IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006527

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Roger Henderson
Date of birth:	24 June 1965
Date of death:	9 November 2024
Cause of death:	1a: Complications of epilepsy and cerebral palsy
Place of death:	Bacchus Marsh Hospital 29-35 Grant Street, Bacchus Marsh, Victoria
Keywords:	In care – Natural Causes – Specialist Disability Accommodation

INTRODUCTION

1. On 9 November 2024, Roger Henderson was 59 years old when he died at Bacchus Marsh Hospital from complications of epilepsy and cerebral palsy.

2. At the time of his death, Roger resided at 5 Manor Street in Bacchus Marsh. The facility is a Specialist Disability Accommodation (**SDA**) facility enrolled under the National Disability Insurance Scheme (**NDIS**). His daily living supports were provided by disability service provider, 'Possability' who managed the SDA facility at Bacchus Marsh.

3. Roger had lived in the SDA facility in Bacchus Marsh since December 1999 along with four other men.

4. Roger received NDIS funded daily independent living support due to his diagnoses of cerebral palsy, epilepsy, scoliosis, quadriplegia, hydrocephaly, intellectual disability and chronic constipation. Roger had a profound intellectual disability. Roger's disabilities meant that he was non-verbal, however he communicated through making noises or via facial expressions. Roger was in a wheelchair and required supports with all day-to-day living tasks.

5. Roger was in state care since birth. He has no known family. Roger never attended schooling or held employment.

6. Roger's carers described him as a "*gentleman*" and remarked that he was 'very well loved and respected by his carers and housemates'.

BACKGROUND

7. In March 2022, Roger's treating clinician Dr Ravin Sadhai referred Roger to palliative care due to a decline in Roger's health following a diagnosis of COVID-19 and chronic constipation.

8. From this date, Roger remained in palliative care and was supported at home by allied health services, including occupational therapy, physiotherapy, and dietetics.

9. In July and November of 2022, Roger's treating clinicians reported that his condition had improved. He was described by a palliative care nurse as "*bright, alert and aware of his surroundings*". Roger was also reported to be "*eating and drinking well*" and had "*put on weight and is engaging more with staff*".

10. Roger remained on a palliative pathway. In July 2023, treating clinicians noted that his allied health supports were ceased as he was considered close to end of life.

THE CORONIAL INVESTIGATION

11. Roger's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). The death of a person in care or custody is mandatory even where the death appears to have been from natural causes. Roger was a 'person placed in custody or care' within the meaning of the Act as a person who was an SDA resident living in an SDA enrolled dwelling.[1]

12. In July 2025, I assumed carriage of the investigation into Roger's death from then Coroner John Olle for the purpose of finalising the case and making findings.

13. 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.

14. 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.

15. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Roger's death. The Coronial Investigator conducted enquiries on behalf of the Court, including taking statements from witnesses- such as Roger's carers, a forensic pathologist and investigating officers – and submitted a coronial brief of evidence. Roger's NDIS care plan was also provided to the court to assist with the investigation.

16. This finding draws on the totality of the coronial investigation into the death of Roger Henderson including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**). Whilst I have reviewed all the material, I will

[1] Under the *Coroners Regulations 2019* (Vic) reg 7 defines a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling' as a 'person placed in custody or care'. Further reg 8 mandates reporting obligations for a responsible person as 'a person who: (ii) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute'.

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

17. At 3.00pm on 8 November 2024, Roger's carers observed that he was short of breath and his temperature was recorded as 37 degrees. Roger was given Ventolin and paracetamol, and a decision was made to monitor him more closely due to his deterioration.

18. At 5.00pm staff observed that Roger was unsettled and short of breath. He was administered morphine for pain management. At approximately 6.00pm, staff contacted emergency services after observing that Roger remained unsettled and short of breath.

19. Ambulance Victoria arrived at 6.45pm and took over care of Roger where they decided he would require further treatment and that he should be conveyed to Sunshine or Footscray Hospital due to the seriousness of his condition. Roger was accompanied in the ambulance by one of his carers.

20. Roger's carer advised paramedics that his palliative care plan indicated that, should he require hospitalisation, he was to be directed to Bacchus Marsh Hospital as they were familiar with his palliative care needs. However, the carer could not locate Roger's palliative care plan. Paramedics therefore determined that Roger should be transported to Sunshine Hospital.

21. In transit, Roger's condition declined and the Mobile Intensive Care Ambulance (**MICA**) was called to assist treating paramedics. The ambulance met with the MICA team at a car park in Melton.

22. After Ambulance Victoria staff consulted with Roger's General Practitioner (**GP**) via telephone, a decision was made to convey Roger to the Bacchus Marsh Hospital. A senior carer from 'Possability', who had cared for Roger and knew him well for an extended period of time met them at the hospital.

[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.

23. On arrival at Bacchus Marsh Hospital, it was noted that Roger was not for resuscitation in accordance with his palliative care plan. He was transferred to the palliative care unit and measures were implemented for his comfort.

24. Roger's condition continued to deteriorate and he subsequently passed away at 5.30am on 9 November 2024.

Identity of the deceased

25. On 9 November 2024, Roger Henderson, born 24 June 1965, was visually identified by his carer, Tammy Bennett.

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

Medical cause of death

27. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and examined the results of a post-mortem computed tomography (**CT**) scan on 11 November 2024 and provided a written report of her findings dated 18 November 2024.

28. Dr Ho noted that post-mortem examination and CT scan were consistent with Roger's clinical history.

29. Dr Ho provided an opinion that the medical cause of death is appropriately formulated as '*1a Complications of epilepsy and cerebral palsy*'. Dr Ho advised that Roger's death was due to natural causes.

30. I accept Dr Ho's opinion.

FINDINGS

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

    a) the identity of the deceased was Roger Henderson, born 24 June 1965;

    b) the death occurred on 9 November 2024 at Bacchus Marsh Hospital, 29-35 Grant Street Bacchus Marsh, Victoria from complications of epilepsy and cerebral palsy; and

    c) the death occurred in the circumstances described above.

32. Having considered all the available evidence, I find that Roger'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 the death and to finalise the investigation in chambers.

CONCLUSION

1. Roger had profound disabilities set out above. Whilst Roger was entirely nonverbal, the witness statements from staff at the residence indicate a deep affection for Roger and an acknowledgement that he expressed much through his facial expressions. This acknowledgement extended to one staff member in particular, who had cared for him for over four years, remarking in her statement upon the fact that she did not believe that Roger had any intellectual disabilities "*because of the way he looked at her, it was like he completely understood what he was hearing*". I infer from this remark that his expressive abilities were very sophisticated, and staff were well aware of his preferences and responses including joy, to questions and concerns when they were communicating with him.

2. Roger was cared for by the community all his life as he had no family from the date of his birth. At the time of his death, he was supported pursuant to an NDIS plan which commenced on 21 June 2023. I have reviewed the NDIS plan dated 21 June 2023 and consider this to be the most recent form of his funding package. The NDIS plan allowed him to live as independently as possible and be supported to engage in activities to the best of his abilities. This included funding to provide him a bed with adjustability and a chair for him to be transported as necessary in daily life. He required assistance with daily living and was provided with this assistance. It also funded the human supports Roger needed to maintain his life. Roger was entitled to no less.

3. I observe that the carers known to Roger remained with him as he passed away, so he was not left only with hospital staff who were not familiar to him.

4. I note this level of care because I consider that Roger's quality of life was the subject of care and consideration and that a social connection was maintained through the last months of Roger's life. This afforded him human dignity and a sense of community, which are key aspirations of the NDIS.

I convey my sincere condolences to those who cared for and knew Roger.

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:

State Trustees Victoria

Possability Group

National Disability Insurance Agency

Senior Constable Stacey Bronchinetti, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 23 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.