IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 007600

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Guy Edwin Gellibrand
Date of birth:	18 August 1961
Date of death:	29 October 2025
Cause of death:	1(a) Complications of Severe Cerebral Palsy (Palliated)
Place of death:	McCulloch House, 246 Clayton Road, Clayton Victoria
Key words:	*In care, Natural Cause Death*

INTRODUCTION

1. On 29 October 2025, Guy Edwin Gellibrand was 64 years old when he died at McCulloch House, having been transitioned from Monash Medical Centre for comfort care.

2. At the time of his death, Mr Gellibrand lived in supported living accommodation in Mount Waverley. He no longer had a next of kin following the passing of his brother in August 2022. Mr Gellibrand was devasted by the loss of his brother.

THE CORONIAL INVESTIGATION

3. Mr Gellibrand'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. However, if a person satisfies the definition of a person placed in care immediately before the death, the death is reportable even if it appears to have been from natural causes.[1]

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 First Constable Elias Saade to be the Coroner's Investigator for the investigation of Mr Gellibrand's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as the disability service provider, forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. In addition, the Court obtained Mr Gellibrand's medical records from Ashwood Medical Group and Monash Health.

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[1] See the definition of '*reportable death'* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *'person placed in custody or care'* in section 3(1) of the Act.

8. This finding draws on the totality of the coronial investigation into Mr Gellibrand'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.[2]

Background

9. Mr Gellibrand was quadriplegic and non-verbal with severe cerebral palsy and intellectual disability. He had epilepsy (Lennox-Gastaut syndrome) which was well controlled on medication; prostatomegaly and bladder diverticulum; dysphagia, a hiatus hernia and suspected gastroesophageal reflux disease. He resided in a residential support facility and was assisted by Life Without Barriers, a National Disability Insurance Scheme (**NDIS**) registered provider, responsible for providing day to day support of residents as part of a supported living arrangement. A statement was provided by Nigel Phillips, Director Victorian Disability Services.[3]

10. Mr Gellibrand became a client of Life Without Barriers on 31 March 2019. He lived with three other men who had similar support needs.

11. Mr Gellibrand required support with all aspects of daily living, including personal care needs and mobility. He was wheelchair bound and required 2:1 support for dressing and undressing. Although he was non-verbal, he was able to communicate using body language, facial expressions and minimal sounds.

12. Mr Gellibrand required his food to be served soft, easy to chew and cut into 2cm pieces.

13. Mr Gellibrand's hobbies and interests included watching football, attending local football games, swimming and attending local cafés.

14. Dr Yuh Shyan Chong (**Dr Chong**) was Mr Gellibrand's general practitioner from November 2021 up until the time of his passing. Leading up to his admission to hospital, he was taking antibiotics, due to pressure wounds present on his back and hips. The pressure wounds were being managed by care staff in consultation with his general practitioner. Dr Chong noted with

[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] Dated 1 May 2026.

respect to his dermatological issues that he had a history of seborrhoeic dermatitis/eczema which flared up from time to time and was recently referred for specialist treatment.

15. Mr Gellibrand underwent regular Comprehensive Health Assessment Program (CHAP) assessments, but functional decline was noted as early as the months before February 2024. He continued to receive medical assistance from his regular general practitioner until 22 September 2025, when he was treated for his skin issues and his vital signs were recorded.

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

Circumstances in which the death occurred

16. On 28 September 2025, Mr Gellibrand appeared lethargic, had reduced food and fluid intake, and had been refusing medication. Care staff contacted emergency services, and he was transported to Monash Medical Centre. A one-week history of poor oral intake, lethargy, and constipation was noted.

17. His medical issues included polymicrobial bacteraemia[4] which was treated with antibiotics; a Klebsiella urinary tract infection which was treated with antibiotics; acute kidney injury with hypercalcaemia and hyperkalaemia in the context of dehydration which gradually improved to baseline throughout admission with rehydration, antibiotics and nasogastric feeds; reduced oral intake; extensive left lower limb deep vein thrombosis[5] which was treated with therapeutic enoxaparin; and multiple pressure wounds and a left natal cleft abscess which was treated with antibiotics and pressure care.

18. Mr Gellibrand did not make any recovery despite two weeks of nasogastric feeds and medical management. The palliative care team became involved on 21 October 2025, and he was transferred to McCulloch House for end-of-life care on the 23 October 2025 where he subsequently passed away on 29 October 2025.

Identity of the deceased

19. On 29 October 2025, Guy Edwin Gellibrand, born 18 August 1961, was visually identified by his carer, Belinda Lewis who had known him for 5 years.

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

[4] Blood culture grew enterococcus faecalis and coagulase negative staph.
[5] He was on prophylactic enoxaparin throughout admission.

Medical cause of death

21. Forensic Pathologist, Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 31 October 2025 and provided a written report of her findings dated 28 January 2026 which was completed by Adjunct Professor Hans de Boer.

22. The post-mortem examination noted that Mr Gellibrand had severe cerebral palsy and was quadriplegic and non-verbal and that this is a significant risk factor for the development of infections, deep vein thrombosis, and pressure wounds. In those circumstances the medical issues identified during his hospital admission are regarded as complications of his severe cerebral palsy.

23. The external examination did not show any significant injuries that may have caused or contributed to death.

24. The post-mortem CT scan showed a thickened bladder wall with some gas within the bladder, which may be secondary to a urinary tract infection. There were also marked coronary artery calcifications.

25. Dr Zhou provided an opinion that the medical cause of death was *1(a) Complications of Severe Cerebral Palsy (Palliated).* She was also of the opinion that Mr Gellibrand's cause of death was due to *natural causes* based on the available information.

26. I accept Dr Zhou's opinion on these matters.

FURTHER INVESTIGATION

Coroners Prevention Unit review

27. As part of my investigation, I obtained advice from the Coroner's Prevention Unit (**CPU**)[6] regarding the appropriateness of the medical care provided to Mr Gellibrand.

28. The CPU reviewed Mr Gellibrand's medical records and provided advice that he received excellent care.

[6] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

29. I accept the advice of the CPU on this matter.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Guy Edwin Gellibrand, born 18 August 1961;

(b) the death occurred on 29 October 2025 at McCulloch House, 246 Clayton Road, Clayton, Victoria, from *1(a) Complications of Severe Cerebral Palsy (Palliated)*; and

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

I convey my sincere condolences to those who loved and cared for Mr Gellibrand.

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:

Monash Health
Wotton Kearney on behalf of Dr Yuh Shyan Chong
Barry Nilsson on behalf of Life with Barriers
NDIS Commission
First Constable Elias Saade, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 15 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.