IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 004264

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**ANTHONY JOHN TOSCANO**
Delivered on:	**19 AUGUST 2016**
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	**19 AUGUST 2016**
Counsel assisting the Coroner:	**Ms Rebecca Johnston-Ryan**

HIS HONOUR:

BACKGROUND

1 Anthony John Toscano was 45 years 9 months old at the time of his death. Prior to his death, Anthony resided at Tamar Street Shared Supported Accommodation (Tamar Street), an accommodation service managed by the Victorian Department of Health and Human Services. Anthony is survived by his parents Maria and Tony, and his siblings and their respective families, with whom he maintained close and loving relationships. Anthony was known for his love of food and insatiable appetite, always seeking a sneaky chocolate on visits to the family home in Bulleen.[1]

2 A coronial brief was provided by Victoria Police to this Court. I have used this information to assist my finding.

3 At inquest, a summary was read into evidence by Coroner's Legal Officer, Rebecca Johnston-Ryan. I am satisfied that the summary accurately reflects the evidence.

THE PURPOSE OF A CORONIAL INVESTIGATION

4 Anthony's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and immediately before death he was a person placed in custody or care.[2] Consequently, this matter is a mandatory inquest.[3]

5 The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

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[1] Coronial brief, statement of Maria Byrnes, dated 4 January 2016, 13.
[2] *Coroners Act 2008* (Vic) s 4.
[3] See *Coroners Act 2008* (Vic) s 52(2)(b); *Coroners Act 2008* (Vic) s 3(i), definition of 'person placed in custody or care'.
[4] *Coroners Act* 2008 (Vic) s 89(4).

6 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7 The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8 For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

10 Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) 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

(c) 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. These powers are the vehicles by which the prevention role may be advanced.

11 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] 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 that they caused or contributed to the death.

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[5] *Keown v Kahn* (1999) 1 VR 69.
[6] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12 Anthony was visually identified by his brother Mr Joseph Toscano on 22 August 2015. Identity is not disputed and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13 On 27 August 2015, Dr Gregory Young, Forensic Pathologist, Victorian Institute of Forensic Medicine (VIFM), conducted an examination of Anthony's body and provided a written report, dated 30 October 2015, concluding a reasonable cause of death to be 'I(a) small bowel obstruction, I(b) plastic bag bezoar[7] with a contributing factor of intellectual disability'. I accept his opinion.

14 The post-mortem examination revealed dilatation of the small bowel proximal to a compressed plastic bag bezoar found in the jejunum. Dr Young reported no evidence of intestinal perforation. The post-mortem Computed Tomography (CT) scan showed dilated loops of small bowel, associated with air-fluid levels. Free air was not seen in the abdomen. Bronchopneumonia was seen in the lungs.

15 Dr Young reported that bowel obstruction occurs where there is blockage of the intestine. Affected loops of bowel often become swollen and this, with reduced reabsorption of secretions, may cause extracellular volume deficiency. Symptoms of small bowel obstruction include vomiting, diarrhoea, abdominal pain and distension, and constipation. Distension of the abdomen by dilated loops may restrict movement of the diaphragm, interfering with respiratory function which can lead to the inhalation of vomitus causing bronchopneumonia.

16 Toxicological analysis of blood detected the presence of diazepam[8] metabolite nordiazepam (~0.04mg/L) and risperidone[9] metabolite hydroxyrisperidone (~36ng/mL).

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[7] A bezoar is a mass of swallowed foreign material (often hair or fibre, but also other materials such as plastics) that can cause a blockage to the intestine. Risk of bezoar is greater among people with an intellectual disability.
[8] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.
[9] Risperidone is an atypical antipsychotic prescribed for schizophrenia and some behavioural disorders (delusions, aggression).

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

17 On 20 August 2015 at approximately 12:30p.m., Anthony became unwell and vomited twice after eating his lunch. Carer Garr Bellah recalled that Anthony wandered around the backyard after vomiting, and then dozed intermittently for a couple of hours. By 3:30p.m. Anthony's condition appeared to improve and he appeared to return to his usual self. The other residents at Tamar Road ate the same meal as Anthony on this day, but did not fall ill.[10]

18 On 21 August 2015, Anthony's vomiting worsened, and he was accompanied by carer Zsar Noter to an appointment with general practitioner Dr Jerry Yang of the East Ringwood Clinic. Anthony would ordinarily see Dr Hoole at the same clinic, but he attended a consultation with Dr Yang as Dr Hoole was unavailable. At the consultation, Ms Noter reported Anthony's vomiting episodes the previous day and advised that he had not had diarrhoea and appeared otherwise well. Dr Yang assessed Anthony and found his mouth mucosa to be moist, and his abdomen was soft with no tenderness. Anthony denied pain anywhere in his body. Dr Yang made a diagnosis of gastroenteritis, advising Ms Noter to encourage him to drink fluids and avoid oily foods. Dr Yang advised that Anthony should return if his vomiting worsened or if there were any other concerns.[11]

19 Anthony remained unwell for the rest of the day. Ms Noter and the other carer on shift, Jacqueline Theodore, gave Anthony small sips of water, but he could not keep the water down. At approximately 8:00p.m., Anthony was showered and put to bed. At 9:00p.m., carers smelled faeces in Anthony's room, and he was subsequently washed, changed and put back to bed. Ms Theodore worked alone at Tamar Street from 9:45p.m. that night on the sleepover shift. Sometime between 1:00a.m. and 2:00p.m., Ms Theodore heard a noise she believed to be Anthony going to the toilet. She checked on Anthony, and found him sitting on a chair at the end of his bed in his bedroom. Ms Theodore helped Anthony back into bed and did not hear anything else from Anthony or the other residents for the remainder of the evening.[12]

20 Ordinarily Anthony would be woken and showered before day staff arrived at 8:00a.m. On the morning of 22 August 2015, Jacqueline left Anthony in bed as she felt he needed his sleep. At approximately 8:00a.m. Mr Bellah and a second carer, Christopher Onions arrived at Tamar

[10] Coronial brief, statement of Garr Bellah, dated 14 December 2015, 19.
[11] Coronial brief, statement of Dr Jerry Yang, dated 30 November 2015, 17.
[12] Coronial brief, statement of Jacqueline Theodore, dated 22 August 2015, 21-22.

Street. Jacqueline briefed Mr Bellah and Mr Onions about what had occurred with Anthony the previous night.

21 Mr Bellah went to Anthony's room to check on him, and found him on the floor on the right hand side of his bed. Mr Bellah tried to wake Anthony by using his hand to nudge him on his shoulder, but Anthony was cold to the touch and unresponsive. Staff called 000, and Mr Bellah and Mr Onions both commenced cardiopulmonary resuscitation compressions as instructed by the emergency services operator. Ambulance Victoria paramedics arrived at the residence, followed by Victoria Police officers. Following a patient assessment, paramedics declared Anthony deceased.[13]

22 Marita Carew, Acting Disability Accommodation Services Manager of the Department of Health and Human Services, advised the court that two types of ziplock plastic bags were used at Tamar Street, measuring 15cm by 9cm, and 18cm by 16.5cm respectively. It was unknown where Anthony may have obtained a plastic bag of a differing size. Ms Carew noted that Anthony had known behaviours of concern including taking the opportunity to eat any food he was able to find. Anthony was also known to break into cabinet doors to access the rubbish bin, and had gone through compost bins on previous occasions. Ms Carew reported that Anthony would consume food in or out of the wrapper or bag if he was unable to open it fast enough. Ms Carew further noted that as a part of Anthony's supervision guidelines, the kitchen at Tamar Street was always locked when he was at home.[14]

FINDINGS

23 Having investigated the death of Anthony, and having held an Inquest in relation to his death on 22 August 2015 at 28 Tamar Street, Ringwood North, make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Anthony John Toscano, born 31 October 1969; and

(b) that Anthony John Toscano died on 22 August 2015, at 28 Tamar Street, Ringwood North from I(a) small bowel obstruction, I(b) plastic bag bezoar with a contributing factor of intellectual disability, in the circumstances described above.

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[13] Coronial brief, statement of Leading Senior Constable Karen Barnes, dated 9 January 2016.
[14] Email correspondence of Marita Carew, dated 29 April 2016.

24 I find that the care provided to Anthony by Department of Health and Human Services staff at Tamar Street was reasonable and appropriate in the circumstances.

25 I convey my sincerest sympathy to Anthony's family and friends.

26 Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) Anthony's family, senior next of kin.

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

Mr John Olle
CORONER
Date: 19 August 2016