IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002112

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Melanie Louise Gregory
Date of birth:	9 January 1985
Date of death:	14 April 2024
Cause of death:	1a: aspiration pneumonia in the setting of general anaesthesia and colonoscopy for investigation of rectal bleeding in a woman with cerebral palsy
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	In care, aspiration pneumonia, inherent risks, medical procedure
Counsel Assisting the Coroner:	Dr Declan McGavin, Coroner's Solicitor
Hearing Dates:	25 June 2025

INTRODUCTION

1. On 14 April 2024, Melanie Louise Gregory was 39 years old when she died in hospital after developing aspiration pneumonia following a colonoscopy.

2. Melanie was a *"happy, engaged young woman who had cerebral palsy."*[1] Melanie used a wheelchair for mobility and was nonverbal using gestures to communicate. She lived at home with her family with NDIS support until moving into Specialist Disability Accommodation (**SDA**) in March 2024.

3. Melanie transitioned well into her new accommodation. Melanie's mother stated that *"Melanie had settled in very well and was well liked by other clients and staff and is sadly missed by them all"*.

4. Melanie's other medical history included dysphagia, sleep apnoea, epilepsy, and a previous aspiration pneumonia.

THE CORONIAL INVESTIGATION

5. Melanie'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 'in care', which includes Melanie as an SDA resident residing in an SDA enrolled dwelling.[2]

6. This category of death is reportable to ensure independent examination of the circumstances leading to death given the vulnerability of this cohort and the level of control exercised by those who care for them. A coroner is also required to hold an inquest into the death,[3] except in circumstances where the coroner considers that the death was from natural causes.[4]

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 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.

[1] Statement of Susan Gregory, Melanie's mother.
[2] *Coroners Regulations 2019*, r 7 read together with the *Coroners Act 2008*, s 3.
[3] The Act, s 52(2)(b).
[4] Ibid, s 52(3A).

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 Melanies's death. The Coronial Investigator conducted initial enquiries on the Court's behalf, including taking statements from witnesses.

10. The Court was also assisted by the Coroners Prevention Unit in the review of medical records, statements and other materials provided by the health services involved in Melanie's care.

11. The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

12. I took carriage of this matter after my appointment to the Court in September 2024 for the purposes of finalising the investigation and making the required findings.

13. This finding draws on the totality of the coronial investigation into the death of Melanie Louise Gregory 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.[5]

[5] 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

14. On 20 October 2023, Melanie was reviewed at an outpatient appointment with the gastroenterology department at Austin Hospital. The referral was made for possible bleeding in the bowel following rectal bleeding and anaemia.

15. Further investigations raised concerns for possible underlying inflammatory bowel disease or malignancy. This required a colonoscopy to investigate further. It was flagged that Melanie would not be able to swallow the bowel preparation in the days prior to the colonoscopy. Instead, an elective admission was arranged for 8 April 2024 with a plan for administration of bowel preparation through a nasogastric tube (**NGT**) prior to colonoscopy on 10 April 2024.

16. On 8 March 2024, the consulting gastroenterologist discussed the colonoscopy with Melanie's mother via telephone. The notes from this discussion documented risks of surgery including a 1 in 100 chance of bleeding and a less than 1 in 1000 chance of perforation which may require further surgery. Further disclosed risks included risks associated with anaesthesia, allergic reactions, and aspirations. It was recognised that Melanie had increased risks, and the case was flagged with the anaesthetic unit for a pre-operative review.

Inpatient admission – 8 April 2024

17. During this admission, insertion of the NGT was difficult, and Melanie became upset and was screaming and gurgling with the multiple attempts.

18. On 9 April 2024, the NGT was placed under fluoroscopy in radiology. A chest Xray confirmed correct placement of the NGT and showed clear lung fields.

19. Melanie was reviewed by a speech pathologist the same day. The medical record noted previous discussions about Melanie's dysphagia and her risk of aspiration in the community. The recommendation was for modified fluids and soft and bite sized food.

20. Melanie's parents declined the recommendation for modified fluids as it was already difficult to maintain Melanie's appropriate oral intake. The records suggest that family felt that the risks of malnutrition and dehydration outweighed the risk of aspiration. An Eating and Drinking with Acknowledged Risk (**EDAR**) was completed at that time.

21. The recommendations were reiterated at this inpatient review as part of discussions about the risks, burdens, and benefits of modified fluids and diet. A further EDAR was documented which confirmed discussion of aspiration, malnutrition and dehydration for modified fluids and nil by mouth.

MET call – 9 April 2024

22. On 9 April 2024, at about 4pm, a call was made to the Medical Emergency Team (**MET**) as nursing staff noted gurgling and distress associated with reduced oxygen saturations to 88% despite receiving 3L oxygen/min. Melanie's parents raised concerns about the NGT causing discomfort.

23. The impression was distress from the NGT at the back of the throat. Nonetheless, a further Xray was ordered which confirmed correct placement. The hypoxia had resolved spontaneously, and Melanie was treated with local anaesthetic spray for throat pain and distress related to the NGT.

24. The Intensive Care Unit (**ICU**) registrar at the MET call noted Melanie's distress with the NGT and explained that this was unavoidable. The registrar noted that minimising distressing or unnecessary interventions was an important value of Melanie and her family and raised whether it was appropriate to proceed with the NGT, bowel preparation, and colonoscopy. The registrar flagged with the treating team that a bigger conversation was required about risks and benefits of proceeding with the colonoscopy or abandoning attempts to administer the bowel preparation through the NGT.

25. The ward round note from the following morning documented this subsequent discussion. While Melanie was more settled, she was still distressed, and it was also distressing for her family to witness. There was noted a discussion about possible aspiration with insertion of the NGT and the ongoing risk of aspiration with non-thickened fluids as noted by the speech pathologist.

26. It was noted that while Melanie was more settled, it was decided with Melanie's family to proceed with the colonoscopy as this was in Melanie's best interest long-term despite her current distress.

27. Bowel preparation was administered over 9 and 10 April 2024 through the appropriately placed NGT.

Anaesthetic Assessment

28. Documentation from an anaesthetic consultation prior to the hospital admission, on 14 March 2024, included that the consulting gastroenterologist had referred the patient via a phone discussion with the off-the-floor anaesthetist.

29. Melanie's mother had concerns regarding a previous anaesthesia reaction causing bleeding which the gastroenterologist thought was related to liver biopsy. The anaesthetic notes from her previous procedures were reviewed, noting that she had a liver biopsy complicated by a haematoma. After the procedure to treat the haematoma, Melanie had issues with respiratory depression, upper airway obstruction and low oxygen saturations which resolved with anaesthetic reversal agents and nasal airway.

30. Melanie's parents were reassured that the colonoscopy procedure only required sedation and that a similar reaction was unlikely to occur.

31. Melanie was reviewed on the ward by the off-the-floor anaesthetist prior to the colonoscopy. It was noted that the NGT had been difficult to insert causing significant distress. On subsequent review after successful insertion there was no evidence of aspiration.

32. Sedation was discussed with Melanie's parents who were happy to proceed. Melanie's mother signed a consent form which noted inherent risks of bleeding, pain, infection, perforation, and failure of the procedure.

Colonoscopy

33. On 10 April 2024, between 3:06pm and 3:53pm, the colonoscopy was performed. There were no complications during the procedure, and Melanie was breathing spontaneously throughout with oxygen saturations at 98%.

34. The colonoscopy showed multiple polyps, which were removed at the time. There were no other abnormalities, and the examination was otherwise normal.

35. Melanie returned to the ward and was well overnight with normal observations. Her diet was upgraded from clear fluids to usual diet of thin fluids and soft bite-sized food. It is not clear from the record exactly when the NGT was removed. There was a note that it should be removed as soon as possible and was presumably removed sometime in the immediate period around the colonoscopy.

36. The next morning, 11 April 2024, Melanie became hypotensive, and a MET call was made. Melanie was treated empirically for aspiration pneumonia.

37. Blood tests showed markedly elevated inflammatory markers and a chest Xray reported by the radiologist as showing *"complete opacification of the left hemithorax, likely represented complete collapse of the left lung"*.

38. It was thought that a mucus plug had occluded the left main bronchus. Chest physiotherapy and mucus suction was performed in an attempt to dislodge the plug with suction with medications being given to assist.

39. The respiratory team were consulted about a possible bronchoscopy. After discussion with the ICU team, it was ultimately judged to be too high risk and was not offered.

40. Non-invasive ventilation was commenced but this was poorly tolerated and stressing for Melanie.

41. Melanie continued to deteriorate and further MET calls were made.

42. During the night of 11 April 2024, it was decided to transition to comfort care and to stop all curative treatment.

43. On 14 April 2024, at about 7pm, Melanie passed away.

Identity of the deceased

44. On 14 April 2024, Melanie Louise Gregory, born 9 January 1985, was visually identified by her mother, who completed a statement of identification.

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

Medical cause of death

46. On 16 April 2024, Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination and provided a written report

of the findings. Dr Lynch considered, among other things, the e-Medical Deposition[6] submitted by Austin Health.

47. The examination showed findings consistent with the history.

48. Dr Lynch provided an opinion that the medical cause of death was *1(a) aspiration pneumonia in the setting of general anaesthesia and colonoscopy for investigation of rectal bleeding in a woman with cerebral palsy*

49. I accept Dr Lynch's opinion.

FURTHER INVESTIGATIONS

50. In a subsequent statement, Austin Health advised that a discussion was held on 17 April 2024 between the Patient Safety Coordinator, the Director of Gastroenterology, the Acting Director of Patient Safety, and the Divisional Manager.

51. The meeting noted that:

"Despite this being a devastating outcome for Ms Gregory's parents, felt by the Gastroenterology, Ward 8 North and Palliative Care teams, shared decision making with all parties was noted to be undertaken and well documented, and the consensus was that the consent process was robust".

52. The case was also discussed and presented at Division of Surgery & Therapeutic Intervention Weekly Audit and the Audit Review Committee on 30 April 2024 where no additional factors were noted.

53. On 2 May 2024, the case was subsequently also discussed at the Gastroenterology Departmental Morbidity and Mortality Audit where it was noted that Melanie's death was an unexpected death which occurred despite taking all necessary preventative measures.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Melanie Louise Gregory, born 9 January 1985;

[6] A clinician's initial summary of the case to the Coroners Court when reporting a death.

b) the death occurred on 14 April 2024 at the Austin Hospital, Heidelberg, from *aspiration pneumonia in the setting of general anaesthesia and colonoscopy for investigation of rectal bleeding in a woman with cerebral palsy*; and

c) the death occurred in the circumstances described above.

55. Having reviewed all the evidence, I am satisfied that the death was unrelated to Melanie's 'in care' status. I am also satisfied that the clinical care and treatment was reasonable.

56. In doing so, I consider that the death was directly related to the materialisation of known risks of the colonoscopy and associated sedation. Further, I am satisfied that the colonoscopy was clinically indicated, and the risks were adequately disclosed with shared decision-making throughout.

57. I convey my sincere condolences to Melanie's family for their loss. It is clear that Melanie's parents had her best interests in mind throughout her life, particularly during this admission for colonoscopy.

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

Susan & Neville Gregory, Senior Next of Kin
Austin Health
National Disability Insurance Agency
Senior Constable Jordan Gorgie, Coronial Investigator

Pursuant to section 73(1) of the Act, this finding must be published on the Court's website in accordance with the rules.

Signature:

CORONER DIMITRA DUBROW

Date: 25 June 2025

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.