IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002905

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Peter Henry Scerri

Delivered On:	22 May 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date:	20 April 2023
Findings of:	Coroner Catherine Fitzgerald
Counsel Assisting the Coroner:	Ms Jess Syrjanen
Solicitor for the Royal Melbourne Hospital:	Ms Jan Moffatt, DTCH Lawyers

INTRODUCTION

1. On 4 June 2021, Peter Henry Scerri was 60 years old when he passed away in the John Cade Adult Acute Inpatient Unit (**JCU**) of the Royal Melbourne Hospital (**RMH**). This is an inpatient mental health ward and at the time of his death, Mr Scerri was a compulsory patient.

2. While Mr Scerri was reported to be a quiet, introverted but otherwise happy child, his behaviour and personality changed when he was about 13 years old. His mother often had to call the police or other services to assist with his challenging behaviour.[1]

3. In 1976 Mr Scerri was formally diagnosed with schizophrenia at the age of 15. He was also diagnosed with a mild intellectual disability, with an IQ of 75.[2] Mr Scerri engaged a social worker in his late teens and was able to live independently for about 20 years, with substantial community support services in place to assist him.[3] Mr Scerri later disclosed to his sister that he was allegedly sexually assaulted by his social worker for a substantial period of time, as well as by other patients during hospital admissions.[4]

4. Mr Scerri was commenced on atypical antipsychotic clozapine from about 1993 to treat his schizophrenia.[5] He experienced twenty admissions to multiple psychiatric inpatient units with long periods of case management by public mental health outpatient services.[6] He also suffered from gout, testicular cancer, dyslipidaemia, and asthma.

5. In about 2009, Mr Scerri experienced increasing involuntary admissions to hospital on a background of medication non-compliance. He moved to a supported residential rehabilitation home, Janoak Villa, where he lived until the time of his death.[7]

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[1] Coronial Brief (**CB**), Statement of Terresa Scerri, 11.
[2] CB, Statement of Dr Jenepher Dakis, 22.
[3] CB, Statement of Ms Scerri, 13.
[4] CB, Statement of Ms Scerri, 14.
[5] CB, Statement of Dr Dakis, 22.
[6] Ibid.
[7] CB, Statement of Ms Scerri, 13.

THE CORONIAL INVESTIGATION

6. Mr Scerri's death was reported to the Coroner as it fell within the definition of a reportable death pursuant to the *Coroners Act 2008* (Vic) (**the Act**), namely it was the death of a person who immediately before death was a "person placed in custody or care"[8]. As Mr Scerri was a compulsory patient at RMH, he was a "person placed in custody or care" because he was a "a patient detained in a designated mental health service within the meaning of the *Mental Health Act 2014* (Vic)"[9]. An inquest into Mr Scerri's death was therefore mandatory under the Act.[10]

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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 cast blame or determine criminal or civil liability.

8. 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 commendations 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 Scerri's death. The Coroner's Investigator conducted inquiries on the coroner's behalf and submitted a coronial brief of evidence. Further material was requested as part of the coronial investigation, including from the RMH.

10. An Inquest was held on 20 April 2023. This finding draws on the totality of the coronial investigation and Inquest into the death of Peter Henry Scerri. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary

[8] Sections 4(1) and (2)(c) *Coroners Act 2008* (Vic).
[9] Section 3 *Coroners Act 2008* (Vic).
[10] Section 52(2)(c) *Coroners Act 2008* (Vic).

for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[11]

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

Circumstances in which the death occurred

11. Mr Scerri's mental and physical health were reportedly declining in the twelve months prior to his passing. He had become incontinent of urine for about twelve months and had become more disorganised in thought.[12] Mr Scerri's sister, Terresa Scerri, noted that he could not speak clearly and was frequently mumbling.[13]

12. On 18 April 2021, staff at Janoak Villa called an ambulance for Mr Scerri due to his increasing distress about his bowels. He was transported to the RMH and was admitted to the JCU. He was noted by treating clinicians "*to be mumbling and very difficult to understand*"[14], which was confirmed by staff at Janoak Villa. Upon admission to JCU, Mr Scerri's medication regime included clozapine 550mg, olanzapine 10mg, diazepam 5-10mg (as needed), and olanzapine 5-10mg (as needed).[15]

13. JCU clinicians determined that Mr Scerri was not experiencing a mental-health related episode, rather, he was suffering from a bowel obstruction and clozapine-related constipation. Mr Scerri's clozapine dosage was reduced slightly to improve his side-effects and he was discharged back to Janoak Villa on 7 May 2021. His clozapine dose at that time was 525mg and his olanzapine dose remained at 10mg[16].

14. Mr Scerri was readmitted to the JCU on 19 May 2021, following an incident at Janoak Villa where he allegedly assaulted a male support worker, who was assisting him to have

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[11] 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] CB, Statement of Dr Dakis, 22.
[13] CB, Statement of Ms Scerri, 16.
[14] CB, Letter from Dr Jenepher Dakis to the Coroners Court of Victoria (**CCoV**), 35.
[15] Ibid.
[16] Ibid.

a shower.[17] Mr Scerri was found to still be experiencing clozapine-induced constipation and this was thought to be the cause of his increased agitation and distress. His clozapine-induced constipation was also causing urinary retention. His clozapine dose was reduced to 500mg, while his regular olanzapine 10mg was continued. He received "as needed" diazepam 10mg or olanzapine 10mg on several occasions, to assist with agitation and distress.[18]

15. Mr Scerri was moved from the JCU to a medical ward on 26 May 2021. His constipation and urinary retention were treated, and Mr Scerri was slowly making progress, with improvements in his mental state also noted.[19] He returned to the JCU on 30 May 2021 and was noted to be "*well orientated and better than prior to transfer to a medical ward with less mumbling evident*"[20]. It was thought that the improvement in his physical condition led to an improvement in his mental condition.

16. Given Ms Scerri's ongoing concern about her brother's speech, Mr Scerri underwent a brain MRI scan on 1 June 2021. The MRI did not reveal any organic cause for his mumbling such as an intracranial bleed or brain tumour. The JCU clinicians confirmed with Janoak Villa staff that in their experience Mr Scerri mumbled most of the time.[21]

17. On the evening of 4 June 2021, the staff at JCU ordered pizzas for the patients to enjoy. Mr Scerri was enjoying pizza with some of the other JCU patients in the dining room when he began choking. At about 8.16pm he collapsed and nearby staff quickly attended to him and called a Code Blue.[22]

18. First responders moved Mr Scerri into the recovery position and attempted to clear his airway. They commenced cardiopulmonary resuscitation (**CPR**) immediately, with the Code Blue team arriving at 8.19pm. Mr Scerri was intubated and administered multiple rounds of adrenaline; however, he remained in asystolic cardiac arrest and did not have a

[17] CB, Statement of Ms Scerri, 16.
[18] CB, Letter from Dr Dakis to CCoV, 35.
[19] CB, Statement of Dr Dakis, 23.
[20] CB, Letter from Dr Dakis to CCoV, 35.
[21] Ibid.
[22] CB, Statement of Dr Veronique Browne, 28.

detectable pulse throughout resuscitative efforts. Despite the efforts of all involved in the resuscitation, Mr Scerri was declared deceased at 8.39pm.[23]

Identity

19. On 9 June 2021, Peter Henry Scerri was visually identified by his care home team leader, Debra Hamilton.

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

Medical cause of death

21. Forensic Pathologist Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted a post-mortem examination on 7 June 2021 and provided a written report of his findings dated 15 June 2021.

22. The post-mortem examination revealed findings consistent with the reported circumstances.[24] Examination of the post-mortem CT scan revealed coronary artery calcifications.[25]

23. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

24. Dr Bedford provided an opinion that the medical cause of death was "*1(a) Respiratory obstruction (choking by food)*"[26].

25. I accept Dr Bedford's opinion.

CONCERNS OF CARE AND FURTHER INVESTIGATION

26. In her statement to the Coroner's Investigator, Ms Scerri queried whether her brother was being administered excessive doses of medication which was leading to sedation, slurred

[23] Ibid.
[24] CB, Medical Examiner's Report (**MER**), 8.
[25] CB, MER, 7.
[26] CB, MER, 8.

speech, and impaired mental and physical functioning. She also expressed concerns that over-sedation may have contributed to her brother choking.[27]

27. Coroner Phillip Byrne previously had carriage of this matter prior to his retirement, at which time I assumed carriage of the investigation. As part of his investigation, Coroner Byrne sought further statements from the RMH regarding the treatment of Mr Scerri during his admissions in April, May, and June 2021.

28. Lead Psychiatrist at the JCU, Dr Jenepher Dakis, provided a statement to the Court and a letter addressed to the Court, which summarised Mr Scerri's treatment and his medication regime whilst he was an inpatient.[28] Dr Dakis explained that Mr Scerri's clozapine dosage was slowly reduced from 550mg upon admission on 18 April 2021 to 500mg at the time of his passing, whilst his olanzapine dosage remained consistent.[29] Dr Dakis noted that from 30 May 2021 to 4 June 2021, Mr Sceri was administered "as needed" sedatives (olanzapine or diazepam) on six occasions. The last dose of "as needed" olanzapine was administered at 7.37pm on 3 June 2021, more than 24 hours prior to Mr Scerri's passing.[30]

29. Dr Dakis further noted that the clinical observations of Mr Scerri during his two inpatient admissions revealed he was not drowsy, drooling, or sleepy during the day, and he did not complain of drowsiness to any staff members. He was noted to be alert and able to clearly state his needs as required. He was occasionally noted to be restless and agitated, but this could usually be settled with reassurance or redirection.[31] His speech was slurred and he frequently mumbled, but this was also occurring when he was at Janoak Villa. The cause of Mr Scerri's mumbling was investigated but no organic cause was found.[32]

30. A statement by RMH's Director of Clinical Services, Dr Veronique Browne, stated that a review of Mr Scerri's medical records did not reveal any history or evidence of Mr Scerri

[27] CB, Statement of Ms Scerri, 19.
[28] CB, Statement of Dr Dakis, 22-23; CB Letter from Dr Dakis to CCoV, 34-36.
[29] CB, Letter from Dr Dakis to CCoV, 35.
[30] Ibid.
[31] Ibid.
[32] Ibid, 36.

experiencing choking or swallowing difficulties. As a result, clinicians determined that he did not require referral to a speech pathologist, nor did he require a modified diet.[33]

31. I am satisfied that Mr Scerri's mumbling and slurred speech was appropriately investigated by treating clinicians and an organic cause of his mumbling was not identified. I am also satisfied that Mr Scerri was appropriately medicated during his inpatient admission, noting that his clozapine dosage had in fact been gradually reduced, and he had not received any additional 'as needed' medication in the 24 hours prior to his death. Significantly, there were no previously reported incidents of Mr Scerri choking or having difficulty swallowing. There is no indication that any unidentified medical cause, or the medication prescribed, caused the choking incident. On the available evidence before me, I am of the view that this was an unfortunate and tragic accident that could not have been foreseen, nor prevented.

FINDINGS AND CONCLUSION

32. Having investigated the death of Peter Scerri, and having held an inquest in relation to this death on 20 April 2023 at Melbourne, I find that:

    a) the identity of the deceased was Peter Henry Scerri, born on 16 February 1961;

    b) the death occurred on 4 June 2021 at the John Cade Unit, Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria 3051, and the cause of death was 1a: Respiratory obstruction (choking by food); 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:

Terresa Scerri, Senior Next of Kin

[33] CB, Statement of Dr Browne, 27.

Royal Melbourne Hospital (Care of DTCH Lawyers)

Senior Constable Kayne Ewin (VP43065), Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 1 June 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.