IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004518

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Jean Marrie Meuleman
Date of birth:	11 May 1974
Date of death:	3 August 2025
Cause of death:	1a: Complication of Parkinson's disease
Place of death:	59 Crole Drive Warragul Victoria 3820
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 3 August 2025, Jean Marrie Meuleman was 51 years old when she died in Warragul of natural causes.

2. At the time of her death, Jean resided at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). She received funded daily independent living support due to a diagnosis of Parkinson's disease, which was provided by disability service provider, Bright Access.

Background

3. Jean was born in Moe to Eric and Barbara. She had a normal upbringing and enjoyed reading, knitting, cooking and baking.

4. Jean was misdiagnosed with abdominal epilepsy in secondary school after her parents noticed that she was experiencing falls and her knees shook when she sat down.

5. After secondary school Jean studied horticulture at TAFE though could not complete the course due to having a fall. At this time Jean was living alone. When her parents became aware that she was unable to walk, they moved her back to their home.

6. Jean was diagnosed with Parkinson's disease in 2015. She continued living with her parents, assisted by carers, until 2020. Jean's Parkinson's disease had progressed, and she was wheelchair bound and required assistance for toileting and showering.

7. Jean first lived in a Bright Access home in Yarragon, before moving to her home in Warragul in December 2023. She was independent in her decision making. She enjoyed crosswords, crocheting and knitting items for charity.

THE CORONIAL INVESTIGATION

8. Jean'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

[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).

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.

9. The coroner must hold an inquest into the death of a 'person placed in custody or care', unless the coroner considers that the death is due to natural causes.[2] Even if the death is due to natural causes, the coroner is required to investigate the death and publish their findings.

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. This finding draws on the totality of the coronial investigation into the death of Jean Marrie Meuleman including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission. 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.[3]

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

Circumstances in which the death occurred

13. Jean's health began to decline in May 2025, and she spent eight days in hospital for severe faecal impaction with pseudo-obstruction of the bowel. Following her discharge on 20 May 2025, she began refusing to take her medication.

[2] Section 52(3A) of the *Coroners Act 2008* (Vic).

[3] 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.

14. In July 2025, Jean was admitted to palliative care at her home. Nurses visited daily and on 31 July 2025 she was commenced on a syringe driver for comfort. Her regular medications were ceased as she was unable to swallow.

15. At around 3pm on 3 August 2025, Jean died at home in the company of her parents.

Identity of the deceased

16. On 3 August 2025, Jean Marrie Meuleman, born 11 May 1974, was visually identified by her father, Eric Meuleman, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Jean Mueleman on 5 August 2025. Dr Ho considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and VIFM contact log and provided a written report of her findings dated 11 August 2025.

19. The findings at external examination and post mortem CT scan were consistent with the clinical history.

20. Dr Ho provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) COMPLICATION OF PARKINSON'S DISEASE.

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 Jean Marrie Meuleman, born 11 May 1974;

    b) the death occurred on 3 August 2025 at 59 Crole Drive, Warragul, Victoria 3820;

    c) I accept and adopt the medical cause of death ascribed by Dr Joanne Ho and I find that Jean Marrie Meuleman died from complications of Parkinson’s disease;

2. AND, there is no evidence before me that would warrant a finding that the care and management of Bright Access or clinical staff caused or contributed to the death of Jean Marrie Meuleman.

3. AND FURTHER, having considered all the available evidence, I find that Jean Marrie Meuleman'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 her death and to finalise the investigation of Jean's death in chambers.

I convey my sincere condolences to Jean's, friends and carers for their loss.

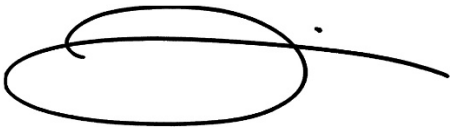
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Eric & Barbara Meuleman, Senior Next of Kin

Senior Constable Zack Donnellan, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 3 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.