IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001918

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Roderick James Milner
Date of birth:	21 April 1970
Date of death:	05 April 2024
Cause of death:	1(a) REFRACTORY SEIZURES SECONDARY TO LENNOX-GASTAUT SYNDROME (PALLIATED) 2 PNEUMONIA
Place of death:	Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152

INTRODUCTION

1. On 5 April 2024, Roderick James Milner (Mr Milner) was 53 years old when he died at Eastern Health Wantirna, 251 Mountain Highway Wantirna.

2. At the time, Mr Milner lived in Specialist Disability Accommodation (SDA) located at 15 Greenwood Ave, Ringwood. The National Disability Insurance Service (NDIS) had provided a Care Package for Mr Milner and the Care Package included funding of his SDA accommodation at 15 Greenwood, Ave Ringwood.

3. The National Disability Insurance Agency (NDIA) had approved the most recent NDIS Care plan for Mr Milner and the plan was approved to commence from 11 December 2023.

4. In his NDIS plan Mr Milner stated:

   I would like to safely discharge from hospital with sufficient supports and services to move to a shared accommodation.

   I would like to be supported to improve my safety and independence both at home and in the community settings and have supports such as therapies and assistive technology to support this.

   I would like to have more capacity and opportunities to get out into the community, to socialise and participate in recreational activities that I enjoy. to regularly participate safely and independently like my peers, and build and maintain friendships in social and recreational activities.

THE CORONIAL INVESTIGATION

5. Mr Milner's 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. In addition, if a person

satisfies the definition of a person placed 'in care' immediately before death, the death is reportable even if it appears to have been from natural causes[1].

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. This finding draws on the totality of the coronial investigation into the death of Roderick James Milner 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.[2]

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

Circumstances in which the death occurred.

9. Mr Milner was a 53-year-old man who lived in a SDA at 15 Greenwood Ave, Ringwood. Mr Milner's medical history included a history of Lennox-Gastaut syndrome with refractory seizures intellectual disability hearing and vision impairment and chronic osteomyelitis of the elbow.

10. Mr Milner presented to Eastern Health on 30 March 2024 from SDA accommodation with increased seizure activity on the background of Lennox-Gastaut Syndrome. He had been having refractory seizures despite management on multiple anti-epileptics. During the admission, he was unable to receive oral anti-epileptics due to poor swallowing and there

[1] See the definition of *"reportable death*" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act.

[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.

were difficulties with intravenous (IV) administration of anti-epileptics. He was subsequently transferred to the Wantirna Palliative care unit for end of life care, and sadly died on 5 April 2024.

Identity of the deceased

11. On 5 April 2024, Roderick James Milner, born 21 April 1970, was visually identified by his father, Henry Robert Milner.

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

Medical cause of death

13. Specialist Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 8 April 2024 and provided a written report of her findings dated 9 April 2024

14. Dr Zhou provided an opinion that the medical cause of death was

    1 (a) REFRACTORY SEIZURES SECONDARY TO LENNOX-GASTAUT SYNDROME (PALLIATED).
    2 PNEUMONIA

15. Dr Zhou commented that;

    - Lennox-Gastaut Syndrome is a severe form of epilepsy that typically becomes apparent during infancy or early childhood.
    - The post-mortem CT scan showed findings suggestive of pneumonia in the lungs. Seizures are a risk factor for the development of pneumonia, particularly aspiration pneumonia.
    - On the basis of the information available to me at this time (as outlined above), I am of the opinion that this death was due to natural causes.

16. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Roderick James Milner, born 21 April 1970;

    b) the death occurred on 5 April 2024 at Eastern Health Wantirna, 251 Mountain Highway Wantirna Victoria 3152, from REFRACTORY SEIZURES SECONDARY TO LENNOX-GASTAUT SYNDROME (PALLIATED); and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Roderick's family for their loss.

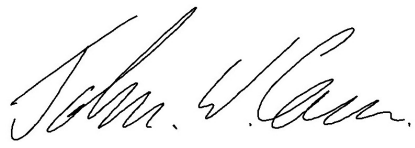
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Henry Milner & Wendy Milner, Senior Next of Kin

Senior Constable Thomas Wilson, Coroner's Investigator

Signature:



Judge John Cain
STATE CORONER
Date:16 May 2024

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.