IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 4524

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

(Amended pursuant to section 76 of the *Coroners Act 2008* as at 7 March 2019)[1]

I, AUDREY JAMIESON, Coroner having investigated the death of RYAN MYERS

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008* (Vic):
find that the identity of the deceased was RYAN MYERS
born 4 June 1989
and the death occurred on 8 September 2017
at 18 Clarke Road, Warranheip, Victoria, 3352
from:

1 (a) ASPIRATION PNEUMONIA IN A MAN WITH CEREBRAL PALSY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ryan Myers was 28 years old at the time of his death. He resided at 201 Victoria Street, Ballarat, in a Disability Accommodation Service (**DAS**) group home funded by the Department of Health and Human Services **(DHHS)**.

[1] Paragraph 5 amended to reflect the correct name of the deceased person: Mr Myers.

2. Mr Myers suffered many conditions including cerebral palsy, treatment resistant epilepsy, cortical vision impairment and global developmental delay. He was treated with numerous medications for these conditions. At the time of his death, Mr Myer's aunt Karen Davies was his co-guardian. She was actively involved in all aspects of her nephew's life, including healthcare and medical treatment.

3. On 8 September 2017, Mr Myers died at Ms Davies' home subsequent to a long decline in his health.

CORONIAL JURISDICTION

4. Mr Myers' death is reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (**'the Act'**) because he was a person placed in care at the time of his death. Section 3 of the Act states that a person placed in care includes a person who is under the control, care or custody of DHHS.

5. Section 52(3A) of the Act provides, *inter alia*, that a Coroner is not required to hold an Inquest into the death of a person who was in custody or care immediately before their death, if the Coroner considers that their death was due to natural causes. Mr Myers' death falls under the auspices of this section of the Coronial legislation and, consequently, I have determined that it was appropriate to finalise my Investigation by way of a Form 38 *Finding into a Death with Circumstances.* Such a Finding must be published, pursuant to section 73(1B) of the Act.

INVESTIGATIONS

Forensic pathology investigation

6. Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an examination upon the body of Ryan Myers, reviewed a post mortem computed tomography (**CT**) scan, a medical record extract and referred to the Victoria Police Report of Death, Form 83. External examination showed no unexpected signs of trauma. Dr Young ascribed the cause of Mr Myer's death to aspiration pneumonia in a man with cerebral palsy. He commented that aspiration pneumonia is infection of the lungs that occurs after inhaling (aspirating) foreign matter, such as vomitus or food. Cerebral palsy is a risk factor for aspiration.

Police investigation

7. Acting Sergeant (**AS**) Anthony Traynor was the nominated Coroner's Investigator.[2] In light of Mr Myers' in care status, I directed AS Traynor to conduct an investigation of the circumstances surrounding Mr Myers' death, including preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms Davies, Dr Kevin Carter (**GP**), Registered Nurse Mandy Martin of Ballarat Hospice Care Inc and Palliative Care Physicians Dr Eve Westland and Dr Penny Cotton of Ballarat Health Services.

8. In the course of the investigation AS Traynor learned that Mr Myers was born prematurely. As an infant, Mr Myers had developed meningitis following insertion of a shunt to treat hydrocephalus[3] resulting in profound cerebral palsy. He also suffered from severe epilepsy which was treatment resistant and he continued to have seizures on a weekly basis despite various medication regimes. Mr Myers was severely impaired physically and required full nursing care for personal hygiene, transfers and feeding.

9. Mr Myers had been cared for by his aunt Karen Davies from the age of two until he entered disability accommodation approximately fourteen years prior to his death. His parents and twin sister maintained an active role in his life and he would often go home for certain family occasions and holidays. Ms Davies stated that Mr Myers had limited verbal language but could make speech in simple terms and was able to make choices.

10. Ms Davies said that during the final few years of his life, Mr Myer's health deteriorated, his muscles were asymmetrical, and he was in pain. He had undergone surgery on his hip in his early teens and required several tendon releases over the years. Mr Myers was unable to say verbally how he was feeling but his carers were able tell Mr Myers was uncomfortable by the way he began to move and position himself.

11. On 24 August 2017 Mr Myers developed a 'small but chesty cough'. On 28 August 2017, Mr Myers attended a consultation with Dr Carter on 28 August 2017. Mr Myers had had a cough for five days, but his behaviour had otherwise been unchanged, and he

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[2] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the Coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

[3] Hydrocephalus is the abnormal enlargement of the brain cavities caused by a build-up of cerebrospinal fluid. Treatment includes a shunt surgically inserted into a ventricle to drain excess fluid.

was eating normally. Dr Carter states that on examination Mr Myers looked comfortable at rest and was afebrile. Mr Myers was not short of breath but had a few scattered mucous crepitations over his lung fields bilaterally. Dr Carter prescribed Mr Myers a course of oral antibiotics for a respiratory infection.

12. On 29 August 2017, Ms Davies received a phone call from a staff member at the group home who advised her Mr Myers had vomited overnight which was unusual. Ms Davies attended the group home at 4.00pm and found that Mr Myers looked unwell. Staff members were concerned as Mr Myers had refused to eat or take on any fluids that day.

13. Ms Davies contacted emergency services to request an ambulance for Mr Myers to St John of God Hospital in Ballarat. Ambulance staff were on bypass and unable to take Mr Myers to Mr Myers' preferred hospital so group home staff transported Mr Myers to St John of God Hospital. Mr Myers was admitted to the Emergency Department at St John of God Hospital. He was diagnosed with presumed aspiration pneumonitis and commenced on intravenous antibiotics. During his admission, Mr Myers had three witnessed tonic-clonic seizures which were treated with intravenous midazolam.

14. On 30 August 2017 Dr Cotton assessed Mr Myers. She witnessed Mr Myers to have two generalised tonic-clonic seizures during the consultation. Dr Cotton found that Mr Myers did not have a fever, had a normal blood pressure of 120/70 and heart rate of 84, with acceptable oxygen saturations of 95% without supplemental oxygen. Dr Cotton noted Mr Myers had a moist cough and did not appear to be able to effectively clear sputum.

15. After discussions between Mr Myers' family and treating health professionals, a decision was made to cease further active treatment and for Mr Myers to be taken to Ms Davies' home to manage his illness conservatively. Dr Cotton prescribed a continuous infusion of midazolam 10mg, administered via a syringe driver over 24 hours to replace Mr Myer's usual oral antiepileptic medications which he was unable to swallow. Mr Myers was also prescribed morphine, metoclopramide and hyoscine butylbromide on an as needed basis to manage distressing symptoms. Mr Myers was referred to the local community palliative care nursing service, Ballarat Hospice Care Inc (**BHCI**).

16. On 1 September 2017, Mr Myers was reviewed by Dr Westland. Mr Myers was alert and able to communicate his discomfort with examination non-verbally. Examination of Mr Myers' chest was unremarkable, and he was well perfused. He was unable to swallow

his usual medications but was still managing small amounts of oral intake. The continuous infusion of midazolam for distress and seizure prophylaxis was increased to 20mg and morphine 20mg for pain and breathlessness was added in response to Mr Myers' symptoms over the previous two days. Dr Westland noted that Mr Myers appeared to be very comfortable and well cared for.

17. On 5 September 2017, Mr Myers was reviewed at home by Dr Westland. Dr Westland found that Mr Myers' condition appeared to have deteriorated. He was clinically dehydrated and less interactive. As Mr Myers had not experienced any seizures since being discharged from the emergency department, the dose of midazolam in the continuous infusion was decreased to 15 mg over 24 hours in order to maximise Mr Myers' capacity to tolerate oral intake.

18. On 6 September 2017, Mr Myers was reviewed by Dr Cotton. Dr Cotton noted that Mr Myers had deteriorated further, he was less alert and remained clinically dehydrated but clearly refused fluids. Mr Myers' family continued to express their wish that Mr Myers be cared for at home and there were no concerns that his care needs were not being met. Mr Myers' condition continued to deteriorate, and he became unresponsive.

19. On 8 September 2017, at 4.00pm, Mr Myers was declared deceased.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. There is no evidence to suggest that there is any public interest in taking this matter to a Hearing by way of an Inquest. Mr Myers' medical care and treatment appears reasonable. There are no family concerns in relation to the same. The Disability Services Commissioner ('**the Commissioner**') conducted an investigation into disability services provided by DHHS to Mr Myers. I am satisfied that the Commissioner's investigation did not identify any issues with Mr Myers' medical care and treatment that were causal or connected to Mr Myers' death.

2. My Investigation has corroborated the information provided to me in the forensic pathology investigation, that is, Mr Myers' death arose from natural causes. As such, section 52(3A) of the Act provides that it is not mandatory to hold an Inquest into this

matter. However, his death has been investigated pursuant to the mandate to investigate and produce written findings in relation to all deaths which occur "in care". Additionally, the Finding must be published, pursuant to section 73(1B) of the Act.

3. I acknowledge that it may be difficult for Mr Myers' loved ones to understand why an Investigation must be conducted in these circumstances. Coronial Investigations into "in care" or "in custody" deaths operate to identify any issues which arise when an individual is in the care of the State of Victoria. In that regard a Coroner's Investigation operates as an important, albeit final, safeguard in relation to the protection of such persons' rights and interests.

FINDINGS

The investigation has identified that Ryan Myers suffered a number of health conditions and that his condition deteriorated significantly in the final weeks of his life, resulting in hospitalisation.

I accept and adopt the medical cause of death indicated by Dr Gregory Young, Forensic Pathologist, and I find that Ryan Myers died from aspiration pneumonia which arose in a man with cerebral palsy.

I find that there is no causal connection between the cause of Ryan Myers' death and the care provided to him by the Department of Health and Human Services by way of the Ballarat Disability Access Service Group Home.

I further find that there is no causal connection between Ryan Myers' death and the medical care and treatment provided to him by St John of God Ballarat Hospital or Ballarat Hospice Care Inc.

I express my sincere condolences to Mr Myers' family and friends.

Pursuant to section 73(1B) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

Mr David Myers and Mrs Patricia Myers
Ms Michelle Franc of St John of God Ballarat Hospital
The Disability Services Commissioner

Signature:

AUDREY JAMIESON
CORONER
Date: **7 March 2019**