

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: 2512/11

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

*Section 67 of the Coroners Act 2008*

**Inquest into the Death of: LEWIS CHETCUTI**

Delivered On:	6 June 2012
Delivered At:	Level 11, 222 Exhibition Street, Melbourne, Victoria 3000
Hearing Dates:	6 June 2012
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	No appearances
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, IAIN WEST, Deputy State Coroner having investigated the death of LEWIS CHETCUTI

AND having held an inquest in relation to this death on 6 June 2012

at MELBOURNE

find that the identity of the deceased was LEWIS CHETCUTI

born on 29 October 1947

and the death occurred 10<sup>th</sup> July, 2011

at Northern Hospital, 185 Cooper Street, Epping, Victoria 3076

**from:**

1a. RESPIRATORY FAILURE

1b. ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

**in the following circumstances:**

1. Mr Lewis Chetcuti, was 63 years of age and an involuntary psychiatric patient at the Adult Psychiatric Unit, Broadmeadows Inpatient Unit, at the time of his death. He had suffered paranoid schizophrenia since 1973 and had been a patient at the unit since July 2010, with his care being in the hands of the public advocate, as guardian appointed by VCAT. Mr Chetcuti's medical history included severe chronic obstructive airways disease, congestive cardiac failure, chronic renal failure, cerebrovascular accident, hypertension, gastric ulcer and high cholesterol.
2. In the three weeks prior to his death, Mr Chetcuti had a number of admissions to the Northern Hospital, Emergency Department, for exacerbation of chronic lung disease and heart failure. On 9 July 2011 he was returned to Northern Hospital presenting with similar symptoms as previously, and in a state of some distress. A chest X-ray was unchanged from one taken on his previously admission on the 2 July, however, an ECG showed cardiac abnormalities. Mr Chetcuti was prescribed antibiotics and nebulising medication, however, on review by a medical officer at 10.00pm, he was observed not to be talking or opening his eyes. Prior consultation with family members on 2 July had determined that there should be no further invasive treatment. Mr Chetcuti's medical condition continued to deteriorate and he died shortly after midnight on the 10 July, 2011. Despite the death being due to natural causes, it was reported to the coroner as Mr Chetcuti was an involuntary patient at the time of his death.

3. No autopsy was performed in this case as the coroner, on advice from Dr Michael Burke, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Burke performed an external examination of Mr Chetcuti at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes the post mortem CT scan and provided a written report of his findings. Dr Burke in his report confirmed the death was due to natural causes and that a reasonable cause of death appeared to be respiratory failure due to acute exacerbation of chronic obstructive airways disease. Toxicological analysis of body fluids was non-contributory.

### COMMENTS

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

4. On the evidence before me I am satisfied that the care and management extended to Mr Chetcuti, whilst an involuntary patient at the Broadmeadows Adult Psychiatric Unit and whilst a patient at the Northern Hospital, were within the normal parameters of reasonable health care practice.

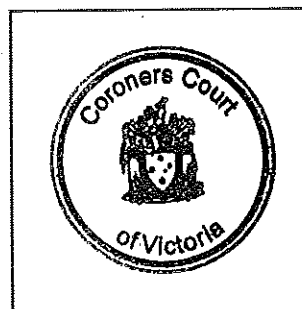
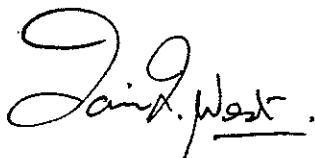
I direct that a copy of this finding be provided to the following:

Family of Mr Chetcuti

North West Mental Health

Northern Hospital

Signature:



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IAIN WEST  
DEPUTY STATE CORONER  
6 June 2012