IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002822

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Gabrielle Mary Garrigan
Date of birth:	15 June 1967
Date of death:	23 May 2025
Cause of death:	1(a) Complications of advanced dementia in the setting of trisomy 21 and other medical comorbidities
Place of death:	Bendigo Health 100 Barnard Street Bendigo Victoria
Keywords:	*In care; Natural causes; Specialist Disability Accommodation*

INTRODUCTION

1. On 23 May 2025, Gabrielle Mary Garrigan was 57 years old when she passed away at Bendigo Health.

2. At the time of her death, Gabrielle resided in Specialist Disability Accommodation (**SDA**) in Woodend managed by disability service provider, Possability.

THE CORONIAL INVESTIGATION

3. Gabrielle's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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.

4. 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.

5. 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.

6. Victoria Police assigned Senior Constable Joshua Gray to be the Coroner's Investigator for the investigation of Gabrielle's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist and treating clinicians – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into Gabrielle'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.[1]

Background

8. Gabrielle grew up as part of a large family, being the eighth child born to her parents, John and Helen. The family lived in Kapooka in New South Wales, but shortly after she was born, her father died serving in Vietnam, and the family moved to Maffra in Victoria where Helen had family and other supports.

9. Gabrielle was born with Down Syndrome (trisomy 21) and was diagnosed as legally blind at the age of four. She started her primary education at a special needs school in Maffra where she remained enrolled until she was about eleven or twelve years old. She then transitioned from a special needs school to a public primary school under a pilot program and was the first child with Down Syndrome in Victoria to do so. As part of the pilot, Gabrielle attended Airly Primary School for a couple of years before going to secondary school in Sale for several more years.

10. When Gabrielle was about 16 years old, she moved to another special needs school and completed several supportive employment programs including working at a hydroponics farm, a café and a supermarket.

11. As an adult, Gabrielle lived at the family home with her mother and her brother, Sean, who also had Down Syndrome. Helen supported and cared for both Gabrielle and Sean for many years until she was about 80 years old and showing signs of dementia.

12. In November 2010, Gabrielle went to live in the Kyneton area with her older brother, Padraigh (**Paddy**), who was able to organise a supported independent living and care arrangement for her through Windarring. Gabrielle lived on her own but would have carers attend her residence throughout the day to assist her with daily tasks.

13. About five or six years before her death, Paddy noticed that Gabrielle was having memory issues as she was having trouble recalling some dates and locations that she was previously

[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.

excellent at remembering. Gabrielle was subsequently diagnosed with early onset dementia in February 2022.

14. Gabrielle's medical history also included osteoporosis, hypothyroidism, atrial septal defect, gastro-oesophageal reflux disease and autism spectrum disorder.

15. In March 2023, Gabrielle moved into an SDA facility in Woodend. The SDA in which Gabrielle resided was enrolled under the National Disability Insurance Scheme (**NDIS**). She received Supported Independent Living (**SIL**) services for daily tasks including personal care, meal preparation, medication administration, and mobility. She also received care from her general practitioner and a geriatrician. Additionally, Gabrielle's family would visit her and keep in contact with her.

16. Paddy stated that *"the staff that worked with Gabrielle at [the SDA] facility were brilliant, they couldn't have done more to help Gabrielle while she was there. They were the best staff and carers she had. They were incredibly professional and well experienced, with staff who were well experienced with dementia patients…"*.

17. Gabrielle's carers described her as being full of life and a bit of a prankster and a jokester. When she began residing in the SDA, Gabrielle was very independent, enjoyed reading, writing, and colouring, and was joyful and happy. She also enjoyed outings and socialising with her housemates and staff. However, as her dementia progressed, she experienced worsening cognitive and functional decline and less independence. She had increasing confusion, forgetfulness, and agitation, and would decline to engage in daily activities.

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

Circumstances in which the death occurred

18. In the evening of 17 May 2025, Gabrielle was at her SDA facility where her carer observed her to appear unwell and behaving unusually. Her hands were blue in colour, she was staring into the distance, shaking, and unsteady on her feet. Her carer suspected she may have suffered an absent seizure. An ambulance was called and Gabrielle was transported to Bendigo Health where she arrived in the early hours of 18 May 2025. She was subsequently discharged home to her SDA facility at about 8.35am that day.

19. Gabrielle did not sleep during the evening of 18 May 2025. In the morning of 19 May 2025, she was observed by her carers to be slouched over, lethargic, shaking and unsteady on her

feet with left-sided weakness. She was given some food, but her awareness dropped while eating and she became extremely docile. Her carers called for an ambulance, and she was conveyed to Kyneton Health. Gabrielle had become more alert but was not agreeable to assessments and was not cooperating with the medical treatment team.

20. As Gabrielle required greater care and management, she was transferred from Kyneton Health to Bendigo Health at about 7.00pm on 19 May 2025. A computed tomography (**CT**) brain scan performed upon her arrival at Bendigo Health revealed a bleed on her brain which was not for neurosurgical intervention due to its location.

21. Whilst in hospital, Gabrielle remained opposed to medical care. She had a history of becoming distressed by invasive tests or treatment which sometimes made assessing and treating her difficult.

22. On 23 May 2025, a loud noise was heard from Gabrielle's hospital room, and she was located unresponsive on the floor with laboured breathing. She was not for resuscitation and was pronounced deceased at 9.32pm.

Identity of the deceased

23. On 24 May 2025, Gabrielle Mary Garrigan, born 15 June 1967, was visually identified by her sister, Angela Mary Gravina.

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

Medical cause of death

25. Forensic Pathologist, Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 26 May 2025 and provided a written report of her findings dated 16 June 2025.

26. The post-mortem CT scan revealed cerebral atrophy, a focal right posterior parieto-occipital haemorrhage and cholelithiasis.

27. Routine toxicological analysis was not indicated and was therefore not performed.

28. Dr Francis provided an opinion that the medical cause of death was *"1(a) Complications of advanced dementia in the setting of trisomy 21 and other medical comorbidities"*.

29. I accept Dr Francis' opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Gabrielle Mary Garrigan, born 15 June 1967;

    (b) the death occurred on 23 May 2025 at Bendigo Health, 100 Barnard Street, Bendigo, Victoria, from complications of advanced dementia in the setting of trisomy 21 and other medical comorbidities; and

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

31. Having considered all of the available evidence, I am satisfied that Gabrielle's death was due to natural causes, and an inquest is therefore not required pursuant to section 52(3A) of the Act.

I convey my sincere condolences to Gabrielle's family, friends and carers 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:

Padraigh (Paddy) Garrigan, senior next of kin
Bendigo Health
Senior Constable Joshua Gray, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 07 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.