



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002612

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Glen Rowan Bailey
Date of birth:	16 August 1956
Date of death:	12 May 2024
Cause of death:	1(a) Bronchopneumonia in the setting of drug-induced parkinsons disease, hypoxic brain injury, schizophrenia and other medical comorbidities
Place of death:	Bendigo Health Hospice & Evaluation Unit 100 Barnard Street Bendigo Victoria 3550
Keywords:	Death in care, natural causes

INTRODUCTION

1. On 12 May 2024, Glen Rowan Bailey was 67 years old when he died at Bendigo Health. At the time of his death, Mr Bailey lived in specialist disability accommodation (SDA) in Strathdale, Victoria.
2. Mr Bailey began living in supported residences from the age of 17 years. From 2000, Mr Bailey resided at the former Sandhurst Centre until its closure in 2015, after which he relocated to the Strathdale residence, where he received 24-hour care for all activities of daily living. He remained living there until his death.
3. Mr Bailey had a complex medical history which included a lifelong intellectual disability secondary to a hypoxic brain injury from birth asphyxia, schizophrenia, hypothyroidism, oesophagitis, cerebral atrophy, Parkinson's disease and recurrent urinary tract infections, amongst other conditions.

THE CORONIAL INVESTIGATION

4. Mr Bailey'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 Mr Bailey 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
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.

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 Bailey resided at an address where the residents meet these criteria.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Bailey's 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 Glen Rowan Bailey 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 19 December 2023, Mr Bailey was admitted to the Older Person's Unit (**OPU**) at Bendigo Health (**BH**) for supervised reduction of anti-psychotic medication after experiencing severe Parkinsonism characterised by slowness of movement, muscle rigidity and mild hand tremors. Clinicians noted that his condition may have been caused by his medications, which were known to produce Parkinsonism as a side effect, in addition to age related brain changes on the background of his neurological vulnerability. During his admission, oral olanzapine was ceased and this led to improvement in his walking and slowness. He was discharged back to his SDA residence on 29 December 2023.
10. Over the following days, Mr Bailey became aggressive and violent, requiring the attendance of emergency services and a further hospital admission on 4 January 2024.
11. Mr Bailey was again cared for in the OPU due to the impulsive and severe violent behaviours he was exhibiting. During his admission, he was recommenced on oral olanzapine at a lower dose, but this was noted to have little effect on his aggression and violence. Mr Bailey was physically aggressive and exhibited problematic sexualised behaviours. He was commenced on cyproterone acetate which improved his condition. Mr Bailey was discharged on 5 February 2024, after his violent behaviours settled.

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.

12. On 9 February 2024, Mr Bailey re-presented to the Emergency Department at BH for a cognitive and functional decline assessment on advice from the Community Psychiatric Team. He was found to have suffered from significant extrapyramidal side effects⁴ after long-term antipsychotic medication usage and acute kidney injury with poor oral intake. He was subsequently admitted under the General Medical Team and managed in consultation with the Psychiatry Team.
13. On 22 February 2024, Mr Bailey was transferred to the Rehabilitation Unit to improve his physical function, however, his extrapyramidal symptoms persisted and he was unable to mobilise. Clinicians noted that Mr Bailey was unwilling to engage with a physiotherapist and there was limited participation in rehabilitation strategies due to his fluctuating levels of drowsiness. The Psychiatry Team was requested to take over his care and manage his symptoms, and the use of Electroconvulsive Therapy (ECT) was discussed to manage his psychotic symptoms. Approval for this treatment was sought from the Mental Health Tribunal (MHT) and granted on 19 March 2024.
14. An MRI scan undertaken on 19 March 2024 showed global brain shrinkage and moderate brainstem shrinkage.
15. On 21 March 2024, Mr Bailey was transferred to the OPU under the care of mental health specialists. Mr Bailey received 12 sessions of ECT with marginal improvement in his movements.
16. Clinicians noted that from 21 March 2024 onwards, there was a continued physical deterioration, and Mr Bailey became progressively weaker, less mobile, chair bound with muscle wasting and weight loss. Mr Bailey's intellectual function and cognitive functions were also deteriorating rapidly.
17. Following discussion with Mr Bailey's family, it was agreed that the appropriate pathway for Mr Bailey would be in palliative care.
18. Mr Bailey was transferred to the specialist palliative care and evaluation unit on 8 May 2024 and commenced on medications to assist with symptom management.

⁴ Extrapyramidal side effects (EPS) are medication-induced movement disorders caused by the blockade of dopamine receptors in the brain's basal ganglia.

19. Whilst in palliative care, Mr Bailey's condition continued to deteriorate, and he died on 12 May 2024.

Identity of the deceased

20. On 12 May 2024, Glen Rowan Bailey, born 16 August 1956, was visually identified by his brother-in-law, Alan Wright.
21. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an external examination of Mr Bailey's body on 13 May 2024 and provided a written report of her findings dated 3 June 2024.
23. The findings on examination were consistent with the reported circumstances and there was no evidence of any significant trauma.
24. A post-mortem CT scan showed an enlarged prostate, gas in the bladder consistent with indwelling catheter, gas in the liver and heart, and increased posterior lung markings, consistent with pneumonia.
25. Dr Francis provided an opinion that the medical cause of death was "1(a) Bronchopneumonia in the setting of drug-induced Parkinson's disease, hypoxic brain injury, schizophrenia and other medical comorbidities" and that the death was due to natural causes.
26. I accept the opinion of Dr Francis.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Glen Rowan Bailey, born 16 August 1956;
 - b) the death occurred on 12 May 2024 at Bendigo Health Hospice & Evaluation unit 100 Barnard Street, Bendigo, Victoria 3550, from bronchopneumonia in the setting of drug-induced Parkinson's disease, hypoxic brain injury, schizophrenia and other medical comorbidities; and
 - c) the death occurred in the circumstances described above.

28. Having considered all the available evidence, I find that Mr Bailey’s death was from natural causes and was not unexpected. The only reason the death was reported was due his status as an “*SDA resident residing in an SDA enrolled dwelling*”, meaning he was a “*person placed in custody or care*” at the time of his death. It was therefore mandatory that the death was reported to the coroner. I have not identified any deficiencies with the disability or medical care provided to Mr Bailey and no concerns have been raised in relation to the care which was provided. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into the death.

I convey my sincere condolences to Mr Bailey’s 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:

May Wright, Senior Next of Kin

Bendigo Health

First Constable Taryn Cooper, Coronial Investigator

Signature:



Coroner Catherine Fitzgerald

Date: 15 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.
