IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 0588**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**MARJORIE HELEN McGIBBONY**
Date of birth:	**20 JULY 1941**
Date of death:	**4 FEBRUARY 2017**
Cause of death:	**HYPOSTATIC BRONCHOPNEUMONIA IN THE SETTING OF DEMENTIA**
Place of death:	**ALPINE HEALTH,** **30 O'DONNELL AVENUE,** **MYRTLEFORD, VICTORIA 3737**

HIS HONOUR:

BACKGROUND

1. Marjorie Helen McGibbony was born on 20 July 1941. She was 75 years old at the time of her death. Marjorie lived in a group home at 2/30 Toner Avenue, Myrtleford, Victoria.

2. Marjorie had an intellectual disability. She had normally very limited communication and a mental health diagnosis of obsessive compulsive disorder and agitation. She was diagnosed with asplenia and tardive dyskinesia. Her declining physical function and not eating was consistent with a dementia process.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Marjorie's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death she was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] 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 that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Marjorie was visually identified by her carer, Fiona Silis, on 4 February 2017. Identity is not disputed and requires no further investigation.

[6] (1938) 60 CLR 336.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 6 February 2017, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Marjorie's body and provided a written report dated 10 February 2017, concluding a reasonable cause of death to be "I(a) Hypostatic bronchopneumonia in the setting of dementia". I accept his opinion in relation to the cause of death.

13. Dr Lynch noted that the death was due to natural causes

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

14. Between April 2016 and August 2017 Marjorie's health was declining. She experienced weight loss and an increase in severity of her agitation and behaviours such as head banging. She had an increasing number of unobserved falls. In August 2016 her General Practitioner had requested weekly reviews of Marjorie, as she continued to lose weight and had general ill health. In November 2016 she was experiencing swallowing difficulties which were diagnosed by her General Practitioner as being associated with dementia.

15. Marjorie's health continued to decline, and on 22 December 2016 a referral to Palliative Care was made. In January 2017 an End of Life plan was made for Marjorie. On 1 February 2017, Marjorie was unable to walk or swallow and she became unresponsive. She was transported to Alpine Health where she remained until her death on 4 February 2017.

FINDINGS

16. Having investigated Marjorie Helen McGibbony's death, and having considered all of the available evidence, I am satisfied that no further investigation is required.

17. I find that the care provided to Marjorie by the Department of Health and Human Services and Alpine Health was reasonable and appropriate in the circumstances.

18. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Marjorie Helen McGibbony, born 20 July 1941;

(b) that Marjorie Helen McGibbony died on 4 February 2017, at Alpine Health, 30 O'Donnell Avenue, Myrtleford, Victoria from hypostatic bronchopneumonia in the setting of dementia; and

(c) that the death occurred in the circumstances described in the paragraphs above.

19. Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) State Trustees, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 30 May 2017