IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000171

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Melissa Louise Arbuckle
Date of birth:	19 June 1989
Date of death:	9 January 2023
Cause of death:	1(a) Mixed drug toxicity
Place of death:	1330 Princes Highway, Flynn, Victoria
Keywords:	Suicide; Family violence; Mental health

INTRODUCTION

1. On 9 January 2023, Melissa Louise Arbuckle was 33 years old when she was discovered deceased at a truck stop at 1330 Princes Highway, Flynn, Victoria. At the time of her death, Ms Arbuckle was living alone in a unit on Mackay Street, Traralgon, Victoria.

2. Ms Arbuckle was born in Morwell in the Gippsland regional part of Victoria. Ms Arbuckle has an older brother and a younger sister. Her parents separated when she was three years old and her mother re-married when she was 16 years old.

3. Ms Arbuckle met her partner Jed Arbuckle in 2015 when they were both students at Melbourne University. The couple got married in 2019 and bought a house together in the Upwey. Ms Arbuckle qualified as a veterinarian and spent a few years in clinical practice before working in pet health sales with Blackmores.

4. During the course of the COVID-19 pandemic, the couple decided to try for a baby and Ms Arbuckle became pregnant in July 2020. Lily Arbuckle was born on 4 April 2021.

5. On 11 July 2021, Ms Arbuckle placed Lily on train tracks approximately halfway between Upwey Railway Station and Tecoma Railway Station and laid down beside her. Both Lily and Ms Arbuckle were struck by a train, causing fatal injuries to Lily.

6. On 7 April 2022, Ms Arbuckle had been found guilty and convicted of infanticide in relation to Lily's death. Ms Arbuckle was released on an adjourned undertaking with conditions requiring compliance with a good behaviour bond and continuing mental health treatment in the community.

7. Ms Arbuckle continued to work at the Blackmores Group and moved in with her mother in Morwell.

8. On 22 April 2022, Ms Arbuckle formed a new relationship with Hayden Brook. Ms Arbuckle was open and forthcoming with Mr Brook about her previous history involving Lily's passing.

9. Around September 2022, Ms Arbuckle moved out of her mother's place and to a new residence on Mackay Street in Traralgon. Ms Arbuckle and Mr Brook lived separately but would stay at each other's homes for the majority of the week.

10. In November 2022, Ms Arbuckle purchased a home in Traralgon where she planning to move in with Mr Brook and live together mid-2023.

THE CORONIAL INVESTIGATION

11. Ms Arbuckle'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.

12. 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.

13. 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.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Arbuckle's death. The Coroner's 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.

15. This finding draws on the totality of the coronial investigation into the death of Ms Arbuckle 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]

[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.

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

Circumstances in which the death occurred

16. On 8 January 2023, Ms Arbuckle had organised a family dinner at a local Chinese restaurant which she attended with Mr Brook, her mother and her step-father. The dinner appeared to go well and Ms Arbuckle's parents went home and Ms Arbuckle went to have dessert with Mr Brook at a local ice creamery.

17. Ms Arbuckle and Mr Brook went their separate ways after visiting the ice creamery and returned to their respective homes as Ms Arbuckle had informed Mr Brook that she was returning to work and wanted to get a good night's rest.

18. Ms Arbuckle sent an email from her home computer to her local GP clinic detailing her desire to kill herself and the location of where she could be found, her car details and parting words to her family and friends.

19. Ms Arbuckle then drove to a truck stop at 1330 Princes Highway in Flynn where she parked her vehicle and took her prescription medication with the assistance of bottled water, in the back seat of her car.

20. On 9 January 2023, a staff member from Ms Arbuckle's local GP clinic discovered the email at approximately 9.00am and called emergency services. Police members arrived at 9.34am and located Ms Arbuckle's body in the rear of her car and she was pronounced deceased by attending Ambulance paramedics.[2]

Identity of the deceased

21. On 16 January 2023, Melissa Louise Arbuckle, born 19 June 1989, was identified by fingerprint impression comparison.

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

[2] *Coronial Brief*, Statement of First Constable Jason Alexander dated 14 April 2023, 54

Medical cause of death

23. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy examination on 16 January 2023 and provided a written report of his findings dated 1 June 2023.

24. The external examination revealed the following:

    a) There was evidence supporting the conclusion that the cause of death was related to mixed drug toxicity including propranolol, oxycodone, diazepam, temazepam, lurasidone and duloxetine.

    b) Post mortem imaging disclosed cerebral oedema, anterior fixation of cervical spine, intrauterine contraceptive device and radiopaque material within the stomach.

25. Toxicological analysis of post-mortem samples identified the presence of propranolol,[3] oxycodone,[4] diazepam, [5] temazepam,[6] lurasidone[7] and duloxetine.[8]

26. Dr Lynch provided an opinion that the medical cause of death was 1 (a) Mixed drug toxicity.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

27. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Arbuckle and her daughter Lily was one that fell within the definition of '*family member*[9] under that Act. Moreover, Ms Arbuckle's actions in placing Lily on dangerous train tracks constitutes '*family violence'*.[10]

28. In light of Ms Arbuckle's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[11] examine the circumstances of Ms

[3] Stomach contents contained 3100 mg and blood concentration levels were 1.9 mg/L.
[4] Stomach contents contained 3.6 mg and blood concentration levels were 0.09 mg/L.
[5] Stomach contents contained 8.7 mg
[6] Stomach contents contained 29 mg and blood concentration levels were 0.07 mg/L
[7] blood concentration levels were 0.07 mg/L
[8] blood concentration levels were 0.2 mg/L
[9] Family Violence Protection Act 2008, section 8(1)(a)
[10] Family Violence Protection Act 2008, section 9
[11] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

Arbuckle's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[12]

Mental health and treatment prior to the fatal incident

24. Ms Arbuckle had no reported history of alcohol or illicit substance abuse. There is no family history of mental illness. Prior to the birth of her daughter Lily, Ms Arbuckle had no reported or known history of mental illness, suicidality or self-harm.

25. Ms Arbuckle's pregnancy was uncomplicated but Lily's birth was by emergency caesarean due to a prolonged labour period.

26. From April to 11 July 2021, Ms Arbuckle experienced a number of issues with breast-feeding Lily and significant post-natal depression. Ms Arbuckle continued to raise lactation concerns with Dr Strybosch (Lactation Consultant) throughout June 2021[13] and Ms Arbuckle relocated to aunt-in-law's residence in Melbourne due to severe storms cutting power in the Upwey area. This caused Ms Arbuckle more stress due to Lily being even more unsettled.

27. On 5 July 2021, Ms Arbuckle became alarmed about a rash on Lily's leg and about her perception of Lily having lost condition in her leg and having a weaker cry. The couple took Lily to Angliss Hospital to be examined and were discharged with medical staff noting no remarkable findings. Ms Arbuckle didn't accept this advice and became increasingly convinced that there was something wrong with Lily.

28. On 7 July 2021, Ms Arbuckle's husband asked a neighbour to check on her because of his concern about her mental state. On that same day, Ms Arbuckle made a list of all the signs that she perceived in Lily that indicated there was something wrong with her, such as weak muscle tone. Ms Arbuckle became preoccupied with concerns that she had somehow injured Lily.

29. On 10 July 2021, Ms Arbuckle told her husband that she had not been sleeping due to her concerns about what she might have done to Lily and that she was having suicidal thoughts. During this period from 8 July to 11 July 2021, Ms Arbuckle drafted and completed a suicide note and had numerous social media conversations with friends expressing anxiety about

[12] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

[13] Statement of J Strybosh dated 16 August 2022, 2

medical issues relating to herself and Lily, lactation issues, feeling stressed without electricity at home and feeling inadequately support and worried about Lily's wellbeing.

30. On 11 July 2021, Ms Arbuckle placed Lily on train tracks approximately halfway between Upwey Railway Station and Tecoma Railway Station and laid down beside her. Both Lily and Ms Arbuckle were struck by a train, causing fatal injuries to Lily.

31. Ms Arbuckle was taken to hospital for medical treatment and was seen by Associate Professor Alexander Holmes of the Royal Melbourne Hospital. He informed police on 12 July 2021 of his diagnosis that she was suffering post-natal depression and possible psychosis.

32. Professor Holmes found that Ms Arbuckle did not have the capacity to make decisions regarding her medical and psychiatric care and she was placed on an order under the Mental Health Act. Professor Holmes has opined that at the time of the incident she was psychotic and clearly of a disturbed mind, suffering severe postpartum major depression with psychotic features consequent to the birth of her daughter three months previously.

33. Professor Holmes opined that postpartum depression occurred on a background of a complicated delivery and a perfectionistic and self-critical personality style. It was noted that she had begun experiencing psychotic phenomenon in the weeks leading up to the death of Lily, including auditory hallucinations, leading her to believe that the actions she took were the only solution.

34. Police were informed of the postpartum depression diagnosis made by Associate Professor Holmes, and although Ms Arbuckle was formally arrested and cautioned on a charge of murder, that charge was never laid and she was ultimately convicted of infanticide.

35. Ms Arbuckle was treated by a private psychiatrist (Dr Edechuku) from 9 September 2021 until the fatal incident. She was concurrently treated by a community health service (Dr Gupta and the La Trobe Health Continuing Care Team).

36. In the 12 months prior to the fatal incident Ms Arbuckle notably reported the following positive reflections:[14]

[14] Statement of Dr Adaobi Udechuku dated 29 May 2023, 4-8

a. Whilst she had felt alone and disappointed in Mr Arbuckle leaving her, she found a new relationship and was positively developing this relationship since Lily's passing. She had gone on trips with her new partner and also met his family as well. She had opened up to the new partner about Lily's death and he was supportive of her.

b. She spoke positively to Dr Udechuku about speaking with another woman overseas in the US who had also been involved in the death of her child and suffered from postpartum psychosis but was able to live a long meaningful life, re-partnering and have another child.

c. She maintained gainful employment in the animal health field.

d. She was exercising and losing weight and forward focused on future goals.

e. She spoke about having another child with her new partner only three weeks prior to the fatal incident with no reports of suicidal plan or intent.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Ms Melissa Louise Arbuckle, born 19 June 1989;

b) the death occurred on 9 January 2023 at 1330 Princes Highway, Flynn, Victoria, from 1(a) Mixed drug toxicity; and

c) the death occurred in the circumstances described above.

30. A finding of suicide can impact upon the memory of a loved one and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

31. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person and sometimes events in the person's life suggest a reason.

32. The available evidence suggests that Ms Arbuckle was significantly affected by a mental health condition arising from the birth and subsequent death of her one and only child, Lily.

33. I find that Ms Arbuckle did intentionally taking her own life by overdosing on medications that were prescribed to her.

34. I convey my sincere condolences to Ms Arbuckle's family for their loss.

35. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

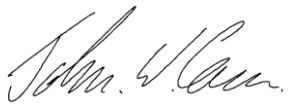
Mr Paul Germano, Senior Next of Kin

Ms Grace Thomas, Senior Next of Kin

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Leading Senior Constable John Park, Coroner's Investigator

Signature:



Judge John Cain, State Coroner

Date : 23 November 2023

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.