

THE CORONIAL INVESTIGATION

2. Ms Ranken's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] 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. Ms Ranken was a person in care at the time of her death and she was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Ms Ranken's death was from natural causes.

3. 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.

4. 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.

5. This finding draws on the totality of the coronial investigation into Ms Ranken's death, including information obtained from her health records and the National Disability Insurance Agency. While I have reviewed all the material, I will only refer to that which is directly

[1] A Medical Certificate of Cause of Death was initially completed by a medical practitioner and submitted to the Registry of Births, Deaths and Marriages. However, the case was subsequently referred to the Court by the Registry on the basis that it was a reportable death.

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

6. On 20 May 2025, Ms Ranken was transported to the Ballarat Base Hospital with severe with community acquired pneumonia. She was treated for severe respiratory sepsis with intravenous antibiotics. Her condition deteriorated and, in consultation with family, she was transitioned to comfort care. She passed away on 28 May 2025.

Identity of the deceased

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

Medical cause of death

8. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine conducted a preliminary examination and provided an opinion that the medical cause of death was *1(a) Respiratory sepsis in a woman with an acquired brain injury*. Further, she advised that the death was due to natural causes.

9. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Melanie Ranken, born 27 April 1992;

    b) the death occurred on 28 May 2025 at Grampians Health Ballarat, 1 Drummond Street North, Ballarat Central, Victoria, from respiratory sepsis in a woman with an acquired brain injury; and

    c) the death occurred in the circumstances described above.

[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.

11. As noted above, Ms Ranken's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Ranken died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into her death

I convey my sincere condolences to Ms Ranken'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.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following *"1(a) Respiratory sepsis in a woman with an acquired brain injury"*.

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

Alex Plucke, Senior Next of Kin

Signature:

Coroner David Ryan

Date: 22 August 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.