IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 0563**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 60(2)*
*Section 67 of the Coroners Act 2008*

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| Findings of: | **MR JOHN OLLE, CORONER** |
| Deceased: | **TROY DOWNEY** |
| Date of birth: | **25 APRIL 1980** |
| Date of death: | **2 FEBRUARY 2017** |
| Cause of death: | **PNEUMONIA IN THE SETTING OF CEREBRAL PALSY** |
| Place of death: | **NORTHERN HOSPITAL**<br>**185 COOPER STREET**<br>**EPPING VICTORIA 3076** |

**HIS HONOUR:**

## BACKGROUND

1. Troy Downey was born on 25 April 1980. He was 36 years old at the time of his death. He lived in a group home in Reservoir, where he received 24 hour support from disability workers.

2. Troy had an intellectual disability and was diagnosed with cerebral palsy and scoliosis. He also had severe dysphagia, which meant he consumed food via a Percutaneous Endoscopic Gastrostomy, and had a persistent cough. He moved around the group home and community with the use of a wheelchair. He attended Northern District Lifestyle Program day service in Coburg five days a week. His medical needs were attended to by his General Practitioner, Dr Ala Alethan, and he also attended appointments with his dietician at the Austin Hospital every 6 to 12 months, or as required.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. Troy's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

4. 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] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*

5. 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.

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

7. 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.

8. 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.

9. 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.

10. 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 Khan* (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*

11. Troy was visually identified by his mother, Debra Downey, on 6 February 2017. Identity is not disputed and requires no further investigation.

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

12. On 6 February 2017, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Troy's body and provided a written report dated 10 February 2017, concluding a reasonable cause of death to be "I(a) Pneumonia in the setting of cerebral palsy". I accept his opinion in relation to the cause of death.

13. Dr Lynch noted that on the basis of the information available to him, the death was due to natural causes.

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

14. On 26 January 2017 group home staff noticed that Troy had an unusual sound to his cough. He was treated by a locum General Practitioner (GP), as his usual GP was not available. The locum GP checked Troy's chest, and reported it was clear. Between 27 January 2017 and 29 January 2017 group home staff reported that Troy was his usual self, went on weekend outings, and slept well.

15. On 30 January 2017 staff made the decision to keep Troy home under observation due to his cough. On 31 January 2017 staff took Troy to his usual GP Clinic, where he was treated by another GP, as Dr Alethan was on leave. The GP reported a crackle in his chest, and prescribed antibiotics.

16. On 1 February 2017 Troy's condition deteriorated and Emergency Services were called. At approximately 3.00pm Troy was transported to the Emergency Department at Northern Hospital, where he was diagnosed with bilateral pneumonia. At 9.40pm Troy's family were informed that Troy's observations were declining and that if treatment was not effective it was unlikely that Troy would survive.

17. At approximately 7.15pm on 2 February 2017, Troy's family were informed that he was not responding to treatment. At 10.30pm, Troy passed away in the company of family and group home staff.

**FINDINGS**

18. Having investigated Troy's death and having considered all of the available evidence, I am satisfied that no further investigation is required.

19. I find that the care provided to Troy by the Department of Health and Human Services and Northern Hospital was reasonable and appropriate in the circumstances.

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

    (a) that the identity of the deceased was Troy Downey, born 25 April 1980;

    (b) that Troy Downey died on 2 February 2017, at Northern Hospital Epping Victoria from pneumonia in the setting of cerebral palsy; and

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

21. I convey my sincerest sympathy to Troy's family and friends.

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

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

    (a) Troy's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

**MR JOHN OLLE**
**CORONER**
Date: 30 May 2017

Coroners Court of Victoria