IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 002939

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Raymond John Cassar
Date of birth:	18 May 1971
Date of death:	20 June 2018
Cause of death:	1(a) Pneumonia 1(b) Motor neurone disease
Place of death:	Yooralla Ventilator Accommodation Support Service, 335 Clarendon Street, Thornbury, Victoria, 3071

INTRODUCTION

1. On 20 June 2018, Raymond John Cassar was 47 years old when he died at Yooralla Ventilator Accommodation Support Service (**VASS**) in Thornbury. At the time of his death, Mr Cassar was receiving Department of Health and Human Services (**DHHS**) funded and regulated disability support. Mr Cassar is survived by his mother Grace, his siblings, nieces and nephews, all of whom regularly visited him.

2. In 2013, Mr Cassar was diagnosed with motor neurone disease. His medical history also included ischaemic heart disease, asthma, urinary incontinence, gallstones, schizophrenia, anxiety and depression.

3. Mr Cassar required ventilation for up to 16 hours each day, including use of a ventilator via a full face mask for overnight respiratory support. He mobilised with the assistance of an electric wheelchair and required full assistance with personal care and pressure care prevention. Mr Cassar experienced difficulties communicating and used a combination of facial expressions, vocalisations, a picture/alphabet board and an electronic communication device to communicate.

4. In 2015, Mr Cassar was commenced on a percutaneous endoscopic gastrostomy (**PEG**) tube to administer nutrition and medications due to issues with swallowing associated with a severely impaired cranial nerve and bulbar function.

5. Also in 2015, Mr Cassar advised via a Statement of Choices completed with Melbourne City Mission, his palliative care support service, that should he experience sudden cardiac or respiratory arrest, he did not wish to undergo cardiopulmonary resuscitation (**CPR**), a tracheostomy or invasive ventilation. Mr Cassar reaffirmed this advice on 14 January 2018 in via an Austin Health Resuscitation Plan.

THE CORONIAL INVESTIGATION

6. Mr Cassar'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 Cassar's death was reportable because, amongst other things he was in the 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

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

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.

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the deceased's identity, cause of death, and the 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.

8. Under the Act, coroners also have the important functions of reducing the number of preventable deaths as well as 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Cassar's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as Mr Cassar's family, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into Mr Cassar's death including evidence contained in his medical records and a review conducted by the Disability Services Commissioner (**DSC**) into services which Yooralla VASS provided to him. 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

11. On 19 June 2018, Mr Cassar consulted his general practitioner after Yooralla Staff noted that he sounded "*very chesty*"; his doctor prescribed antibiotics for a chest infection.

[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.

12. Throughout the evening, Mr Cassar was provided clonazepam for increased anxiety and morphine for abdominal pain. At approximately 1.48am on 20 June 2018, he was administered further clonazepam and morphine.

13. At approximately 3.00am, Mr Cassar was observed by Yooralla staff to gesture to his chest to indicate he was experiencing discomfort. While staff were administering a saline nebuliser at approximately 3.30am, Mr Cassar lost consciousness and became unresponsive. Staff immediately contacted emergency services and commenced first aid, including CPR and the use of a mask for ventilation.

14. Ambulance Victoria paramedics arrived a short time later but were unable to find signs of life and pronounced Mr Cassar deceased at 3.41am.

Identity of the deceased

15. On 20 June 2018, Sadhna Chettri identified the deceased as their patient, Raymond John Cassar, born 18 May 1971.

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

Medical cause of death

17. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 22 June 2018 and provided a written report of his findings dated 30 October 2018.

18. Histological analysis revealed infective changes within the lungs with areas of acute bronchitis and pneumonia.

19. Toxicological analysis of post-mortem samples identified the presence of risperidone (and its metabolite, hydroxyrisperidone),[3] 7-aminoclonazepam,[4] sertraline,[5] metoprolol,[6] chlorpheniramine[7] and paracetamol.[8]

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[3] Risperidone is an atypical antipsychotic prescribed for schizophrenia and some behavioural disorders (delusions, aggression).
[4] 7-aminoclonazepam is a metabolite of clonazepam, which is clinically used for the treatment of seizures.
[5] Sertraline is an antidepressant drug for use in cases of major depression.
[6] Metoprolol is an antihypertensive drug.
[7] Chlorpheniramine is an antihistamine.
[8] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

20. In his report Dr Bedford opined that Mr Cassar's medical cause of death was 1(a) Pneumonia, 1(b) Motor neurone disease. He considered that Mr Cassar's death was due to natural causes.

21. I accept Dr Bedford's opinion.

REVIEW OF CARE

22. Following Mr Cassar's death, the DSC undertook a review of the disability services provided to him by Yooralla VASS. During the course of its review, the DSC examined Mr Cassar's health support plans, incident reports, his resident file notes, and other records that outlined the disability support provided to Mr Cassar. While the review identified some shortfalls in respect of Yooralla's incident record keeping and management of Mr Cassar's rapidly deteriorating health, the DSC considered that these issues did not contribute to the circumstances that gave rise to his death.

23. Nevertheless, Yooralla undertook to address these shortfalls and advised the DSC that several service improvements were undertaken since Mr Cassar's death, including the introduction of a new roles in quality and risk and a VASS site coordinator, the redesign of the progress notes template, improved systems for ordering medication, and the development of a staff training module with respect to managing customer health in emergency and non-emergency situations.

24. The DSC concluded that Yooralla staff were attentive to Mr Cassar's health and wellbeing needs as per directions outlined in his support plans, and also supported his access to multidisciplinary health care services for management of his complex health needs. Further, the DSC was satisfied that the services provided to Mr Cassar were provided in a manner that promoted his rights, dignity, wellbeing and safety, and that his quality of life was enriched by staff supporting his social activities and meaningful relationships with family and friends.

25. The DSC ultimately considered that no further action was required in this regard, and I am satisfied with this course. I am also satisfied that the care provided by Yooralla staff to Mr Cassar in the period proximate to his death was both reasonable and appropriate.

26. As noted above, Mr Cassar'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 Cassar 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

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

(a) the identity of the deceased was Raymond John Cassar, born 18 May 1971;

(b) the death occurred on 20 June 2018 at Yooralla Ventilator Accommodation Support Service (VASS), 335 Clarendon Street, Thornbury, Victoria, 3071, from 1(a) Pneumonia, 1(b) Motor neurone disease; and

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

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:

Mary Cassar, Senior Next of Kin

Senior Constable Shane Flaherty, Coroner's Investigator

Signature:

Coroner Darren J. Bracken

Date : 15 October 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.