IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004968

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Melissa Joanne Dibble
Date of birth:	25 June 1970
Date of death:	06 September 2023
Cause of death:	1(a) BRONCHOPNEUMONIA 1(b) CEREBRAL PALSY
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004
Keywords:	In care, natural causes death, disability

INTRODUCTION

1. On 6 September 2023, Melissa Joanne Dibble (**Melissa**) was 53 years old when she died at the Alfred Hospital (**The Alfred**) in Prahran, Victoria.

2. At the time of her death, Melissa lived in specialist disability accommodation at 22 Sixth Street, Parkdale.

Background[1]

3. According to her sister, Karen Tyler (**Karen**), after Melissa was born, she had a 'very difficult neo natal period'. As a neonate, Melissa was diagnosed with cerebral palsy (spastic quadriplegia), cortical blindness and intellectual disability.

4. The youngest of three daughters, Melissa had a close bond with her nuclear family and their extended family. Karen related how their family enjoyed the support of their extended family in raising and caring for Melissa.

5. During her infancy, Melissa was referred to the Royal Children's Hospital (**RCH**) where she was assessed and treated. Karen described Melissa's treatment as a "wrap around service" which included speech therapy, physiotherapy and special education during her kindergarten years at 'Uncle Bob's Early Childhood Centre' which was affiliated to the RCH at the time. The service provided by the RCH also provided Melissa with access to a paediatrician, neurologist and ophthalmologist. The evidence indicates that Melissa had access to ongoing treatment at the RCH to manage her disabilities.

Effects of Melissa's disability

6. Karen related how the level of Melissa's disability affected the manner in which she related to others and the extent to which she was able explore and develop friendships. By Karen's account, her sister did not have 'many friends as a child, but as a young adult and (. . .) [during her] adulthood, [Melissa] made several friends at school'.

7. However, Karen did not believe that Melissa 'had any friendships in her later years'.

[1] Coronial Brief of Evidence [**CB**], statement of Karen Tyler

Melissa's move to a residential care unit[2]

8. Initially, Melissa was placed into weekly boarding at the school she attended, coming home over weekends. Melissa left school when she was about 19 years old.

9. When Melissa reached adulthood, however, her care needs became increasingly demanding on her 'aging parents'. Her parents were then able to secure a place for her in a 'Community Residential Unit' in Parkdale, Victoria, administered by SCOPE Disability Support Services.

10. According to Karen, her sister lived there and attended a SCOPE day service until her death. Karen related how Melissa 'loved her home' and her family was satisfied with the 'excellent' care provided to Melissa for the '32 years she lived there'. Karen did not 'recall any significant issues involving [Melissa's] care'.

Melissa's health concerns

11. Throughout her life, Melissa had 'several ongoing medical issues'. According to Karen, most of her health issues were related to her disabilities diagnosed in her infancy and early childhood.

12. Approximately 15 years before her death, Melissa was 'diagnosed with diabetes' which was managed by 'diet and medication'. Karen did not believe that her sister had any 'significant issues related to her diabetes'. The evidence indicates that Melissa's diabetes was appropriately managed.

13. However, in 2020, Melissa had a bout of cellulitis. Although this condition took several months to heal, the staff at her home 'provided excellent care during this episode'.

Decline in Melissa's health

14. Over the years, as Melissa grew older, her sister noticed that she was 'gradually losing some of her function'. Karen related how Melissa's mobility decreased, her vision deteriorated even further and, most significantly, her ability to swallow and eat became increasingly impaired. According to Karen, Melissa's 'lost function' in eating and swallowing 'caused a persistent cough'.

[2] Ibid. Melissa was a participant in the National Disability Insurance Scheme (**NDIS**).

15. From 2018 onwards, as Melissa's coughing bouts became progressively worse, she was reviewed by appropriate health care professionals, which included undergoing various speech pathology assessments, who made the necessary adjustments to Melissa's care needs to manage her conditions. Despite these adjustments, Melissa was admitted to hospital on at least two occasions, diagnosed with pneumonia.

16. Karen believed that the medical management of her sister's health concerns while she was 'in care' was excellent. Karen commented that Melissa was 'loved, cared for and valued' and further that she 'cannot speak highly enough of the care Melissa received'.

THE CORONIAL INVESTIGATION

17. Melissa'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

18. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspect that the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

19. Immediately before her death, Melissa was a person placed in care. However, section 52(3A) of the Act provides an exception to the position under section 52(2), that the coroner is not required to hold an Inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an Inquest into Melissa Joanne Dibble's death.

20. 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.

21. 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.

22. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Melissa'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.

23. This finding draws on the totality of the coronial investigation into the death of Melissa Joanne Dibble 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.[3]

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

Circumstances in which the death occurred[4]

24. On 27 August 2023, Melissa was admitted to The Alfred where attending clinicians diagnosed multiple significant health issues including, *inter alia*, bronchial pneumonia, upper limb oedema, iron deficiency anaemia and faecal loading'.

25. Melissa's treating team identified that her 'primary issue' was the bronchial pneumonia 'related to aspiration due to [her] copious secretions'. To manage her condition, clinicians of The Alfred's respiratory team performed 'pleural effusion drainage' and other associated procedures.

26. However, over the course of the next few days, Melissa's condition deteriorated and she experienced 'several days [with] episodes of hypotension', Glascow Coma Scale '(**GCS**) drops and dysphagia'. A multi-disciplinary team attended to Melissa's medical care needs during her time at The Alfred.

[3] 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.

[4] CB, E-Medical Deposition Form

27. After Melissa experienced a 'hypoxic event', in consultation with her family, the decision was taken to transition her to end of life care. She was then transferred to the palliative care team at The Alfred.

28. On 6 September 2023 at 1 am, Melissa passed away.

Identity of the deceased

29. On 6 September 2023, Melissa Joanne Dibble, born 25 June 1970, was visually identified by her sister, Karen Tyler, who signed a formal Statement of Identification.[5]

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

Medical cause of death[6]

31. Forensic Pathologist Dr Paul Bedford of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination upon the body of Melissa Joanne Dibble on 7 September 2023 and provided a written report of his findings dated 8 September 2023.

32. In the execution of his duties, Dr Bedford considered the following sources documents, inter alia:

    i. GP/Nursing Home Notes—Parkdale Medical Surgery;
    ii. E-Medical Deposition Form;
    iii. Post-mortem computed tomography (**CT**) scan;
    iv. Victoria Police Report of Death, Form 83.

33. Dr Bedford commented that Melissa Joanne Dibble passed away after she contracted pneumonia. The post-mortem examination did not reveal that any suspicious circumstances could have contributed to Melissa Joanne Dibble's death.

34. Dr Bedford provided an opinion that the medical cause of death was 1 (a) Bronchopneumonia and 1 (b) Cerebral Palsy. Dr Bedford opined further that Melissa Joanne Dibble's death was 'due to natural causes'.

[5] CB, Statement of Identification.

[66] CB, Medical Examiner's Report

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Melissa Joanne Dibble, born 25 June 1970;

    b) the death occurred on 06 September 2023 at The Alfred Hospital, Melbourne; and

    c) I accept and adopt the medical cause of death as ascribed by Dr Bedford and I find that Melissa Joanne Dibble died from bronchopneumonia on a background of cerebral palsy.

2. Having considered the factual matrix within which the death occurred, I am satisfied that the weight of the available evidence does not support a conclusion that a causal nexus existed between the fact that Melissa Joanne Dibble was 'in care' at the time of her death and the medical cause of her death. Consequently, on the evidence available to me, I am unable to definitely find that Melissa Joanne Dibble's status as a person who was 'in care' at the time of her death, is connected with or contributed to the medical cause of her death.

3. Further, the weight of the available evidence supports a conclusion that the medical care Melissa Joanne Dibble received while she was 'in care' at her 'Community Residential Unit' administered by SCOPE Disability Support Services and at The Alfred Hospital leading to her death was reasonable in the circumstances. Accordingly, I find that Melissa Joanne Dibble died by natural causes.

I convey my sincere condolences to Melissa's family 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:

Frank Dibble, Senior Next of Kin

Alfred Health

Senior Constable Jared Eames, Coroner's Investigator

Signature:

Coroner John Olle

Date: 15 October 2024

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.