IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 004568

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: KATRINA JANE CERVASIO

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	4 August 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	4 August 2023
Representation:	Ms Bridget Linton of MinterEllison on behalf of Yooralla (via Webex)
Counsel assisting the Coroner:	Ms Anna Pejnovic of the Coroners Court of Victoria
Catchwords	Disability services; person in care; NDIS; natural causes

I, AUDREY JAMIESON, Coroner, having investigated the death of KATRINA JANE CERVASIO

AND having held a Summary Inquest in relation to this death on 4 August 2023

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was KATRINA JANE CERVASIO

born on 22 July 1975

died on 10 September 2018

at 2 Clota Avenue, Box Hill, Victoria 3128.

from:

1 (a) COMPLICATIONS OF OBESITY INCLUDING CARDIOMEGALY

in the following summary circumstances:

Katrina Jane Cervasio was 43 years of age and lived in a group home at 2 Clota Avenue, Box Hill at the time of her death. The group home was managed by Yooralla, a National Disability Insurance Scheme (**NDIS**) provider of disability support services. Ms Cervasio died at the group home on 10 September 2018 following a deterioration in her health. She was the much-loved daughter of Gerry and Daniela Cervasio, and younger sister of Olivia.

BACKGROUND CIRCUMSTANCES

1. Ms Cervasio was born with arthrogryposis (congenital joint contractures), and her medical history included moderate intellectual disability, sleep apnoea, cerebral palsy and anxiety. She was also obese and required the assistance of a wheelchair for mobility.

2. Ms Cervasio had been a resident of another Yooralla-managed group home in Chadstone since 1998. In 2014, she moved to the group home at Clota Avenue. Mrs Cervasio reported that her daughter was content with the living situation at the group home. She enjoyed participating in community activities organised by Yooralla.

3. Due to her sleep apnoea, Ms Cervasio was provided a continuous positive airway pressure (**CPAP**) machine to assist her breathing during her sleep at night. Her latest Client Support Plan (**CSP**) revised in 2018, indicates that she was switched to a bi-level positive airway pressure (BiPAP) machine. Her Health Support Plan referred to her sleep apnoea condition and the risk of her condition as follows:

Kate experiences sleep apnoea; a condition that causes a person to stop breathing for short periods of time continually when they are asleep. Kate's airway blocks because the muscle relax when she is deeply asleep. Kate will always start breathing again as the lack of oxygen alerts Kate take a breath. This can be quite exhausting as Kate can experience this several times throughout the night and mean that she is extremely tired during the day. It also increases her risk of heart disease and other related diseases.

4. Ms Cervasio's Medical Authority Form[1] recorded that her *Pro Re Nata* (**PRN**) medication[2] included Panamax (paracetamol), which was indicated for pain relief.

THE CORONIAL INVESTIGATION

Jurisdiction

5. The death of Katrina Jane Cervasio was a reportable death under section 4 of the *Coroners Act 2008* (Vic) ("the Act") because it occurred in Victoria and appeared to be unexpected.

6. Ms Cervasio was not formally 'in care' at the time of her death on 10 September 2018, having transitioned to the NDIS shortly before her death. However, her care requirements were materially the same as when she was 'in care' pursuant to section 3(1) of the Act.[3] The shift in funding for disability services in Victoria from the Department of Families, Fairness and Housing to the NDIS meant that the definition of *person placed in custody or care* in section 3(1) was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended. As Ms Cervasio's circumstances were analogous to that of a person 'in care', I determined to treat her death as an 'in care' death pursuant to section 3(1) of the Act.

7. It is of significance that the Coroners Regulations have now been updated to capture the deaths of potentially vulnerable persons such as Ms Cervasio, to ensure that any issues

[1] A form completed by the prescribing health professional(s) for a Yooralla customer.
[2] PRN medication means any non-prescription or prescription medication that is to be taken as needed.
3 The definition of person placed in custody or care in section 3(1) of the *Coroners Act 2008* includes 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health'.

associated with their care are appropriately and independently canvassed by the coroners of this state.[4]

8. An investigation into Ms Cervasio's death was also conducted under the auspices of the *Disability Services Act 2006* (Vic) ("the Disability Services Act") by the Disability Services Commissioner (**DSC**). DSC investigations have a different scope to that of a coronial investigation, although they can sometimes overlap. The jurisdiction of the DSC provides important oversight of disability services involved in the care of a particularly vulnerable group of persons. The DSC's jurisdiction expands to the services provided to the deceased during their lifetime, whether or not those services are connected with the death. The purpose of the DSC investigation is to identify issues in the services being investigated and to consider any action that the service provider should take in response to those issues or to otherwise improve the services being investigated.

9. Pursuant to section 7(a) of the Act, a Coroner should liaise with other investigation bodies to avoid unnecessary duplication and expedite the investigation. I have therefore conducted my investigation through a restorative and preventative lens without mirroring the DSC's investigation.[4]

Purpose of a coronial investigation

10. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[5]

11. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances

[4] The *Coroners Regulations 2019* were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. This amendment would have captured the death of Ms Cervasio.
[5] Section 67(1),= of the Act.

sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[6]

12. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[7]

13. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8] These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.[9]

14. The Coroners Court of Victoria is an inquisitorial jurisdiction.[10] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[11]

Inquest into the death of a person in care

15. Pursuant to section 52(3) of the Act, a Coroner must hold an Inquest if a person was a person *who immediately before death* was in the care of the State. However, pursuant to section 52(3A) of the Act, an Inquest is not mandatory as part of the coronial investigation into the death of a person in care, if the Coroner considers the death of a person in care was due to natural causes.

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[6] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[7] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".
[8] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[9] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[10] Section 89(4) of the Act.
[11] Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

16. The medical cause of Ms Cervasio's death has been ascribed to natural causes. Section 52(3A) of the Act could apply, however, I determined that it is appropriate to hold an Inquest because the circumstances surrounding her death appear to be unnatural.

17. In addition, Coroners have unfettered discretion on whether to hold an Inquest into any death being investigated.[12] Coroners must exercise their discretion on whether or not to hold an Inquest in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, Coroners should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

18. In all the circumstances, it was appropriate to hold an Inquest.

Sources of evidence

19. This Finding is based on the totality of the material produced by the coronial investigation into the death of Katrina Jane Cervasio. That is, the Court File and Coronial Brief of evidence compiled by Leading Senior Constable Anthony Magner. I have also had the benefit of reading the *Investigation Report into disability services provided by Yooralla to Ms Cervasio* ("Investigation Report") issued on 23 September 2020 by the DSC.

20. The Brief and the Investigation Report will remain on the Court File, together with the Inquest transcript.[13] In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Standard of proof

[12] See section 52(1) of the Act.
[13] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*[14]. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to
    - the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

IMMEDIATE CIRCUMSTANCES OF DEATH

22. In the months preceding her death, Ms Cervasio's health gradually deteriorated. Entries in her progress notes between 8 July and 12 August 2018 recorded that she experienced continuous menstrual bleeding and that the bleeding extended for over four weeks.

23. On 27 August 2018, staff noticed that Ms Cervasio was unwell and exhibited cold-like symptoms. Support staff administered paracetamol as per her Medical Authority Form.

24. Over the following days, Ms Cervasio's condition did not improve. Staff noted that she was *"still not feeling well"* and became *"very tired"*, especially in the evenings. The progress

[14] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

notes indicate that staff continued to administer paracetamol twice a day in the morning and evening until 31 August 2018, in order *"to relieve her cold"*.[15]

25. In the days leading to Ms Cervasio's death, support staff noticed a decline in her mood and appetite. Apart from noting that Ms Cervasio was noticeably tired in the evenings, support staff recorded that she attended her regular activities and outings as usual, and there were *"no issues"* identified.

26. On 6 September 2018, support staff noted that Ms Cervasio *"seems bit down* [sic]*"* in the evening and did not respond to them asking her, "are you ok?".

27. On the evening of 8 September 2018, night shift support staff noted in the Shift Report Book that Ms Cervasio *"was calling several times at night. She cough and sounds likes cold [sic]"*.

28. On the evening of 9 September 2018, support staff reported that Ms Cervasio continued to look tired after returning from her family visit. Support staff also reported that Ms Cervasio refused to eat her dinner. When asked how she was feeling, Ms Cervasio did not indicate to support staff whether she was feeling unwell and was then assisted to bed.

29. Throughout the night, active night support staff noted Ms Cervasio had *"many body adjustments"* during her sleep and that her breathing was "laboured".[16]

30. On 10 September 2018, at 7.00 am, support staff members Sharon Johnson and Lindsay Russell commenced their dayshift. They checked on Ms Cervasio and observed that she was asleep. At 7.50 am, Ms Johnson noticed Ms Cervasio was unresponsive and immediately called out to Mr Russell for assistance. Emergency services were contacted, and Ms Johnson and Mr Russell took turns performing cardiopulmonary resuscitation (**CPR**).

31. Ambulance Victoria arrived shortly after and took over CPR. Ms Cervasio was unable to be assisted and was declared deceased.

32. Victoria Police also attended the premises and commenced an investigation. No suspicious circumstances were identified.

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[15] CF, Attachment 15 – Progression Notes.
[16] CF, Attachment 19 – Shift Report Book – September 2018.

INVESTIGATION PRECEDING THE INQUEST

Identification

33. On 10 September 2018, Katrina Jane Cervasio, born 22 July 1975, was visually identified by her mother, Daniela Cervasio, who completed a Statement of Identification.

34. The identity of Katrina Jane Cervasio is not in dispute and requires no further investigation.

Medical cause of death

35. On 14 September 2018, Forensic Pathologist, Clinical Professor David Leo Ranson[17] from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Katrina Jane Cervasio. In preparing his report, Professor Ranson reviewed a post-mortem computed tomography (**CT**) scan and referred to the preliminary examination report, Victoria Police Report of Death (Form 83), E-Medical Deposition Form and medical records from Austin Health and Eastern Health. Professor Ranson provided a written report of his findings dated 20 October 2019.

36. Professor Ranson noted Ms Cervasio had WHO Class III obesity with a body mass index (**BMI**) of 45.22 kg/m^2.[18] She was known to have significant breathing difficulties and obstructive sleep apnoea for which she was using a BiPAP machine.

37. At autopsy, Professor Ranson noted the evidence of significant natural diseases in the form of cardiomegaly, in keeping with Ms Cervasio's degree of obesity, kyphoscoliosis, cholelithiasis, mild tracheobronchitis and coronary artery atheroma.

38. Professor Ranson commented that kyphoscoliosis could impede respiration if there is significant distortion of the thorax.

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[17] Dr Ranson is also the Deputy Director-Head of Forensic Services of VFIM.

[18] Body Mass Index is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²). According to the World Health Organisation, the normal range is 18.5 to 24.99 kg/m². 45.22 kg/m² is classified as obese.

39. Post-mortem CT scanning confirmed the macroscopic findings on the internal examination did not reveal significant additional pathology that might be expected to have contributed directly to the death.

Toxicology

40. Toxicological analysis of post-mortem samples did not reveal the presence of ethanol (alcohol) or common drugs or poisons.

Forensic pathology opinion

41. Professor Ranson concluded that Ms Cervasio's death was due to natural causes and ascribed the medical cause of death to: 1 (a) complications of obesity including cardiomegaly.

DISABILITY SERVICES COMMISSIONER INVESTIGATION[19]

42. Upon completion of its independent investigation into the disability services provided by Yooralla, the Commissioner provided the Court with an Investigation Report[20]. Upon provision of the report, the Commissioner requested that I comply with the conditions for further use and disclosure of the same.

43. As part of its investigation, the DSC considered documents relating to Ms Cervasio's care, as well as Yooralla's response to DSC questions relating to its service provision.

44. A draft Investigation Report, including a draft of the proposed Notice to Take Action, was subsequently provided to Yooralla to enable an opportunity to respond.[21]

45. The DSC identified the following issues pertaining to Ms Cervasio's care.

BiPAP machine maintenance

[19] Disability Services Commissioner, Investigation Report into disability services provided by Yooralla to Ms Cervasio, dated 23 September 2020.
[20] Pursuant to section 132ZB of the Disability Amendment Act.
[21] Section 132ZF of the Disability Act 2006 (Vic) requires that if a DSC Investigation Report makes an adverse comment on or gives an adverse opinion of an individual or a service provider, at least 14 days before giving the report, the DSC must give a copy of the relevant part of the report to the individual or service provider and give a reasonable opportunity to comment on the adverse comment or opinion.

46. The DSC advised that it could not find evidence of Yooralla ensuring appropriate maintenance of Ms Cervasio's BiPAP machine in accordance with the maintenance instructions in her Health Support Plan.

47. The DSC found that Yooralla did not follow the correct procedure for addressing the broken BiPAP machine. Yooralla staff also often erroneously referred to Ms Cervasio's BiPAP machine as a CPAP machine.

48. The DSC outlined that Ms Cervasio's BiPAP machine was broken on at least two consecutive nights (8 and 9 September 2018). The Yooralla Shift Roster Notes on 8 September 2018 recorded that Ms Cervasio *"didn't use Cpap machine…the wire seemed bit broken* [sic]*"* and on 9 September 2018, it recorded that the "*CPAP machine needs to be fixed ASAP"*.

49. While Yooralla later responded to the DSC and advised that Austin Hospital staff had reviewed Ms Cervasio's BiPAP machine following her death, finding it to be functional, the DSC noted it could not locate any technical report to support that the review had taken place.

50. In response to this issue, as indicated in the draft Investigation Report, Yooralla advised that following Ms Cervasio's death it had taken the initiative to implement improved practices and procedures to address the ongoing requirements of the maintenance and repair of essential equipment.

51. Particularly, concerning Ms Cervasio's circumstances, Yooralla advised that they had introduced specialised training on the use, maintenance and care of all CPAP and BiPAP machines. Yooralla assured that it will continue to ensure instructions addressing damage and repairs of ventilators including CPAP and BiPAP machines are easily accessible via the client's Health Support Plan.

<u>Management of Ms Cervasio's deteriorating health</u>

52. During the investigation into the care provided to Ms Cervasio, the DSC noted Ms Cervasio's continuous menstrual bleeding between 8 July and 12 August 2018, which was particularly uncommon given she had a contraceptive implant. The DSC was of the opinion that such an event should have triggered a medical review.

53. The DSC noted that on 27 August 2018, Yooralla support staff did not refer Ms Cervasio to medical attention when they suspected that she was developing a cold. In response, Yooralla advised that Ms Cervasio "had mild cold symptoms for a few days but was otherwise well".

54. Despite Yooralla's response, the DSC outlined that Ms Cervasio continued to exhibit signs of being unwell in the days leading up to her death. The DSC considered that Ms Cervasio's laboured breathing and noticeable change in mood and appetite were indications of deteriorating health and should have triggered a referral for further medical attention.

55. While the DSC considered that Ms Cervasio did not experience any major health complications in the period leading up to her death, the DSC was of the opinion that the series of minor deteriorations in her health should have been managed more effectively.

56. In response, Yooralla advised that it had updated and reinforced policies such as the *Recognising and Responding to Changing Support Needs Policy* and *Recognising and Responding to Emergency and Non-Emergency Health Events Policy*.

57. Yooralla also advised that they had implemented a new Customer Overnight Observation Record and improved its handover procedures.

Management of Ms Cervasio's weight

58. In their Investigation Report, the DSC noted a key principle of the Disability Act, that *disability services and regulated disability services should be provided in a manner that promotes the upholding of the rights, dignity, wellbeing and safety of persons with a disability*.[22]

59. Additionally, the DSC noted that the 2019 *Human Services Standards Policy* provided that *"all health (both physical and mental), nutritional, developmental and cultural and social strengths and needs are assessed, with services planned to support or address all aspects of those strengths and needs".*

60. Having reviewed all of Yooralla's records of Ms Cervasio, the DSC noted that Ms Cervasio weighed 71 kilograms (**kg**) in September 2017. Her weight had increased to 79kg around the time of her death.

61. Given her increasing weight, the DSC considered Ms Cervasio's Health Support Plan and found Yooralla did not actively manage her weight by way of any tailored weight management plan. The plan only indicated that *"I [Ms Cervasio] don't have special dietary requirements, but I like to maintain a healthy diet and need support in this. I often ask for more food or unhealthy food, but I would like staff to avoid giving it to me as I am sorry once I've eaten it"*.

62. The DSC identified that there were five occasions over a six-month period where Ms Cervasio was taken on an outing to consume coffee and cake, and that in those instances Yooralla's care and supervision did not align with Ms Cervasio's Health Support Plan to assist Ms Cervasio in maintaining a healthy diet.

63. Despite these outings not being a regular occurrence, the DSC noted that the six-month period in which the five outings took place was the same period during which Ms Cervasio had gained weight.

64. In response to the increase in Ms Cervasio's weight, Yooralla advised the DSC that she weighed 86kg when she first entered their care in 2014 and had lost 15kg by September

[22] Section 5(3)(ma) of the *Disability Act 2006* (Vic).

2017. Yooralla did not, however, indicate that Ms Cervasio had ever seen a dietitian or nutritionist.

65. Moreover, in response to the draft Investigation Report by the DSC, Yooralla advised that support staff last measured Ms Cervasio's weight on 5 August 2018 at 76.5kg. Yooralla further outlined that while there was an increase over the 12-month period as indicated by the DSC, regardless, Ms Cervasio still weighed 9.5kg less then when she first entered their care.

66. The DSC expressed concern that *"due attention was not given to [her] health and weight management, as reflected by the outings for cake and weight gain in the months leading up to her death"*.

Record keeping

67. The DSC identified that the main concern for Yooralla's record keeping of Ms Cervasio's information was the records kept in relation to her BiPAP machine, such as the cleaning and maintenance of the machine and the hourly records for overnight observation.

68. In that regard, the DSC could not locate any records of the BiPAP machine being cleaned regularly. The DSC could not identify any records of hourly checks undertaken during active night shifts, especially when the BiPAP machine was ordinarily used in the evenings.

69. In response to the DSC's request for further information, Yooralla advised that it had self-initiated service improvements after an internal review following Ms Cervasio's death. The internal review included reviews of the existing cleaning schedules and overnight observation records of staff monitoring clients using BiPAP machines.

Person-centred approach to care

70. Under section 5 of the Disability Act, *persons with a disability have the* r*ights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities*. *Persons with a disability* also *have the same rights as other members of the community,* particularly, *to respect for their human worth and dignity as individuals;* and *to live free from abuse, neglect or exploitation.*

71. The DSC noted Yooralla's policy on "*Recognising and Responding to Changing Support Needs*" defines person-centred care as *"an approach in planning that focuses on the people with disabilities and their needs by putting them in charge of defining the direction for their lives".*

72. In considering the policy, the DSC considered several examples of practices at Ms Cervasio's group home that were not consistent with the principles as provided under section 5 of the Disability Act and person-centred active support. It was identified that Yooralla support staff, on numerous occasions, inappropriately included derogatory comments about Ms Cervasio in her progress notes.

73. In response to this issue, Yooralla conceded that some of the notes in Ms Cervasio's file did not accurately reflect Yooralla's best practice, person-centred approach to service provision, nor the broader practice of its staff members.

DSC's Findings

74. Given the above consideration, the DSC made the following Findings: [23]

Finding 1: Yooralla did not follow the recommended procedures for maintaining Ms Cervasio's essential equipment (her BiPAP machine) and did not adhere to the requirement to replace damaged BiPAP equipment immediately.[24]

Finding 2: Yooralla did not effectively manage Ms Cervasio's deteriorating health prior to her death and did not contact a doctor or NURSE-ON-CALL.

Finding 3: Yooralla did not support Ms Cervasio to manage her weight appropriately.

Finding 4: Yooralla did not maintain adequate records relating to the care of Ms Cervasio's BiPAP machine.

[23] Disability Services Commissioner, Investigation Report into disability services provided by Yooralla to Ms Cervasio, dated 23 September 2020.

[24] The DSC made this finding regardless of whether the BiPAP machine was in fact functional on the night of 8 and 9 September 2018. This is because Yooralla staff did not take further action after having identified functional issues of the BiPAP machine.

<u>Finding 5:</u> Yooralla's progress notes about Ms Cervasio did not reflect a person-centred approach to the provision of services.

Notice to Take Action

75. As the result of the DSC investigation, a final *Notice to Take Action* was issued to Yooralla with the following requirements:

i. Share the findings and subsequent recommendations for service improvement detailed in this investigation with staff at 2 Clota Avenue, Box Hill.

ii. All current and future staff at 2 Clota Avenue, Box Hill, to undergo training by a qualified practitioner to improve capability in:

a) maintaining essential equipment (such as BiPAP and CPAP machines);

b) maintaining adequate records in relation to the care and maintenance of essential equipment;

c) weight management for residents assessed as obese;

d) person-centred practice; and

e) recognising and responding to residents who are demonstrating a deterioration of health and seeking assistance from a resident's doctor or NURSE-ON-CALL as early as possible.

iii. Yooralla to undertake a self-assessment of person-centred care at 2 Clota Avenue. Yooralla to develop and implement a mechanism to assess staff competency in person-centred care or use an existing tool such as the *Australian Commission on Safety and Quality in Health Care: Person-Centred Organisations Self Assessment Tool.*[25]

[25] https://www.safetyandquality.gov.au/publications-and-resources/resource-library/person-centred-organisations-self-assessment-tool.

iv. Yooralla to audit their health records for all residents at 2 Clota Avenue, Box Hill. Where residents have been assessed by their doctor as obese, Yooralla to arrange an appointment with a dietician to develop and implement a weight management plan where:

a) There is no weight management plan in place

b) The existing plan is older than 12 months and/or

c) The resident has gained more than 5kg in the last 12 months.

FURTHER INVESTIGATION

76. Following the completion of the DSC's investigation and after Yooralla responded to the DSC's *Notice to Take Action*, I considered that there remained some unaddressed concerns in relation to remedial actions taken to prevent similar deaths. Accordingly, I sought further information from Yooralla regarding the support provided to Ms Cervasio.

77. By email dated 22 February 2022, Yooralla Chief Operating Officer Leanne Turner, on behalf of Yooralla, responded to my letter that included a series of questions requesting further information about the outstanding concerns.

78. Ms Turner advised that Yooralla's East Region Group Manager conducted a case review into the circumstances of Ms Cervasio in October 2018. The case review did not generate any specific recommendations.

79. Despite that, Ms Turner advised that Yooralla had actively responded to the DSC's findings and *Notice to Take Action*. Accordingly, Yooralla undertook an extensive review of its processes and practices.

Subsequent actions – Training implemented after Ms Cervasio's death

80. When asked about the details of staff training implemented as a result of the DSC investigation, Ms Turner advised that Yooralla had taken steps to continue to ensure staff are familiar with and competent in operating CPAP and BiPAP machines. These include specialised training in using, maintaining and caring for all CPAP and BiPAP machines across its residential services. Ms Turner detailed that this training focusses on the importance of maintaining ventilation equipment to safe operational standards, and how to address malfunctions or hazards.

81. Ms Turner advised that as a result of the progressive transition of disability services funding to individualised NDIS funding, clients with additional health requirements, such as the use of medical equipment, are now entitled to specific funding. Ms Turner explained that a part of the funding goes towards support staff training associated with using the medical equipment.

82. In relation to managing a client's deteriorating health, Ms Turner advised that Yooralla has undertaken training to support staff in identifying and differentiating emergency and non-emergency health events that require advanced medical attention. This training also reminds support staff of the expectations of their roles in supporting clients to seek necessary medical review and advice from the nurse-on-call.

83. In relation to weight management for clients assessed as overweight or obese, Ms Turner advised that Yooralla has undertaken training to educate staff in supporting clients on how to eat well, maintain a healthy weight and the adverse effects of being overweight or underweight. This training was developed and implemented under Yooralla's *"Healthy Eating Program"*.

<u>Other quality enhancements</u>

84. In addition to the above training, Ms Turner advised that Yooralla has undertaken the following quality enhancements:

    - Development and implementation of the "*Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) Maintenance Checklist*". The

purpose of this checklist is to ensure that all staff consistently document the maintenance and cleaning of the machines on a regular basis. The checklist also provides instructions about who staff must contact if the machine is not working properly. The checklist is also used in conjunction with the "*Overnight Observation Record"*;

- Establishment of a centralised CPAP and BiPAP Register to provide Yooralla management with adequate oversight of the use of machines throughout the Residential and Respite Support Services Division;

- Inclusion of the *"Enhanced Healthy Eating"* and *"Supporting Customers to Maintain a Healthy Weight"* as part of the mandatory training requirements for all residential and respite support staff;

- Additional mandatory training as indicated by individual customer support needs, which includes training on maintenance for equipment such as CPAP and BiPAP machines;

- Implement site-specific Service Profiles that capture all staff training requirements to support individual customer needs. As part of this implementation, these profiles have been enhanced to incorporate all core mandatory training, customer-specific training and NDIS high-intensity staff training requirements. These profiles are also regularly shared with Yooralla's Learning and Development team to ensure the provision of adequate training calendars to maintain compliance;

- Implement training on Yooralla's incident reporting system, *"Effective Incident Writing in RiskMan"* to all staff during induction and as a refresher course when required. This training provides employees with an overview of the characteristics and features of a well-written Customer Incident Report. It includes Incident Types and Categories and a guide to reporting incidents and feedback; and

- Introduce a course on maintaining customer documentation. This course provides staff members with an explanation of the importance of customer documentation. For instance, when and how to use different types of customer documentation and how

to construct well-written customer documentation. This course is provided by Yooralla's Lead Support Customer Incidents and Feedback as a refresher training.

THE INQUEST

85. The actions taken by Yooralla to address the issues about Ms Cervasio's service provision were consistent with the Findings in the Investigation Report and the DSC's *Notice to Take Action.* Moreover, I determined that Yooralla had made concessions and provided adequate response in addressing the outstanding concerns, obviating any need to hear witness evidence.

86. I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 4 August 2023.

COMMENTS

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

1. My investigation into Ms Cervasio's death has highlighted the inherent difficulties faced by people with advanced care needs, as well as the importance of providing diligent care to respond to those needs.

2. Ms Cervasio was a vulnerable person who was not provided with a supportive and safe environment with respect to a significant aspect of her disability. She was not supported by a dietician or nutritionist after entering into Yooralla's care in 1998. The health consequences of being overweight were not well-understood by support staff.

3. Furthermore, there was limited staff training concerning the proper operation and maintenance of essential medical equipment such as a CPAP or BiPAP machine. Evidently, staff did not take further actions or escalate the problem of possible machine malfunctions. There also appears to have been limited understanding and staff training on Yooralla's *Recognising and Responding to Changing Support Needs Policy* to appropriately manage and escalate a resident's deteriorating health in a timely manner.

4. I acknowledge that Yooralla has made substantial concessions to the Court (as well as the Disability Services Commissioner during its independent investigation) regarding its failures in the provision of disability services to Ms Cervasio. The Court has been informed of the restorative and preventative actions taken since her death. In light of the changes and concessions, I have not identified further opportunities for prevention and, therefore, I do not intend to make any formal recommendations.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Katrina Jane Cervasio, born 22 July 1975, died on 10 September 2018 at 2 Clota Avenue, Box Hill, Victoria 3128.

2. I find that in the weeks leading up to her death, Katrina Jane Cervasio had been unwell and her deteriorating condition at the time of death was partly exacerbated by the irregular use of the bi-level positive airway pressure machine.

3. AND while I cannot find with any degree of certainty Katrina Jane Cervasio's death was preventable had an early medical intervention taken place, I do find that the absence of a timely escalation of her deteriorating condition was an opportunity lost to afford her a better outcome.

4. I accept and acknowledge the restorative measures implemented by Yooralla in response to Katrina Jane Cervasio's death, and I am satisfied that there are no further prevention opportunities to be pursued.

5. I accept and adopt the medical cause of death ascribed by Dr David Leo Ranson, and I find that Katrina Jane Cervasio died from complications of obesity, including cardiomegaly.

I convey my sincere condolences to Ms Cervasio's family for their tragic loss.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

I convey my sincere condolences to Ms Cervasio's family for their tragic loss.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

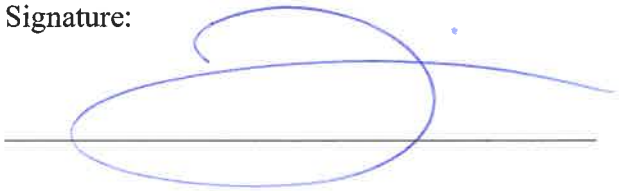
I direct that a copy of this finding be provided TO:

Gerry & Daniela Cervasio

MinterEllison, Lawyers for Yooralla Society of Victoria

Disability Services Commissioner

Signature:



Date: 4 August 2023

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 inquest. 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.