IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2026 003945

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Heather Margaret Bryce
Date of birth:	29 March 1963
Date of death:	12 July 2026
Cause of death:	Complications of multiple sclerosis
Place of death:	54B Banff Street Reservoir Victoria
Keywords:	In care - natural causes

INTRODUCTION

1. On 12 July 2026, Heather Margaret Bryce was 63 years old when she passed away at her home in Reservoir. At the time of her death, Ms Bryce lived in a residential care facility managed by Scope Australia. Her medical history included multiple sclerosis, gastro-oesophageal reflux disease and neuropathic pain.

THE CORONIAL INVESTIGATION

2. Ms Bryce'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. Ms Bryce 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 s52(3A) of the Act given that Ms Higgins'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 Bryce'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 relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[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

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

Circumstances in which the death occurred

6. Ms Bryce's health had declined in the months before her death with recurrent hospital admissions. She had reduced oral intake and was experiencing significant fatigue. In the month prior to her death, she had been in receipt of palliative care.

7. On 12 July 2026 at around 10.00am, a palliative care nurse attended Ms Bryce's home to administer her medication. She passed away that afternoon at 1.45pm.

Identity of the deceased

8. On 12 July 2026 Heather Margaret Bryce, born 29 March 1963, was visually identified by her sister, Katrina Jane Bryce.

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

Medical cause of death

10. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine, conducted an examination on 14 July 2026 and provided a written report of her findings dated 15 July 2026.

11. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Fronczek expressed the opinion that the death was due to natural causes.

12. Dr Ho provided an opinion that the medical cause of death was: 1*(a) Complications of multiple sclerosis*.

13. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Heather Margaret Bryce, born 29 March 1963;

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

b) the death occurred on 12 July 2026 at 54B Banff Street, Reservoir, Victoria from complications of multiple sclerosis; and

c) the death occurred in the circumstances described above.

15. As noted above, Ms Bryce'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 Bryce 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 Bryce'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:

Katrina Bryce, Senior Next of Kin

Scope Australia

Constable Jack Smith, Coronial Investigator

Signature:

Coroner David Ryan

Date: 03 September 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.