IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007736

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Marian Gibson
Date of birth:	3 October 1961
Date of death:	4 November 2025
Cause of death:	1(a) Alzheimer's dementia and epilepsy in the setting of trisomy 21
Place of death:	Golf Links Road Rehabilitation Centre, Palliative Care Unit 125 Golf Links Road, Frankston, Victoria
Keywords:	*In care; Natural causes; Specialist Disability Accommodation*

I, Coroner Sarah Gebert, having investigated the death of Marian Gibson and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (Vic) (**the Act**):

a) the identity of the deceased was Marian Gibson, born 3 October 1961;

b) the death occurred on 4 November 2025 at Golf Links Road Rehabilitation Centre, Palliative Care Unit, 125 Golf Links Road, Frankston, Victoria, from Alzheimer's dementia and epilepsy in the setting of trisomy 21; and

c) the death occurred in the circumstances described below.

1. Marian was 64 years old at the time of her death and resided in Specialist Disability Accommodation (**SDA**) in Mount Martha managed by disability service provider, Focus Individualised Support Services (**Focus**), which is now named Doable.[1]

2. Marian was an only child and grew up on a farm in Bittern with her parents, Andrew and Merle. She was born with Down Syndrome (trisomy 21) and had an intellectual disability but was relatively high functioning. From around 12 years of age, she lived in assisted accommodation. Marian had a complex medical history which included epilepsy, osteoporosis, hypercholesterolaemia, hearing impairment, hydrocephalus and Alzheimer's dementia.

3. Merle passed away when Marian was 21 years old, and Andrew later re-married Marian's stepmother Lorna who helped care for Marian for many years. For the last five years of her life, Marian's cousin David became her primary care contact.

4. The SDA in which Marian 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. Marian was also linked with Dementia Australia and supported by behavioural support and allied health services. David noted that the Focus staff at Marian's SDA were *"fantastic"*.

[1] Marian's death fell within the definition of a reportable death in the Act as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death. This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

5. Marian was a long-term patient of Village Clinic Mount Eliza for 25 years and was treated by her general practitioner Dr Joel Buikstra (**Dr Buikstra**) from April 2021.

6. In the two years prior to her death, Marian's health was declining. From early 2025, she required a wheelchair to mobilise, she was experiencing hallucinations and had fluctuating eating patterns. Marian also had increasingly frequent seizures with some episodes requiring ambulance attendance. Additionally, her Alzheimer's dementia was progressively deteriorating. She had become prone to frequent falls due to her cognitive decline and limited mobility. Her carers had to use crashmats to reduce her risk of injury.

7. A palliative care multidisciplinary team meeting was held in April 2025 in light of Marian's complex care needs.

8. On 12 October 2025, Marian was admitted to Peninsula University Hospital with a referral from Dr Buikstra for management and investigation of her epilepsy as she had suffered a seizure with incontinence the day before and presented as non-verbal. She was reviewed by the neurology team which decided to increase her dosage of anticonvulsant medication. Marian did not experience any further seizures for 72 hours and was discharged back to her SDA on 15 October 2025. She had unremarkable blood test results and a largely normal computed tomography (**CT**) scan of her brain prior to discharge.

Circumstances of death

9. On 25 October 2025, Marian suffered a fall from her wheelchair in the context of her advanced Alzheimer's dementia and epilepsy.

10. David visited Marian on 27 October 2025 and observed her to be quiet but still chatting and in good spirits. Marian's carers told David that Marian had suffered a fall two days prior and was having small seizures and tremors.

11. Over the next couple of days, Marian was rapidly declining. She had a reduced conscious state, was agitated when awake and had minimal to no oral intake. She was subsequently referred and admitted to the Palliative Care Unit at the Golf Links Road Rehabilitation Centre on 31 October 2025. After a family discussion with the medical team, it was agreed to transition Marian into end-of-life care.

12. During her palliative care admission, Marian became less rousable and was commenced on a syringe driver of morphine and midazolam on 3 November 2025. She passed away peacefully in her sleep in the morning of 4 November 2025.

Medical cause of death

13. Senior Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 5 November 2025 and provided a written report of his findings dated 12 November 2025.

14. The post-mortem examination was consistent with the reported circumstances. The post-mortem CT scan revealed hydrocephalus ex vacuo and surgical metal within the distal left radius.

15. Dr Lynch provided an opinion that the death was due to natural causes and that the medical cause of death was *"1(a) Alzheimer's dementia and epilepsy in the setting of trisomy 21".*

Having considered all of the available evidence, I am satisfied that Marian'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 Marian'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:

David Cole, senior next of kin

Dr Joel Buikstra

Leading Senior Constable Damien Linden, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 22 July 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.