IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5518

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Giuseppe Luci
Date of birth:	10 June 1966
Date of death:	31 October 2017
Cause of death:	Lobar pneumonia
Place of death:	The Sunshine Hospital, 176 Furlong Road, St Albans, Victoria
Other matters	*Person placed in custody or care*, natural causes, Department of Health and Human Services, Disability Services Commissioner

Introduction

1. Giuseppe Luci, born 10 June 1966, was 51 years of age at the time of his death. He lived in a Department of Health and Human Services **(DHHS)** managed group home in Taylors Lakes and had done so for approximately 20 years. There were four other residents.

2. Mr Luci had a medical history which included Fragile X syndrome,[1] epilepsy and a hearing impairment. His level on impairment was described as severe and he was unable to communicate verbally but could do so by gesture.

3. On 30 October 2017, Mr Luci was admitted to the Sunshine Hospital with signs of acute respiratory distress. Despite continued supportive care, Mr Luci's condition continued to deteriorate and he was declared deceased at 12.10am on 31 October 2017.

The Coronial Investigation

4. Mr Luci's death was reported to the coroner as he was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

5. A coroner independently investigates 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

6. Victoria Police assigned Senior Constable Rebecca Grayland to be the Coroner's Investigator for the investigation into Mr Luci's death. Senior Constable Grayland conducted inquiries on my behalf[3], including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Mr Luci's family, the forensic pathologist who examined Mr Luci, treating clinicians and investigating officers.

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[1] A genetic condition resulting in an intellectual disability. Mr Luci's level of intellectual disability was severe.
[2] In the coronial jurisdiction facts must be established on the balance of probabilities 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.
[3] The carriage of the investigation was transferred from Acting State Coroner English.

7. In addition to the material contained in the coronial brief, Mr Luci's medical records from the Sunshine Hospital and his DHHS records were obtained.

8. As part of the investigation this case was referred to the Coroners Prevention Unit (**CPU**) for review of the adequacy of Mr Luci's care proximate to his death. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

Disability Services Commissioner

9. I also considered the *Investigation Report into disability services provided by DHHS to Mr Joseph Luci* prepared by the Disability Services Commissioner (**DSC**) which was provided to the Court on a confidential basis. The DSC investigation was conducted under the auspices of the *Disability Services Act 2016* with a different scope to that of a coronial investigation (although it may overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[4] Ultimately the thoroughness of the coronial investigation is improved.

10. I have based this finding on the review conducted by CPU, information contained in medical records, the DHHS records and the coronial brief.

11. As advice was received from a pathologist that Mr Luci's death was due to natural causes[5], a mandatory inquest was not required.[6]

12. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

13. 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.

Background

14. According to Mr Luci's brother, Frank Luci, his brother liked to keep busy and had a healthy appetite. He enjoyed playing sport and keeping fit. He was recorded as having a

[4] S.7 of the Act.
[5] Paragraph 32.
[6] S52(3A) of the Act.

wide range of interests including music and dance. Mr Luci nominated Allara (the day program he attended every day in Deer Park - Mambourin Disability Services) and coffee as amongst the things most important to him. He recorded as part of his dreams and hopes that he was always to have his family nearby.

15. Mr Luci regularly attended the gym and engaged weekly with a personal trainer.

16. In his statement the house supervisor at Mr Luci's group residence, Dean Buchanan stated that Mr Luci was on medication for his epilepsy and that it was well controlled. Mr Luci would require hospitalisation when a seizure occurred, and he was susceptible to seizures in warmer weather. Mr Luci had trouble communicating due to hearing impairment. He declined to wear a hearing aid and would often communicate through hand signals or pointing.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. At approximately 1.30pm on 29 October 2017, Dr Jake Osborne a general practitioner (**GP**) at the National Home Doctor Service attended Mr Luci's group home to review him after he was noted to be unwell. Dr Osborne stated that he was told by facility staff that Mr Luci had an episode of vomiting at 7.00am that morning and three episodes of diarrhoea in the 12 hours prior to Dr Osborne's arrival.

18. Mr Luci was unable to verbalise his symptoms, but staff told Dr Osborne that Mr Luci did not appear to be lethargic or in distress. Upon examination Dr Osborne noted that Mr Luci's temperature was 36.6 degrees Celsius, his blood pressure was 130/80 and he had a heart rate of 120. Mr Luci appeared comfortable and did not appear to be distressed. His abdomen was distended but was not tender to palpation and bowel sounds were present.

19. Dr Osborne made a preliminary diagnosis of viral gastroenteritis and advised staff to encourage oral intake. Dr Osborne prescribed Ondansetron[7] and noted that Mr Luci could have Hydralyte, however it was not added to Mr Luci's treatment sheet, so it was unable to be administered by staff. Dr Osborne stated that if Mr Luci's condition worsened an ambulance should be called to transfer him to hospital. If Mr Luci remained stable Dr Osborne recommended that Mr Luci's general practitioner conduct a review the following day.

[7] Ondansetron is a medication used to prevent nausea and vomiting.

20. At 3.30pm, 29 October 2017 the DHHS records note, *Joseph has showed no signs of deterioration or vomited any further throughout the day. Joseph appears to be stable. Can staff please monitor Joseph's condition and seek further medical attention should it be required.*

21. On 30 October 2017, Mr Luci attended day placement. According to Mr Buchanan he stated that the doctor '*said he* [Mr Luci] *could go to Day Placement in the morning if the vomiting had stopped*'.[8]

22. According to Mr Buchanan a staff member rostered on that day determined Mr Luci was well enough to go to day placement. She noted that he had not vomited and appeared happy to attend.

23. That morning, Mr Buchanan received a call from another staff member who told him that Mr Luci had been sent home from day placement due to vomiting. Mr Buchanan arrived at the group home at approximately midday. Mr Luci was awake on the couch. Mr Buchanan noted that Mr Luci looked pale and uncomfortable.

24. Staff continued to monitor Mr Luci's condition, however he did not improve, and vomited at 12.30pm. At 4.15pm, the locum service was contacted for a GP to attend the group home to review Mr Luci. He was recorded as vomiting and having loose bowels at both 5.30pm and 6.30pm.

25. At 7.45pm, Dr Nadir Adelrazig, GP attended to review Mr Luci. Staff told Dr Adelrazig that Mr Luci had been unable to keep anything down including his epilepsy medication. Dr Adelrazig noted that Mr Luci was difficult to rouse with black vomitus on his pillow. He formed the opinion that Mr Luci was very unwell and that he presented with symptoms of pneumonia and signs of septicaemia. Emergency services were called, and Mr Luci was transferred via ambulance to the Sunshine Hospital Emergency Department.

26. Mr Luci presented with severe shortness of breath, drowsiness, hypoxia and tachycardia. A mobile chest radiography showed right lower zone opacity consistent with pulmonary aspiration.

27. Mr Luci was treated with supplemental oxygen including a trial of non-invasive ventilation, intravenous antibiotics (Ceftriaxone, Metronidazole and Tazocin), intravenous fluids, supportive care and non-invasive blood pressure monitoring.

[8] Statement of Dean Buchanan dated 16 January 2018.

28. He was referred to the General Medical service for admission, however died prior to being transported to the inpatient ward at 12.10am on 31 October 2017.

IDENTITY

29. On 3 November 2017, Frank Luci visually identified his brother Giuseppe (Joseph) Luci, born 10 June 1966.

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

CAUSE OF DEATH

31. On 3 November 2017, Dr Matthew Lynch, a senior forensic pathologist practising at the Victorian Institute of Forensic Medicine, conducted a partial autopsy and provided a written report dated 2 March 2018. In that report, Dr Lynch concluded that a reasonable cause of death was *Lobar Pneumonia*.

32. Toxicological analysis identified the presence of carbamazepine and its metabolite levetiracetam, valproic acid, metoclopramide and paracetamol.

33. Dr Lynch stated that there was no evidence available to suggest that Mr Luci's death was due to anything other than natural causes.

34. I accept Dr Lynch's opinion as to cause of death.

REVIEW OF CARE

35. As part of the investigation into Mr Luci's death a referral was made to the CPU. The advice sought related to whether an ambulance should have been called earlier on 30 October, and if it had, whether the outcome would have been altered. In addition, whether there were any concerns regarding the medical management of Mr Luci at the Sunshine Hospital.

36. The review noted that according to the DHHS records on 30 October 2017 Mr Luci appeared tired but keen to participate in placement, he ate breakfast and didn't present with any further symptoms. In addition, that at 4.00pm Mr Luci's breathing was observed to be heavier than usual; the locum service was called at 4.15pm; at 5.00pm Mr Luci took himself to his room to lay down; and staff kept a close eye on him regularly checking on him every 5 minutes.

36 The review further noted the following account outlined in the statement of Jason Moverley, Disability Care Worker dated 3 February 2019:

- *Joey had a couple of showers ...he vomited a couple of times again throughout the day. He didn't seem to go downhill, he sort of stayed the same.*
- *Throughout the day Joey was walking around to and from the toilet.*
- *Joey went really downhill when the doctor came. He looked really sick. I was surprised because he was up not long before, I helped him shower.*
- *Earlier on when he was in bed, I was checking on him, nothing he was doing alarmed me that he was in real distress, he just looked sick.*

37. According to DHHS records and the statement from the Disability Care Worker Mr Luci was unwell with vomiting and diarrhoea during the day on 30 October 2017 but still able to mobilise around the facility and that he appeared to deteriorate rapidly when the doctor arrived.

38. The CPU concluded that Mr Luci had a rapid decline and had been monitored appropriately during the day by staff at the DHHS facility. The CPU notes the documented 'breathing heavier than usual' at 4.00pm following which the doctor was called and that there appeared to be no clear indication to call an ambulance earlier in the day.

39. The CPU provided advice that an ambulance attendance three to four hours earlier would have been unlikely to affect the final outcome, although it would be impossible to say with certainty.

40. The CPU also reviewed the medical management of Mr Luci at the Sunshine Hospital and were unable to identify any areas of concern.

41. I accept the CPU's advice on these matters.

FINDINGS

42. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the Act that Giuseppe Luci, born 10 June 1966, died on 31 October 2017 at the Sunshine Hospital, Victoria, from *Lobar pneumonia* in the circumstances described above.

43. I convey my sincere condolences to Mr Luci's family for their loss.

44. Pursuant to section 73(1B) of the Act. I order that this finding be published on the internet

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

Mrs Giuseppina Luci, senior next of kin

Disability Services Commissioner

Department of Health and Human Services

Senior Constable Rebecca Grayland, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 29 October 2019