IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005837

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Raymond Charles Levy
Date of birth:	15 November 1947
Date of death:	19 October 2023
Cause of death:	1a: Aspiration pneumonia in the setting of epilepsy and cerebral palsy
Place of death:	Sunshine Hospital 176 Furlong Road St Albans Victoria 3021
Keywords:	Disability Support for Older Australians, DSOA, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 19 October 2023, Raymond Charles Levy (**Raymond**) was 75 years old when he died at Sunshine Hospital from natural causes, being aspiration pneumonia in the setting of epilepsy and cerebral palsy.

2. Raymond lived with cerebral palsy throughout his life, secondary to complications of a forceps delivery, and had longstanding right hemiplegia and limited mobility. Raymond's medical history also included epilepsy, longstanding left occipital and parietal cerebral abnormalities, chronic left subdural hygroma, osteoporosis and hypertension.

3. At the time of his death, Raymond was a Disability Support for Older Australians (**DSOA**) funded resident in a government transfer house. Raymond received disability services from Possability Group (**Possability**). He required full nursing care and was non-ambulant, but was able to sit with nursing support, stand with the support of a single-point stick, and to mobilise with a wheelchair. Raymond required staff assistance for all personal care.

4. Raymond's Speech Pathology Mealtime Management Plan noted that Raymond's conditions also impacted his eating and drinking and noted that he was at "*high risk*" of developing aspiration pneumonia, as well as choking. The plan set out requirements and strategies to mitigate such risks, including that Raymond required 1:1 supervision and assistance during mealtimes.

5. Raymond's home medications at the time of his admission to Sunshine Hospital included aspirin, candesartan, esomeprazole, risedronate, valproate, carbamazepine, Movicol, lactulose, fludrocortisone, and metoclopramide.

6. The Possability Operations Manager described Raymond as "*a very active member of the Melton community*". He attended Annecto Day Services Bacchus Marsh 3 days a week where he engaged in pottery, music, and other social activities. Raymond also attended the Anglican Church every Sunday. Raymond was a member of the Didyabringyarodalong Fishing Club and attended their meetings and fishing days. Despite Raymond's intellectual disability, he was very capable of making his own decisions and choices in his life. Raymond had a love of music, particularly Elvis Presley, and would listen to music most days on his CD player.

7. Raymond lived in supported disability care since age 14 and had limited contact with his family for much of his life but had happily reconnected with family in the last decade before he died. Raymond's brother described that during these final years, he and his wife visited

Raymond as often as possible and celebrated Christmas and birthdays together. His brother stated, "*I am glad we got to spend what time we had together getting to know each other again*."

THE CORONIAL INVESTIGATION

8. Raymond's death was reportable under the *Coroners Act 2008* (Vic) (**the Act**) as he was a Specialist Disability Accommodation (**SDA**) resident[1] living in an SDA enrolled dwelling, meaning that he fell within the definition of a person 'placed in custody or care'.[2]

9. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

10. 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 purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

11. 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.

12. This finding draws on the totality of the coronial investigation into the death of Raymond Charles Levy including evidence contained in the coronial brief and information provided by Possability. 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.[3]

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[1] SDA resident is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Raymond's death, was a person who is a National Disability Insurance Scheme participant funded to reside in an SDA enrolled dwelling, or a person who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program (**DSOA**)). Raymond was an SDA resident as he was a DSOA supported accommodation client.

[2] *Coroners Regulations 2019*, r 7(1)(d).

[3] 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

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

Circumstances in which the death occurred

13. On the morning of 18 October 2023 at approximately 7.30am, Raymond told Possability support staff that he felt "*very tired*" and "*was not himself*". It was observed by staff that he was leaning extremely on the right side and that his speech was unclear, although he was able to remember where he was and staff names. The Operations Manager determined to call an Ambulance and Raymond was transferred to Sunshine Hospital Emergency Department (**ED**).

14. Raymond presented to the ED with fatigue, drowsiness, and fever, on a background of two days' couch and episodic epigastric pain. On examination, the clinical impression was of sepsis without a clearly identified source. Raymond was prescribed ceftriaxone for infection.

15. Raymond was admitted under General Internal Medicine and continued intravenous (**IV**) ceftriaxone, with the addition of IV flucloxacillin. Amongst other things, he was prescribed prophylactic subcutaneous enoxaparin.

16. Unfortunately, Raymond deteriorated on the ward. On 19 October 2023 at 6.25am hours, he became drowsier and developed hypoxia with oxygen saturation 66% on room air. On examination, brown liquid was seen discharging from his nose. An emergency CXR showed no consolidation, but dilated small bowel loops were seen on abdominal x-ray. His level of consciousness remained poor (unresponsive) and hypoxia persisted. The clinical impression was of severe aspiration pneumonia, possibly due to small bowel obstruction.

17. Given Raymond's severe illness and premorbid quality of life, the decision was made to adopt a palliative approach to management, after discussion with family.

18. Raymond subsequently died at 11.39pm on 19 October 2023.

Identity of the deceased

19. On 19 October 2023, Raymond Charles Levy, born 15 November 1947, was visually identified by a staff member at his supported disability accommodation.

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

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

21. On 23 October 2023, Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed the post mortem computed tomography (**CT**) scan and relevant materials including the Victoria Police Report of Death (**Form 83**), the medical deposition and records from Sunshine Hospital, and information contained in the VIFM contact log. Dr Lynch provided a written report of her findings dated 23 October 2023.

22. The CT scan revealed calcific coronary artery disease, bilateral pulmonary consolidation and small kidneys. The post mortem examination was consistent with known medical history.

23. Toxicological analysis of ante mortem samples identified the presence of carbamazepine, valproic acid and salicylic acid.[4]

24. Dr Lynch provided an opinion that the medical cause of death was *1(a) aspiration pneumonia in the setting of epilepsy and cerebral palsy.*

25. Dr Lynch also provided an opinion that the death was due to natural causes.

26. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Raymond Charles Levy, born 15/11/1947;

    b) the death occurred on 19/10/2023 at Sunshine Hospital, 176 Furlong Road, St Albans Victoria 3021 from *1a: aspiration pneumonia in the setting of epilepsy and cerebral palsy*; and

    c) the death occurred in the circumstances described above.

28. Taking into account all available information, I am satisfied that Raymond died from natural causes while receiving palliative care.

29. I am satisfied that Raymond's death was not caused, or contributed to, by any issue in relation to the care and management provided by disability support staff at Possability or clinical staff

[4] The statement on behalf of Western Health notes that these results were consistent with his home medications.

at Sunshine Hospital. In this respect, I note comments by Ramond's brother that the care facilities provided by Possability were "*wonderful*" and that he felt Raymond had "*a good life*" in care.

30. In these circumstances, I am satisfied that no further investigation is required and have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation by way of a written finding.

I convey my sincere condolences to Raymond's family, friends and carers 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:

Peter Levy, Senior Next of Kin

Possability

Senior Constable Terrence Dixon, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 17 October 2025

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.