IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 007446

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Graeme William Kenny
Date of birth:	13 February 1963
Date of death:	25 December 2024
Cause of death:	1(a) Right lower lobe pneumonia Contributing Factor Trisomy 21 with dementia
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria
Keywords:	Specialist Disability Accommodation, SDA resident, in care, natural causes

INTRODUCTION

1. On 25 December 2024, Graeme William Kenny was 61 years old when he died in hospital following palliative care. At the time, Mr Kenny lived in Specialist Disability Accommodation (**SDA**) in Clarinda.

2. Mr Kenny was the eldest of three, and his parents were Bill and Ann Graeme. Mr Kenny was born with trisomy 21[1] and his parents cared for him at their family home until 2019 when they no longer had the capacity to do so.

3. According to his sister, Alison Manning, Mr Kenny was educated at a dedicated special needs school where he learned to read and write. In the following years, he engaged in supported employment where he made many friends. Despite his condition, Mr Kenny enjoyed a rich social life, attending the disco, church and sporting events. He was an avid fan of the Melbourne Football Club and never missed a game.

4. Mr Kenny's past relevant medical history also included dementia, epilepsy, Crohn's disease, hyperthyroidism, osteoarthritis, neutropenia and depression. Medical records show that he was in chronic pain, with poor mobility and frequent falls in the last few years of his life.

5. Between 12 July 2019 to 16 November 2023, Mr Kenny resided in an SDA facility operated by SCOPE in Rowville. According to Lisa Maree Evans, chief operating officer of SCOPE, during his stay, Mr Kenny's condition deteriorated, and it became evident he needed additional physical and medical support.

6. From late November 2023, Mr Kenny received additional funding from the National Disability Insurance Scheme (**NDIS**) and relocated to an SDA facility operated by Life Without Barriers (**LWB**) in Clarinda. According to acting house supervisor at LWB, Irene Matthiesson, Mr Kenny required assistance and support with almost all aspects of daily living.

THE CORONIAL INVESTIGATION

7. Mr Kenny's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person

[1] Commonly known as Down Syndrome.

satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[2]

8. Relevantly, section 52 of the Act requires an inquest to be held in respect of all 'in care' deaths, except where the death was due to natural causes. For the purposes section 52(3A) of the Act, I am satisfied that Mr Kenny essentially died from natural causes and have exercised my discretion not to hold an inquest into his death. The formulation of the cause of death in Mr Kenny's case is discussed below.[3]

9. 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.

10. 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.

11. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Kenny's death. The Coronial 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.

12. This finding draws on the totality of the coronial investigation into Mr Kenny'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.[4]

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[2] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.
[3] See paragraphs 15 and following below.
[4] 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.

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

Identity of the deceased

13. On 25 December 2024, Graeme William Kenny, born 13 February 1963, was visually identified by sister, Allison Ann Manning, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

15. Forensic Pathologist, Dr Joanna Moira Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 27 December 2024 and provided a written report of her findings dated 30 December 2024.

16. The postmortem external examination as consistent with the reported clinical history.

17. The post-mortem computerised tomography (**CT**) scan showed cerebral atrophy. There was scoliosis but no acute skeletal trauma. The scan also showed consolidation of the right lung lower lobe with a background of diffuse increase in lung markings.

18. Based on the information available, Dr Glengarry noted that the death was due to natural causes.

19. Dr Glengarry provided an opinion that the medical cause of death was *"1(a) Right lower lobe pneumonia"* and including *"2 trisomy 21 with dementia"* as a contributing factor.

20. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

21. On 30 May 2024, Mr Kenny was admitted to Monash Medical Centre (**MMC**) for a likely respiratory infection with possible aspiration pneumonia. According to Dr James Fordyce, Emergency Physician at MMC, Mr Keny's condition steadily improved, and he was discharged on 2 June 2024.

22. According to Ms Matthiesson, on 29 November 2024, Mr Kenny had a runny nose with a temperature of 39 degrees. He was seen by the LWB palliative care team and a locum doctor

who advised he be commenced on ibuprofen if his temperature exceed 38.5 degrees. After some time, his temperature lowered to 36 degrees and ibuprofen was ceased.

23. On 3 December 2024, Mr Kenny developed a cough and a husky voice and was sneezing. LWB staff organised a telehealth appointment with his general practitioner, Dr Anton Knieriemen at East Bentleigh Medical Group. Based on the description provided, Dr Knieriemen found the likely cause of hi symptoms to be an upper respiratory tract infection.

24. On 4 December 2024, LWB staff observed Mr Kenny with a wheezy chest and ongoing cough. He was seen by Dr Knieriemen and commenced on oral antibiotics.

25. A follow up appointment was made with Dr Knieriemen on 11 December 2024. LWB staff reported Mr Kenny had gurgled breathing and an increasing productive cough.[5] Dr Knieriemen prescribed another course of antibiotics. In the ensuing days, LWB staff observed that Mr Kenny continued to cough and appeared lethargic.

26. On 19 December 2024, Mr Kenny was reviewed again by Dr Knieriemen. On examination, Mr Kenny appeared well and was breathing comfortably, with slight large airway noises.

27. On 21 December 2024, LWB staff observed Mr Kenny appeared unwell but lethargic with poor oral intake. At about 10.40pm he was assessed by a locum doctor who advised LWB staff to continue monitoring him and seek medical attention if his condition worsened. His temperature at the time was 37 degrees.[6]

28. At about 7.00am on 22 December 2024, LWB staff observed Mr Kenny was *"very shaky"*, with noisy breathing and generally looked unwell. LWB staff called emergency services, and he was transported to the Emergency Department (**ED**) at MMC.

29. On admission to MMC, he presented with a fever, low blood pressure and difficulty breathing. Dr Fordyce noted that medical staff believed he had sepsis, likely from an underlying chest infection. Mr Kenny's condition was discussed with Ms Manning, who expressed that the family had planned for comfort care and palliation in the event of acute illness.

[5] A productive or wet cough is a type of cough that produces mucus.
[6] Normal body temperature is around 37°C (give or take a degree, but this can vary from person to person).

30. Following this discussion, the general medicine and palliative care team commenced a plan for comfort end of life care. Mr Kenny was commenced on medication to prevent discomfort and seizures.

31. That night, Mr Kenny was admitted to the MMC inpatient palliative care unit, McCulloch House. During his stay, Mr Kenny experienced frequent seizures, appeared to be in distress and was treated with morphine and midazolam.

32. Night staff from LWB attended McCulloch house to provide him with support. Mr Kenny's family also visited him frequently.

33. Mr Kenny was kept comfortable until he passed away on 25 December 2024 at 6.18am.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Graeme William Kenny, born 13 February 1963;

    (b) the death occurred on 25 December 2024 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria;

    (c) immediately before death, Mr Kenny was a *"person placed in custody or care"* as defined in section 4 of the Act;

    (d) the cause of Mr Kenny's death was right lower lobe pneumonia, with trisomy 21 and dementia as a contributing factor, which I consider to be a death from natural causes for the purposes of section 52(3A) of the Act; and

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

35. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at SCOPE, Life Without Barriers, East Bentleigh Medical Group or the Monash Medical Centre that caused or contributed to Mr Kenny's death.

I convey my sincere condolences to Mr Kenny'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:

Allison Ann Manning, senior next of kin

Barry Nilsson Lawyers

Scope Australia Ltd

First Constable Kieran Urquhart, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 08 December 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.