



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004549

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Julie Henrys
Date of birth:	14 February 1957
Date of death:	6 August 2024
Cause of death:	1(a) Multisystem failure complicating urosepsis and acute myeloid leukaemia
Place of death:	McCulloch House 246 Clayton Road Clayton Victoria 3168
Keywords:	Death in care, natural causes

INTRODUCTION

1. On 6 August 2024, Julie Henrys was 67 years old when she died following palliative care at McCulloch House at Monash Medical Centre. At the time of her death, Ms Henrys lived in specialist disability accommodation (SDA) in Mount Waverley, Victoria, managed by Life Without Barriers (LWB).
2. Ms Henrys moved into the Mount Waverley residence in approximately March 2019 and remained living there until her death. She preferred to be as independent as possible with her everyday living activities but due to her intellectual disability she required assistance with medication administration, meal preparation, supervision during mealtimes, organising her personal belongings and personal care. Ms Henrys was well liked by her housemates, she enjoyed travelling to different places and meeting her friends outside of the home.
3. Ms Henrys had a complex medical history which included a mild intellectual disability, hydrocephalus, epilepsy, inguinal hernia repair and oophorectomy. On 1 May 2024, Ms Henrys was diagnosed with Acute Myeloid Leukaemia (AML). Multiple treatment options were discussed with her family and due to Ms Henrys' complex health presentation, it was decided that she would not tolerate intensive chemotherapy. Clinicians proceeded to treat her with low-intensity chemotherapy aimed at controlling the AML, with a lower risk of major side-effects that would impact on Ms Henrys' quality of life. Ms Henrys remained at home during her treatment, and a nurse attended every two days to administer the chemotherapy. Following the completion of chemotherapy, Ms Henrys underwent a restaging bone marrow biopsy on 3 July 2024 which showed an absence of leukemia cells.

THE CORONIAL INVESTIGATION

4. Ms Henrys' death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).¹ Ms Henrys was a "person placed in custody or care" pursuant to the definition in section 4 of the Act, as she was "a prescribed person or a person belonging to a prescribed class of person" due to her 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 Ms Henrys resided at an address where the residents meet these criteria.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances in which the death occurred. These 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.
6. 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.
7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Henrys' death. The Coronial Investigator conducted inquiries and submitted a coronial brief of evidence.
8. This finding draws on the totality of the coronial investigation into the death of Julie Henrys 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

9. On 12 July 2024, Ms Henrys was admitted to the Emergency Department of Monash Medical Centre (MMC) with a fever. She was commenced on antibiotics and diagnosed with pyelonephritis.⁴ Ms Henrys remained in hospital and completed two weeks of antibiotics.
10. During her stay at MMC, Ms Henrys experienced multiple complications, including delirium with a fluctuating conscious state and agitation related to her cognitive impairment with concurrent pyelonephritis.

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 A kidney infection.

11. On 21 July 2024, Ms Henrys developed left-sided weakness and a computed tomography (CT) scan showed right corona radiata hypodensity, consistent with an acute stroke. She was commenced on 100 mg aspirin and 80g atorvastatin for secondary prevention of stroke.
12. On 23 July 2024, a neck CT incidentally revealed sub-segmental and segmental pulmonary emboli which had not been present on an earlier chest CT completed on 14 July 2024. Clinicians noted that on 18 July 2024, Ms Henrys was commenced on prophylactic enoxaparin, which is routine for venous thrombosis prophylaxis for medical patients admitted to hospital. Prior to this date, due to her chemotherapy, it was not deemed safe for her to have this medication.
13. Due to the accumulation of complications, Ms Henry experienced significant physical deterioration and required full assistance for personal care. On 29 July 2024, a bone marrow biopsy was performed and revealed an increase in the number of leukemia cells, which was consistent with a relapse of AML.
14. Clinicians advised the family of Ms Henrys that she had a poor prognosis and it was agreed that the appropriate treatment pathway would be palliative care. On 1 August 2024, Ms Henrys was transferred to the palliative care unit at McCulloch House.
15. Dr Matthew Dellit, General and Palliative Physician at MMC, noted that Ms Henrys' main symptoms were agitation due to delirium and pain. Ms Henrys' family preferred to have her transferred home to the residence in Mount Waverley for end-of-life care, however this was not possible as clinicians needed to stabilise her symptoms first before considering discharging her.
16. While in palliative care, Ms Henrys was treated with buprenorphine, clonazepam and olanzapine. On 5 August 2024, Ms Henry became increasingly drowsy, and it was apparent that she was entering a terminal phase. Thereafter, Ms Henrys received comfort care at at McCulloch House until her death on 6 August 2024 at 12.20 pm.

Identity of the deceased

17. On 6 August 2024, Julie Henrys, born 14 February 1957, was visually identified by her sister, Sandra Henrys.
18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an external examination of Ms Henrys' body on 7 August 2024 and provided a written report of his findings dated 8 August 2024.
20. The findings on examination were consistent with the reported circumstances. There was no evidence of any injuries that could have caused or contributed to the death.
21. A post-mortem CT scan showed coronary calcification, splenomegaly and no pneumonia.
22. Dr Lynch provided an opinion that the medical cause of death was "1(a) multisystem failure complicating urosepsis and acute myeloid leukaemia" and that the death was due to natural causes.
23. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Julie Henrys, born 14 February 1957;
 - b) the death occurred on 6 August 2024 at McCulloch House, 246 Clayton Road, Clayton, Victoria 3168, from multisystem failure complicating urosepsis and acute myeloid leukaemia; and
 - c) the death occurred in the circumstances described above.
25. Having considered all the available evidence, I find that Ms Henrys' death was from natural causes and was not unexpected. I have not identified any issues with the disability or medical care provided. On the contrary, she was clearly very well cared for at her residence in Mount Waverley. I note that Ms Henrys' family wanted her to return to her home in Mount Waverley for end-of-life care as they reported that she loved living there, and they have described the care that she received from the staff of Life Without Barriers as being "exceptional". As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to Ms Henrys' 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:

Sandra Henrys, Senior Next of Kin

First Constable Tanner Hope, Coronial Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 22 October 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.
