IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1952

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	David Musicka
Date of birth:	11 April 1963
Date of death:	28 April 2018
Cause of death:	1(a) Complications of pneumonia
Place of death:	11 Burn Street, Ararat, Victoria

INTRODUCTION

1. On 28 April 2018, David Musicka was 55 years old when he died in his sleep from natural causes. At the time of his death, Mr Musicka was in the care of the Department of Health and Human Services and lived in a residential care home.

THE CORONIAL INVESTIGATION

2. Mr Musicka'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. 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.

3. As Mr Musicka was in care at the time of his death, his death is a reportable death. An inquest is mandatory for the death of a person in care, however section 52(3A) of the Act states that a coroner is not required to hold an inquest if the death was due to natural causes, as is the case here.

4. 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.

5. 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.

6. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Musicka's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. The Court also obtained a statement from Mr Musicka's general practitioner and had access to a report by the Disability Services Commissioner.

7. This finding draws on the totality of the coronial investigation into Mr Musicka's death, 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.[1]

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

Identity of the deceased

8. On 24 April 2018, David Musicka, born 11 April 1963, was visually identified by his support worker, Peter Kaup.

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

Medical cause of death

10. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 2 May 2018 and provided a written report of his findings dated 19 November 2019.

11. The post-mortem examination revealed acute bilateral bronchopneumonia and organising pneumonia on a background of chronic bronchitis. There were cavitating lung lesions and microbiology cultures detected *Streptococcus pneumoniae and milleri*, which are often associated with lung infections.

12. Toxicological analysis of post-mortem samples identified the presence of oxycodone,[2] mirtazapine,[3] olanzapine,[4] and paracetamol.[5]

13. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Complications of pneumonia"*, which was a natural cause of death.

14. I accept Dr Bouwer's opinion.

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[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.

[2] Oxycodone is a semi-synthetic opiate narcotic analgesic used clinically to treat moderate to severe pain.

[3] Mirtazapine is used in the treatment of depression.

[4] Olanzapine is used for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.

[5] Paracetamol is an analgesic drug.

Circumstances in which the death occurred

15. Mr Musicka had cerebral palsy and had moved to the residential care home in Ararat approximately 10 months before his death. According to house supervisor, Peter Kaup, Mr Musicka had been transferred from a rehabilitation hospital and was homeless due to receiving assault charges and being removed from a private care facility.

16. On 31 March 2014, Mr Musicka had been found not guilty on the grounds of mental impairment[6] and was made subject to a five-year Non-Custodial Supervision Order, commencing on 22 August 2014, which required him to be under the supervision of the Department of Health and Human Services.

17. Mr Kaup stated that Mr Musicka often complained about *"pain all over"*, he suffered regular knee pain, and his right hip was deteriorating. He would also suffer from chest infections.

18. Mr Musicka's healthcare was managed by Dr Chee Sheng Wong at the Ararat Medical Centre. Mr Musicka regularly attended the Medical Centre and last attended on 20 April 2018 for polymyalgia rheumatica and received a prescription for prednisolone (steroid medication).

19. On 27 April 2018, Mr Musicka enjoyed an outing to Stawell. According to his support worker, Milagros Jamieson, he appeared *"quite happy"* and ate and walked normally. She noted that there was nothing unusual about Mr Musicka's behaviour that day and she could not recall him complaining of anything, such as an illness or symptoms of an illness, that day.

20. Mr Musicka retired to bed at 9.00pm that evening.

21. Ms Jamieson noted that she heard Mr Musicka snoring at approximately 2.00am the next morning, 28 April 2018, while she was assisting another resident.

22. That morning, Mr Musicka did not awaken at his usual time of 6.00am.

23. Ms Jamieson checked on Mr Musicka at approximately 6.20am, at which time she could see the rise and fall of his chest, which indicated he was breathing.

24. Noting that this was unusual that Mr Musicka was still asleep, Mr Kaup asked Ms Jamieson to check on him at approximately 7.30am. When Ms Jamieson checked on him, Mr Musicka appeared to be asleep.

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[6] Pursuant to the *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997.

25. When Ms Jamieson checked on Mr Musicka again at approximately 8.20am, she found him unresponsive. Both she and Mr Kaup tried to awaken Mr Musicka, who appeared still warm to touch but did not have a pulse. Mr Kaup administered cardiopulmonary resuscitation while awaiting paramedics. When paramedics attended, they confirmed that Mr Musicka was deceased.

FURTHER INVESTIGATIONS

26. Given Mr Musicka's cause of death was determined to be due to pneumonia, it appeared unusual that his carers did not mention him exhibiting any symptoms before his death. I requested information from the VIFM pathologist, Dr Bouwer, about whether someone with pneumonia could appear asymptomatic and enjoy an outing on the day before his death.

27. In an email dated 7 May 2020, Dr Bouwer explained that he had determined that the severe pneumonia had been ongoing for some time. He noted symptoms would include fever, breathing difficulty, chest pains, mucus, sweating, chills or shivering, muscle aches, and low energy or fatigue. Dr Bouwer believed it would have been unusual for someone to be completely asymptomatic with the degree of lung infection found in Mr Musicka.

28. Given Dr Bouwer's advice, I sought a statement from Mr Musicka's general practitioner, Dr Wong, as to whether Mr Musicka had presented with any pneumonia-like symptoms before his death.

29. In a statement dated 21 May 2020, Dr Wong recalled that he had been informed Mr Musicka had a left lung nodule when he first consulted him. At that time, it was being monitored with no active treatment. Mr Musicka also had generalised body pain, for which he had been prescribed Targin (oxycodone with naloxone). Dr Wong subsequently referred Mr Musicka to Ballarat Health Services for investigation of the nodule and started Mr Musicka on prednisolone for the generalised body pain, which he believed was due to polymyalgia.

30. Mr Musicka first presented with respiratory symptoms on 4 December 2017, at which time he complained of breathlessness and cough. Dr Wong believed these symptoms were due to an upper respiratory tract infection of likely viral origin.

31. On 22 February 2018, Mr Musicka again presented as *"chesty"* and Dr Wong prescribed an antibiotic. Mr Musicka had also recently been reviewed by an oncologist at Ballarat Health Services who determined he had a sclerosing pneumocytoma (a benign tumour of the lung).

There had been some recent increase in size, which may have been due to infection and antibiotics had been prescribed.

32. On 23 March 2018, Mr Musicka again presented as chesty and Dr Wong directed observation only as he detected only fine crepitations in the lungs.

33. Dr Wong last saw Mr Musicka on 20 April 2018 at which time there was no obvious chest complaint. Mr Musicka had in fact walked down the corridor to Dr Wong's office rather than use his wheelchair.

34. Given Dr Wong's evidence that Mr Musicka did not have an obvious chest complaint just days before his death, I requested the Court's Health and Medical Investigation Team (**HMIT**) to review Mr Musicka's medical records and the statements from Dr Wong and the carers.

35. The HMIT is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

36. After reviewing the evidence, the HMIT noted that Mr Musicka was receiving active surveillance by the oncology team at Ballarat Health Services for a benign but enlarging lung lesion. His last review was on 14 February 2018 at which time results were discussed and a plan was made with the Office of the Public Advocate. At that time, antibiotics were prescribed for an infection.

37. The HMIT also noted that Mr Musicka's carers did not notice any symptoms of pneumonia the day before his death.

38. The HMIT advised that although it is uncommon not to display acute symptoms, there are cases where people who have marked signs of pneumonia at post-mortem examination have exhibited few clinical signs before death. The HMIT therefore concluded that the medical care Mr Musicka received before his death was reasonable and there were no prevention opportunities. I accept and agree with the HMIT's advice.

39. I also note that the Disability Services Commissioner also conducted an investigation after Mr Musicka's death. While the Commissioner identified some deficiencies with the

documentation at his care home and supervision, these did not contribute to Mr Musicka's death.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was David Musicka, born 11 April 1963;

(b) the death occurred on 28 April 2018 at 11 Burn Street, Ararat, Victoria, from complications of pneumonia; and

(c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Musicka'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:

Karen Musicka, senior next of kin

First Constable Wayne Glover, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 29 January 2021

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 six 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.