IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 005866

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Robin Frank Henry Wisseling
Date of birth:	3 April 1960
Date of death:	25 October 2019
Cause of death:	1(a) Pneumonia in a man with Lennox-Gastaut syndrome
Place of death:	Monash Health, Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria

INTRODUCTION

1. On 25 October 2019, Robin Frank Henry Wisseling was 59 years old when he died at Casey Hospital. At the time of his death, Mr Wisseling resided in a Department of Health and Human Services (**DHHS**) group home in Berwick and was receiving DHHS funded and regulated support through Home@Scope.

2. Mr Wisseling's medical history included Lennox-Gastaut syndrome, epilepsy, spastic quadriplegia, scoliosis, and a severe intellectual disability.

THE CORONIAL INVESTIGATION

3. Mr Wisseling's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (the Act). Mr Wisseling's death was reportable as he was in care of the State immediately before the time of his death.[1] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

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. This finding draws on the totality of the coronial investigation into the death of Mr Wisseling including evidence contained in his medical records and the review conducted by the Disability Services Commissioner (**DSC**). Whilst I have reviewed all the material, I will only

[1] Section 4(2)(c).

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

7. Throughout July 2019, Mr Wisseling experienced persistent congestion and coughing, for which he was admitted to Casey Hospital for a week and received oxygen therapy.

8. On 15 August 2019, Mr Wisseling was readmitted to Casey Hospital following two seizures. He remained in hospital overnight and was discharged the following day with clobazam, a strong anti-epilepsy medication.

9. Throughout September 2019, Mr Wisseling consulted his general practitioner due to increased lethargy, tiredness, and low temperature.

10. On 2 October 2019, Mr Wisseling underwent a speech pathology assessment, which concluded that he was at a significant risk of choking and aspiration pneumonia. His mealtime management plan was amended to highlight that he required assistance with eating and drinking.

11. Mr Wisseling's lethargy and low temperature continued, prompting an admission to Casey Hospital on 6 October 2019. His carer and the Home@Scope housing supervisor, Catherine Little, provided collateral history to his treating clinicians. Ms Little indicated that Mr Wisseling recently experienced a "*moist cough/gurgling*" and his general practitioner trialled him on two courses of oral antibiotics. His oral intake was poor, but he had not experienced vomiting or constipation, nor had he experienced any visible signs of pain or distress.[3]

12. On admission, Mr Wisseling experienced respiratory acidosis and was commenced on oxygen therapy. A chest X-ray was conducted, which revealed "*consolidation and ?pleural effusion on left side*", and a full blood examination revealed a platelet deficiency.

---

[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.

[3] e-Medical deposition completed by Dr Amreeta Kaur of Casey Hospital.

13. Due to his poor prognosis, Mr Wisseling was commenced on a palliative pathway and comfort measures were implemented. Mr Wisseling's condition continued to deteriorate, and he was subsequently pronounced deceased at 10.20pm on 25 October 2019.

Identity of the deceased

14. On 29 October 2019, Robin Frank Henry Wisseling, born 3 April 1960, was visually identified by Catherine Little.

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

Medical cause of death

16. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 29 October 2019 and provided a written report of his findings dated 30 October 2019.

17. Dr Young consulted a post-mortem computed tomography (CT) scan, which revealed increased markings in the left lung and extensive deformities to the skeleton and brain. Dr Young did not observe any unexpected signs of trauma.

18. Dr Young provided an opinion that the medical cause of death was 1(a) Pneumonia in a man with Lennox-Gastaut syndrome, and considered that Mr Wisseling's death was due to natural causes.

19. I accept Dr Young's opinion.

REVIEW OF CARE

20. Following Mr Wisseling's death, the Home@Scope undertook a review of their disability services and reported to the DSC the results of their review. Home@Scope indicated that formal action plans were implemented for recognising and managing deteriorating health and communication. Home@Scope also identified the need for improvement of records management in order to better support residents with deteriorating health, and subsequently implemented staff training and monthly meetings in this regard.

21. The DSC ultimately considered that no further action was required, and I am satisfied with this course. I am also satisfied that the care provided by Home@Scope to Mr Wisseling in the period proximate to his death was reasonable and appropriate.

22. As noted above, Mr Wisseling's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Wisseling died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into his death.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Robin Frank Henry Wisseling, born 3 April 1960;

    (b) the death occurred on 25 October 2019 at Monash Health, Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria, from pneumonia in a man with Lennox-Gastaut syndrome; and

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

I convey my sincere condolences to Mr Wisseling'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:

Rosa Wisseling, Senior Next of Kin

Disability Services Commissioner

Lanii Birks, Monash Health

Senior Constable Lana McGuire, Coroner's Investigator

Signature:

DARREN J. BRACKEN

CORONER

Date: 21 May 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 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.