IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004096

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Michael Francis Gribble
Date of birth:	11 August 1966
Date of death:	16 July 2025
Cause of death:	1a : Sepsis of unknown origin on a background of multiple co-morbidities
Place of death:	Rosebud Hospital 1527 Point Nepean Road Capel Sound Victoria 3940
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 16 July 2025, Michael Francis Gribble (**Mr Gribble**) was 58 years old when he died at Rosebud Hospital following an acute deterioration.

2. At the time of his death, Mr Gribble resided in Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Mr Gribble received funded daily independent living support due to his disability and complex medical conditions including alcoholic cardiomyopathy, degenerative brain disorder presumably due to chronic excessive alcohol consumption, schizophrenia, lacunar infarction, normal pressure hydrocephalus and an acquired brain injury. Evidence indicates that Mr Gribble's baseline function had declined in the years prior to his death.

3. Mr Gribble loved living in SDA in Rosebud. In his NDIS plan he wrote, *'It is very close to the beach and it really feels like a home'*. His family often visited him, and he felt well supported and cared for. A gifted musician, Mr Gribble enjoyed listening to music and watching his favourite musicians on the television. He also liked going for walks to the beach or going to the local RSL with his support workers.

THE CORONIAL INVESTIGATION

4. Mr Gribble's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he 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 his death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

5. 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] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Michael Francis Gribble. 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.[2]

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

Circumstances in which the death occurred

8. On the morning of 15 July 2025, at around 6:30am, support workers found Mr Gribble in his room, and he was *'gasping for air'*. He was admitted to Rosebud Hospital that day and upon assessment he had an elevated heart rate of 220 beats per minute, a fever of 40.3 C and reduced consciousness with a Glasgow Coma Scale of 3.[3]

9. Clinicians formed the impression that Mr Gribble had an infection. His sister and Medical Power of Attorney, Jennifer Beale, discussed his condition with clinicians and indicated that Mr Gribble was not for any interventions such as antibiotics. He was transitioned to a comfort pathway.

10. Mr Gribble passed away at 5:36am on 16 July 2025.

Identity of the deceased

11. On 16 July 2025, Michael Francis Gribble, born 11 August 1966, was visually identified by his sister, Jennifer Beale.

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

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[2] 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.

[3] The Glasgow Coma Scale (**GCS**) is a clinical tool used to assess a person's level of consciousness, particularly after a brain injury. It evaluates three aspects of responsiveness: eye opening, verbal response and motor response with a total score ranging from 3 to 15. The GCS is used to assess and monitor a patient's neurological state and to guide treatment decisions.

Medical cause of death

13. Forensic Pathologist Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 18 July 2025 and provided a written report of his findings dated 25 July 2025.

14. The post-mortem computed tomography (**CT**) scan showed posterior cerebral hypodensities bilaterally, mild hydrocephalus, borderline cardiomyopathy, marked coronary artery calcification, bilateral increased lung marking, mainly posterior and early fatty liver changes.

15. Dr Beer provided an opinion that the medical cause of death was 1(a) *Sepsis of unknown origin on a background of multiple co-morbidities.*

16. Dr Beer provided an opinion that the cause of death was due to natural causes.

17. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Michael Francis Gribble, born 11 August 1966;

    b) the death occurred on 16 July 2025 at Rosebud Hospital 1527 Point Nepean Road, Capel Sound Victoria 3940 from *1a: Sepsis of unknown origin on a background of multiple co-morbidities*; and

    c) the death occurred in the circumstances described above.

19. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Rosebud Hospital that caused or contributed to Mr Gribble's death.

20. Having considered all the available evidence, I find that Mr Gribble's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Gribble's death in chambers.

I extend my sincere condolences to Mr Gribble'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:

Ms Jennifer Beale, Senior Next of Kin

Peninsula Health

Leading Senior Constable Scott Giles, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 27 January 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.