IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001794

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Stephen Dennis Webster
Date of birth:	9 September 1961
Date of death:	4 April 2025
Cause of death:	1a: Aspiration pneumonia in a man with cerebral palsy
Place of death:	Box Hill Hospital 8 Arnold Street Box Hill Victoria 3128
Keywords:	In care death, aspiration pneumonia, cerebral palsy, natural causes

INTRODUCTION

1. On 4 April 2025, Stephen Dennis Webster was 63 years old when he died at Box Hill Hospital. At the time of his death, Stephen lived in specialist disability accommodation (**SDA**) in Box Hill, managed by Life Without Barriers (**LWB**).

2. Mr Webster was born with severe intellectual and physical disabilities which required significant care throughout his life and he required assistance with all daily living activities. Mr Webster had diagnoses of cerebral palsy, epilepsy, and severe oropharyngeal dysphagia. He had a history of respiratory issues including asthma and recurrent aspiration pneumonia due to his disability, for which he was admitted to hospital on multiple occasions.

3. LWB assumed Mr Webster's care in 2019 after the Department of Health and Human Services divested their care services. Mr Webster moved into a shared supported living space in Box Hill where he received 24-hour care including in-home support and supported access to the community.

4. During an extended inpatient admission for his recurrent aspiration pneumonia in September 2024, Mr Webster's treating team had discussions regarding Mr Webster's future medical management. Due to his chronic dysphagia, it was expected that he would continue to present with recurrent aspiration episodes. The decision was made to refrain from invasive monitoring and treatment of any future deterioration, and he would receive supportive care in hospital for any further aspiration events.

THE CORONIAL INVESTIGATION

5. Mr Webster's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] The sole reason for the report was that Mr Webster was a person placed in custody or care pursuant to the definition in section 4 of the Act, as he was a prescribed person or a person belonging to a prescribed class of person due to his status as an SDA resident residing in an SDA enrolled dwelling.[2]

[1] Section 4(1), (2)(c) of the Act.
[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a *prescribed person or a prescribed class of person* includes a person in Victoria who is an *SDA resident residing in an SDA enrolled dwelling*, as defined in Reg 5. I have received information that Mr Webster resided at an address where the residents meet these criteria.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Webster's death. The Coronial Investigator conducted inquiries and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Stephen Dennis Webster 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

10. On 2 April 2025, Mr Webster had returned from a day trip with his housemate when his carers noticed that he was having difficulty breathing. At approximately 7:50 pm, Mr Webster's carers provided him with Ventolin, and he was assisted to bed with the bedhead raised up. Mr Webster's carers continue to monitor him, but his condition did not improve and they requested an ambulance at approximately 9:30 pm.

11. Mr Webster was taken to Box Hill Hospital and reviewed by a Registrar in the Emergency Department. He was noted to have a cough with tachypnoea, hypotension, and low oxygen saturations. The medical team undertook investigations, finding right midzone opacification

[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.

on chest x-ray, elevated inflammatory markers, and dehydration. Mr Webster was given intravenous antibiotics and fluids.

12. Mr Webster was reviewed overnight by the General Medicine team and admitted under their care. Goals of care from previous admissions were reviewed, and active treatment was ceased. Mr Webster was given palliative care medications and referred to the palliative care team. On 3 April 2025, a meeting between one of Mr Webster's carers and the palliative care team confirmed that Mr Webster was not for active investigation and treatment.

13. Mr Webster was documented as being settled in the evening of 3 April 2025. He died in his hospital bed in the early morning of 4 April 2025.

Identity of the deceased

14. On 4 April 2025, Stephen Dennis Webster, born 9 September 1961, was visually identified by his carer, Glady Faki.

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

Medical cause of death

16. Specialist Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of Mr Webster's body on 7 April 2025 and provided a written report of her findings dated 9 April 2025.

17. The post-mortem examination and post-mortem CT scan revealed findings in keeping with Mr Webster's medical history and the reported circumstances in the lead-up to his death.

18. Dr Glengarry provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia in a man with cerebral palsy.

19. Dr Glengarry was satisfied that Mr Webster's death was due to natural causes.

20. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

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

    a) The identity of the deceased was Stephen Dennis Webster, born 9 September 1961.

b) The death occurred on 4 April 2025 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from 1(a) Aspiration pneumonia in a man with cerebral palsy.

c) The death occurred in the circumstances described above.

22. Having considered all the available evidence, I find that Mr Webster's death was from natural causes. No concerns have been raised regarding the disability or medical care provided to Mr Webster and there are no issues regarding the care provided to him which require further investigation. Mr Webster's death was not unexpected, and the only reason for the report to the Coroner was due to his status as a person placed in custody or care pursuant to the Act. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death.

23. I convey my sincere condolences to Mr Webster'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:

Paul Webster, Senior Next of Kin

Life Without Barriers (c/- Barry Nilsson)

Eastern Health

Senior Constable Ashleigh Crothers, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 01 September 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.