



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000107

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Dimitra Dubrow
Deceased:	Laura Claire Brady
Date of birth:	23 March 1983
Date of death:	06 January 2025
Cause of death:	1a : ASPIRATION PNEUMONIA COMPLICATING AN ISCHAEMIC STROKE IN A WOMAN WITH EPILEPSY, CEREBRAL PALSY AND INTELLECTUAL DISABILITY
Place of death:	Sunshine Hospital 176 Furlong Road, St Albans Victoria 3021
Keywords:	In care, SDA resident, natural causes death

INTRODUCTION

1. On 06 January 2025, Laura Claire Brady (**Laura**) was 41 years old when she died at the Sunshine Hospital. Laura is survived by her parents, Eileen Brady and Patrick Brady, and siblings, Tara, Daniel and Gavin.
2. Laura was born with cerebral palsy and had a history of severe epilepsy and intellectual disability. She required assistance with all activities of daily living.
3. At the time of her death, Laura was a Specialist Disability Accommodation (**SDA**) resident in an SDA enrolled dwelling at 42 Cooke Avenue, North Sunshine. She received Supported Independent Living services from Scope.
4. Laura's General Practitioner noted that she presented as well in the months leading up to her death. Scope staff did not report any concerns about her general health or demeanour. Laura attended the Beyond Disability Activity Centre and participated in her usual activities. She enjoyed visiting her family, going for walks and listening to music.
5. On 26 November 2024, Laura experienced a seizure that lasted approximately 60 seconds. She was administered her pro re nata (**PRN**) medication as per her Epilepsy Management Plan and medication treatment sheet. Staff noted that she recovered well and resumed her regular activities.

THE CORONIAL INVESTIGATION

6. Laura'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 custody¹ is a mandatory report to the coroner, even if the death appears to have been from natural causes. Laura was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as she was "*a prescribed person or a person belonging to a prescribed class of person*" due to her status as an "*SDA resident residing in an SDA enrolled dwelling.*"²
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

¹ See the definition of 'reportable death' in section 4 of Act, especially section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) of the Act

² Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Laura's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.
10. This finding draws on the totality of the coronial investigation into the death of Laura Claire Brady 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.³

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

Circumstances in which the death occurred

11. On 5 December 2024, Scope staff observed that Laura was pale, was not responding verbally and appeared confused. Emergency services were contacted and whilst staff were on the call, Laura had a seizure.
12. Laura was subsequently transported by ambulance to the Sunshine Hospital Emergency Department. She was noted to be drowsy and not responsive to voice. Investigations completed included a brain CT scan which did not reveal any acute abnormality. Laura was subsequently admitted to the Neurology Department where she remained until 31 December 2024. Consultant Neurologist Dr Zelko Matkovic stated that the initial impression of the neurology unit was that Laura had seizures with a prolonged post-ictal period.

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.

13. On 6 December 2024, a chest X-ray showed a left basal infiltrate / pneumonia / chest infection which was treated with intravenous antibiotics. Dr Matkovic further stated that during Laura's hospital stay, she had intermittent episodes of hypoxia and tachypnoea. She remained drowsy and did not significantly improve. The treating team's opinion was that the chest infection / sepsis was mainly responsible for her condition. An electroencephalogram (EEG) confirmed that ongoing seizure activity was not responsible for Laura's continued reduced conscious state. The treating team's opinion was that hypoactive delirium was contributing to her fluctuating drowsiness and decreased consciousness.
14. As Laura failed to improve, she underwent a magnetic resonance imaging (MRI) scan of her brain on 16 December 2024. Brain MRI showed a subacute right cerebral infarct in the territory of the left middle cerebral artery. Dr Matkovic indicated that Laura's family were fully informed of her condition, including discussion that in the presence of seizures, severe chest infection, delirium, large stroke and poor conscious state her prognosis for significant recovery was very poor.
15. On 31 December 2024, Laura was transferred to the palliative care unit and subsequently died on 6 January 2025.

Identity of the deceased

16. On 10 January 2025, Laura Claire Brady, born 23 March 1983, was visually identified by her mother, Eileen Brady.
17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an external examination on 8 January 2025 and provided a written report of his findings dated 10 January 2025.
19. The post-mortem examination revealed no unexpected signs of trauma. A post mortem CT scan confirmed the presence of right MCA territory cerebral infarct and no intracranial haemorrhage. In addition, a repaired right hip, increased lung markings and right upper limb subcutaneous air were seen.

20. Dr Young noted that aspiration pneumonia is an infection of the lungs that occurs after inhaling (aspirating) foreign material such as food or vomitus. Risk factors include stroke, epilepsy, cerebral palsy, intellectual disability and poor or absent dentition.
21. Dr Young provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA COMPLICATING AN ISCHAEMIC STROKE IN A WOMAN WITH EPILEPSY, CEREBRAL PALSY AND INTELLECTUAL DISABILITY. He considered that the death was due to natural causes.
22. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

23. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Laura Claire Brady, born 23 March 1983;
 - b) the death occurred on 06 January 2025 at Sunshine Hospital, 176 Furlong Road, St Albans Victoria 3021, from aspiration pneumonia complicating an ischaemic stroke in a woman with epilepsy, cerebral palsy and intellectual disability; and
 - c) the death occurred in the circumstances described above.
24. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Laura died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.
25. I convey my sincere condolences to Laura's family for their loss.
26. 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:

Eileen and Patrick Brady, Senior Next of Kin

Senior Constable Montana Holmes, Coronial Investigator

Signature:



Coroner Dimitra Dubrow

Date: 10 June 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.
