IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 0172

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Simon McGregor
Deceased:	Raymond Henry Dempster
Date of birth:	3 July 1955
Date of death:	10 January 2020
Cause of death:	1(a) Pneumonia in a man with Lennox-Gastaut syndrome
Place of death:	Austin Health, Austin Hospital, 145 Studley Road, Heidelberg

INTRODUCTION

1. On 10 January 2020, Raymond Henry Dempster was 64 years old when he passed away in hospital. At the time of his death, Raymond lived at 20 Sturdee Street, Reservoir.

2. Raymond was a jovial man and an avid Essendon supporter.[1] He came from a large family – the youngest of eight children to parents Charlie and Ann Dempster, with five brothers and two sisters.[2]

3. Raymond suffered severe and difficult-to-treat epilepsy (Lennox-Gastaut syndrome) and had an intellectual disability.[3] As a child, his condition was less apparent but, as he grew older, his condition worsened and, progressively, he required more extensive care.[4]

4. Raymond also suffered from severe dysphagia.[5] He had frequent reviews by speech pathologists and dietary modifications made.[6]

5. For about the first decade of his life, Raymond lived with his family, but began attending a residential specialist facility thereafter and, later, moved into supported accommodation provided by Aruma Disability Services (**Aruma**).[7] Ultimately, he had become non-ambulant and required full assistance with all aspects of his daily living.[8]

THE CORONIAL INVESTIGATION

6. Raymond'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.

7. 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

[1] Statements of Fred Dempster and Dr Mark Newton.
[2] Statement of Fred Dempster.
[3] Statements of Dr Mark Newton and Dr Philip Smith.
[4] Statement of Fred Dempster.
[5] Statement of Sarah Knight.
[6] Statement of Dr Philip Smith.
[7] Statement of Fred Dempster.
[8] Statement of Sarah Knight.

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 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Raymond'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.

10. This finding draws on the totality of the coronial investigation into Raymond'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.[9]

11. In considering the issues associated with this finding, I have been mindful of Raymond's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

12. At 3.20am on 8 January 2020, night staff heard Raymond coughing and struggling to breathe.[10] He was in severe respiratory distress and an ambulance was called to transport him to the Austin Hospital Emergency Department.[11] Paramedics found Raymond to have a temperature of 38.3 degrees, with an elevated heart rate and acute shortness of breath.[12]

[9] 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.
[10] Statement of Dr Linda Dalic.
[11] Statement of Sarah Knight.
[12] Statement of Dr Linda Dalic.

13. Hospital staff determined that Raymond had pneumonia which was either community-acquired or aspiration-related.[13] Episodes of aspiration pneumonia had become more frequent for Raymond over the past few years, with the most recent having occurred on 28 December 2018, 14 August 2019, 23 November 2019, 19 December 2019, and 2 January 2020.[14]

14. On the afternoon of 8 January 2020, he was seen by a speech pathologist to assess his swallowing.[15] His swallow could not be assessed at that time, so a further review was planned for the following day.[16] However, his condition further deteriorated overnight.

15. At 4.00am on 9 January 2020, Raymond exhibited further signs of respiratory distress, including increased respiratory rate and low oxygen levels.[17] His oxygen saturation fell to as low as 65 per cent and, after being administered morphine and supplemental oxygen, it slowly improved but fluctuated between 70 and 85 per cent.[18]

16. In view of Raymond's continued deterioration despite receiving maximal medical therapy, palliative care treatment was instituted.[19]

17. At or about midday on 10 January 2020, the palliative care team reviewed Raymond, but he was unresponsive and in the terminal phase.[20] He passed away at 12.20pm.

Identity of the deceased

18. On 10 January 2020, Raymond Henry Dempster, born 3 July 1955, was visually identified by his brother Arthur Dempster.

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

Medical cause of death

20. Forensic pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 13 January 2020 and provided a written report of her findings dated 21 January 2020.

[13] Statement of Dr Linda Dalic.
[14] Statement of Dr Philip Smith.
[15] Statement of Dr Linda Dalic.
[16] Statement of Dr Linda Dalic.
[17] Statement of Dr Linda Dalic.
[18] Statement of Dr Linda Dalic.
[19] Statement of Dr Linda Dalic.
[20] Statement of Dr Linda Dalic.

21. Dr Isles opined that the medical cause of death was 1(a) pneumonia in a man with Lennox-Gastaut syndrome. On the information available to her, she also opined that death was due to natural causes.

22. I accept Dr Iles' opinion.

FURTHER INVESTIGATIONS

23. An investigation into Raymond's death was conducted by the Disability Services Commissioner (**DSC**), the findings of which were provided to this Court on 2 March 2022.

24. The DSC investigation considered documents relating to Mr Dempster's care, including an internal review of services conducted by Aruma following Mr Dempster's death, as well as their responses to DSC questions relating to service provision.[21]

25. Several issues were identified during the course of Aruma's internal review, including inconsistencies in recording contemporaneous weight charts and diary entries. These areas of concern were discussed at a team meeting held on 4 March 2020, with remedial actions established to ensure that weight charts and diary entries are kept up to date going forward.[22]

26. Further issues identified during the course of the DSC investigation included:

    (a) Inadequate management to Raymond's dysphagia and a lack of adherence to his mealtime support plan;

    (b) A lack of consistent and contemporaneous documentation available to staff supporting Raymond; and

    (c) Inadequate support for Raymond's individual communication needs through the provision of a speech pathologist assessment and communication plan.[23]

27. The conclusions of the DSC investigation, including a draft of the proposed Notice to Take Action, were provided to Aruma to enable an opportunity to respond.[24]

[21] Disability Services Commissioner Investigation Report dated 2 March 2022.
[22] Disability Services Commissioner Investigation Report dated 2 March 2022.
[23] Disability Services Commissioner Investigation Report dated 2 March 2022.
[24] Disability Services Commissioner Investigation Report dated 2 March 2022.

28. On 11 February 2022, Aruma advised the DSC that they had made a number of service improvements to their mealtime and communication support practices since Raymond's death. These included an alignment of policy and procedures with the "NDIS[25] Practice Standards for Severe Dysphagia" and participating in mealtime management training. New communication support procedures were also developed to assist residents with complex communication needs.[26]

29. Following the conclusion of the DSC investigation into Raymond's death on 10 January 2020, a Notice to Take Action was issued to Aruma. The areas and issues identified for improvement in this notice are as follows:

    i. Aruma to share the findings and subsequent recommendations for service improvement detailed in this investigation with staff at 20 Sturdee Street, Reservoir.

    ii. Aruma to ensure that residents with dysphagia at 20 Sturdee Street, Reservoir are provided with support from group home staff that is in line with their current mealtime support plans.

    iii. Aruma to ensure that information regarding support needs for residents of 20 Sturdee Street, Reservoir is up to date, accurate and consistent across all documents by auditing resident files and identifying and updating information where necessary.

    iv. Aruma to ensure that residents at 20 Sturdee Street, Reservoir with complex communication needs have a speech pathologist communication assessment and a current communication plan in place.[27]

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Raymond Henry Dempster, born 3 July 1955;

    (b) the death occurred on 10 January 2020 at Austin Health, Austin Hospital, 145 Studley Road, Heidelberg, from pneumonia in a man with Lennox-Gastaut syndrome; and

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

[25] National Disability Insurance Scheme.
[26] Disability Services Commissioner Investigation Report dated 2 March 2022.
[27] Disability Services Commissioner Investigation Report dated 2 March 2022.

31. Having considered all of the circumstances, I am satisfied that Raymond's death was due to natural causes.

32. I note the findings of the internal review conducted by Aruma and the report prepared by the DSC, as well as the areas directed for improvement in the DSC Notice to Take Action. I am satisfied that these adequately address the identified areas of deficiency and should assist in preventing of the reoccurrence of similar incidents in the future.

I convey my sincere condolences to Raymond'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.

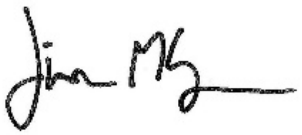
I direct that a copy of this finding be provided to the following:

Frederick Dempster, Senior Next of Kin

Pauline Chapman, Austin Health

Constable Taylor Spence, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 6 June 2022

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.