



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004868

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

INQUEST INTO THE DEATH OF ANTHONY JOSEPH MOORE

Findings of:	Coroner David Ryan
Delivered on:	17 March 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	17 March 2026
Counsel Assisting the Coroner:	Dominique Cuschieri Coroners Court of Victoria
Keywords:	In care – fall – palliative care

INTRODUCTION

1. On 17 August 2025, Anthony Joseph Moore was 71 years old when he passed away at the Royal Melbourne Hospital (**RMH**). At the time of his death, he lived in Supported Disability Accommodation (**SDA**) operated by Scope (Aust) Ltd (**Scope**) in Kew Victoria. He lived in the house with four other residents and was cared for by staff employed or contracted by Scope. He also received care and support from his cousin, Pauline O'Maley and her husband, Norman O'Maley.
2. Anthony was a warm and friendly person who loved trains, gardening and watching television.

BACKGROUND

3. Anthony's medical history included epilepsy, Parkinson's disease, gout, hypertension and gastric reflux. He also had an intellectual disability and was non-verbal.
4. Anthony had been residing in disability residential care since he was nine years old. He had been living in the SDA accommodation in Kew since November 2017. He was in receipt of support services funded by the National Disability Insurance Scheme which included those provided by an occupational therapist, speech pathologist, physiotherapist, a positive behaviour support practitioner and a support coordinator.
5. Anthony was able to stand independently but required supervision and support with walking. Pursuant to recommendations from a physiotherapist, it was suggested that his arm was held by his support worker when he was walking outdoors.

CORONIAL INVESTIGATION

6. Anthony'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. Anthony was a person in care at the time of his death and he was an SDA resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. An inquest was required to be held into his death which occurred on 17 March 2026.
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. At the hearing, a summary of the evidence was provided to the Court by Counsel Assisting. Individual witnesses were not required to give evidence at the inquest as, after carefully considering all of the material, I was satisfied that there were no significant factual disputes or controversies which remained unresolved in order for me to make the findings required under section 67 of the Act. The interested parties were given an opportunity to make submissions.

10. This finding draws on the totality of the coronial investigation into Anthony's death, including information his health records, the National Disability Insurance Agency and Scope. While 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.¹

IDENTITY OF THE DECEASED

11. On 17 August 2025, Anthony was visually identified by his cousin, Pauline O'Maley.
12. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

13. On 20 August 2025, Dr Joanne Ho, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an examination and prepared a report of her findings dated 1 September 2025.
14. Dr Ho reviewed a post-mortem computed tomography (CT) scan and observed right-sided rib fractures and spinal compression fractures. She also observed small liver subcapsular haematoma.
15. Dr Ho provided an opinion that the medical cause of death was: *1(a) Complications of rib fractures, liver laceration and pneumothorax sustained in a fall in a man with multiple medical comorbidities (palliated).*
16. I accept Dr Ho's opinion.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

17. In the morning on 15 August 2025, in accordance with his usual routine, Anthony was being assisted by a disability support worker to access the community, which often

¹ 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.

included visiting parks. His support worker drove him to Bundoora Park where he regularly visited. At around 10.50am, the support worker was assisting Anthony towards a bench seat when he stumbled. Despite being held by the arm, Anthony fell and hit his back on the seat.

18. The support worker did not observe any obvious signs of injury and Anthony did not give any indication that he was in pain. Anthony was assisted back to the bus by the support worker who arranged an appointment with his General Practitioner that afternoon.
19. When Anthony arrived back at home, before going to the GP appointment, he was unable to get out of the bus. Staff contacted emergency services at 11.25am and Ambulance Victoria attended shortly afterwards and transported him to RMH for assessment and treatment. Scans revealed right-sided rib fractures, a pneumothorax and a punctured liver. Clinicians considered that Anthony's injuries were life-threatening and in consultation with family, he was transitioned to comfort care.
20. Anthony passed away at RMH on 17 August 2025 at 4.32pm.
21. The evidence discloses that Anthony was provided reasonable care at his home and that his fall was an accident that occurred while he was accessing the community with the assistance of a support worker. I am satisfied that staff responded appropriately to the incident and he was provided appropriate medical care at RMH.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the Act, I make the following findings:
 - a) the identity of the deceased was Anthony Joseph Moore, born 8 May 1954;
 - b) the death occurred on 17 August 2025 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from complications of rib fractures, liver laceration and pneumothorax sustained in a fall in a man with multiple medical comorbidities (palliated); and
 - c) the death occurred in the circumstances described above.

I convey my sincere condolences to Anthony's family for their loss.

Pursuant to section 73(1) 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:

Pauline O'Maley, Senior Next of Kin

Scope (Aust) Ltd

Royal Melbourne Hospital

St Vincent's Hospital Melbourne

Constable Fanny Lamesta, Coronial Investigator

Signature:



Coroner David Ryan

Date: 17 March 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 inquest. 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.

*Delete if inapplicable

