IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003698

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Gary Norman Rogers
Date of birth:	10 February 1955
Date of death:	30 June 2025
Cause of death:	1a : Complications of cerebral palsy 2 : Covid-19 infection
Place of death:	125 Whites Road Warrnambool, Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 30 June 2025, Gary Norman Rogers was 70 years old when he passed away at his home. At the time of his death, Mr Rogers lived in a residential care facility in Warrnambool managed by Scope Australia. His medical history included cerebral palsy, epilepsy, bronchiectasis and a previous lung resection. He also had an intellectual disability. He is warmly remembered as a happy and engaging person.

THE CORONIAL INVESTIGATION

2. Mr Rogers' 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. Mr Rogers was a person in care at the time of his death, and he was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Mr Rogers' death was from natural causes.

3. 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.

4. 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.

5. This finding draws on the totality of the coronial investigation into Mr Rogers' death, including information obtained from his health records and the National Disability Insurance Agency. While 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.[1]

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

Circumstances in which the death occurred

6. It had been reported that Mr Rogers had been generally unwell in the 12 months leading up to his death, and he had been experiencing increased difficulty with his mobility. His condition had further deteriorated shortly before his death in the context of a Covid-19 infection and reduced oral intake and, in consultation with family, he was transitioned to comfort care. Death was not unexpected.

Identity of the deceased

7. On 30 June 2025, Gary Norman Rogers, born 10 February 1955, was visually identified by his carer, Lisa Trigg.

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

Medical cause of death

9. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine conducted an examination on 2 July 2025 and provided a written report of her findings dated 8 July 2025. A review of a post-mortem computed tomography (**CT**) scan showed a large mass in the abdomen which Dr Ho stated was favouring malignancy.

10. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Ho expressed the opinion that the death was due to natural causes

11. Dr Ho provided an opinion that the medical cause of death *was 1(a) Complications of cerebral palsy, 2 Covid-19 infection*.

12. I accept Dr Ho's opinion.

[1] 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.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Gary Norman Rogers, born 10 February 1955;

    b) the death occurred on 30 June 2025 at 125 Whites Road, Warrnambool, Victoria, from complications of cerebral palsy and a Covid-19 infection as a contributing factor; and

    c) the death occurred in the circumstances described above.

14. As noted above, Mr Rogers' death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Rogers died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death

I convey my sincere condolences to Mr Rogers' 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:

Thomas Rogers, Senior Next of Kin

Scope Australia

Constable Lisa Anders, Coronial Investigator

Signature:

Coroner David Ryan

Date: 13 October 2025

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.