IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006658

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended pursuant to section 76 of the **Coroners Act 2008***

Findings of:	Coroner Leveasque Peterson
Deceased:	Gregory Bernard Duffy
Date of birth:	27 October 1965
Date of death:	8 December 2020
Cause of death:	1(a) Urosepsis and Pneumonia Contributing Factor: Down's Syndrome
Place of death:	Eastern Health, Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128
Keywords:	Death in Care; Natural Causes

INTRODUCTION

1. On 8 December 2020, Gregory Duffy (Mr Duffy) was 55 years old at the time of his death.

2. Prior to his death, Mr Duffy lived at a group home at 5 Carveen Avenue, Mitcham for approximately two years. This group home was originally operated by the Department of Health and Human Services (**DHHS**), now Department of Families, Fairness and Housing (**DFFH**), but was transferred to Life Without Barriers on 26 May 2019.

3. Mr Duffy had a severe intellectual disability, Down Syndrome, and was blind in his left eye. His medical conditions included chronic constipation, chronic cystitis, gout, psoriasis, epilepsy and diabetes (Type 2).

4. Mr Duffy had frequent urinary tract infections (**UTIs**) and cystitis. Staff provided prompting and support to Mr Duffy to go to the toilet as per his toileting guidelines. In addition, Mr Duffy used continence aids (urine bottle and pads) to assist with bladder and bowel management.

THE CORONIAL INVESTIGATION

5. Mr Duffy's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

6. 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.

7. 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.

8. Taking into account the circumstances of Mr Duffy's death, I directed that an external examination be performed by a medical investigator from Victorian Institute of Forensic Medicine (**VIFM**). On 14 December 2020, Forensic Pathologist Dr Paul Bedford provided a written report of his findings which concluded that Mr Duffy died from natural causes. On

this basis, pursuant to section 52(3A) and (3B) of the Act, I determined that I was not required to hold an inquest into the death of Mr Duffy.

9. Taking into account the conclusion that Mr Duffy's death occurred as a result of natural causes, I have relied heavily in my investigation on information provided by the Disability Services Commissioner (**DSC**) following its investigation conducted under s 128I of the *Disability Act 2006* into the disability services provided by Life Without Barriers to Mr Duffy.

10. This approach is in keeping with the objective in section 7 of the Act that a coroner should liaise with other investigative authorities to avoid unnecessary duplication of inquiries an investigations.

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

Circumstances in which the death occurred

11. During 2020, Mr Duffy was unwell with urinary tract infections (**UTIs**) on multiple occasions.

12. On 21 August 2020, staff noted that Mr Duffy's blood glucose level (**BGL**) was 30.[1] Despite staff following the instructions from the diabetes management plan, his BGL did not fall.

13. He was subsequently admitted to hospital where he was treated for sepsis due to a UTI. He was discharged on 23 August 2020.

14. On 16 November 2020, Mr Duffy appeared to be in pain. Staff provided support to him in line with the management of a UTI. He also had a telehealth consultation with his doctor and was administered analgesics. Mr Duffy remained unwell through the night but appeared to have recovered the next day.

15. On 21 November 2020 at 8.30am, Mr Duffy had his BGL checked by the visiting district nurse. It was moderately high so she administered insulin to Mr Duffy. At 9:30am, Mr Duffy was observed to be pale and quiet. Staff checked his BGL again and it was high. Staff followed his management plan and continued to check his BGL through to lunchtime. His levels slowly decreased.

16. At 2.50pm, Mr Duffy was looking flushed in the face and he felt hot. Staff took his temperature and it was 38.2 degrees Celsius. Mr Duffy appeared unwell and he was shaking

[1] Normal blood glucose levels are between 4.0–7.9mmol/L.

at times, quiet and unsteady on his feet. Staff applied a cold compress to his head and neck and checked his BGL again, which was moderately high. Staff called Nurse-On-Call who advised to call an ambulance.

17. When paramedics arrived at approximately 3.40pm, Mr Duffy's temperature was noted to be 36.6 degrees Celsius. Given Mr Duffy's complex medical issues and presentation, he was taken to hospital where he was admitted.

18. Mr Duffy was treated for a UTI and on 26 November 2020, it appeared that he would be discharged within the week.

19. However, Mr Duffy's condition deteriorated, and following a meeting between hospital staff and his family, it was decided that he would not have any invasive treatment.

20. On 30 November 2020, he was thought to have developed hospital acquired pneumonia. His condition deteriorated further and he was transitioned to palliative care.

21. On 8 December 2020, Mr Duffy passed away.

Identity of the deceased

22. On 9 December 2020, Gregory Bernard Duffy, born 27 October 1965, was visually identified by his sister, Helen Mausecz. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 10 December 2020 and reviewed the Medical Deposition, post mortem computerised tomography (**CT**) scan, and Police Report of Death (Form 83). Dr Bedford provided a written report of his findings dated 14 December 2020.

24. Dr Bedford noted that there was good documentation of infections involving the urinary tract and the lungs, leading to Mr Duffy's passing.

25. Dr Bedford provided an opinion that the medical cause of death was '*1 (a) Urosepsis and Pneumonia, with a contributing factor of Down's Syndrome.'*

26. I accept Dr Bedford's opinion.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

27. On 14 December 2020, the Disability Services Commissioner (**DSC**) commenced an investigation under section 128I of the *Disability Act 2006* into disability services provided by Life Without Barriers to Mr Duffy.

28. Following notification of Mr Duffy's death, the DSC requested that Life Without Barriers undertake a review of their service provision to Mr Duffy. Following its review, Life Without Barriers identified opportunities to improve service provision with respect to better documentation and undertook remedial measures.

29. The DSC assessed Life Without Barriers' review of service provision and plan for service improvements. Taking into account the remedial measures identified, the DSC determined that no further action was required with regard to Mr Duffy's case.

30. I commend Life Without Barriers on its efforts to improve service provision.

31. Noting there is no evidence to suggest that any of the issues identified by Life Without Barriers were contributing factors to Mr Duffy's death, I find that is not appropriate for me to investigate these specific matters further, or to make any comment or finding as to the appropriateness or otherwise of Life Without Barriers' care of Mr Duffy more generally.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Gregory Bernard Duffy, born 27 October 1965;

    b) the death occurred on 8 December 2020 at Eastern Health, Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from urosepsis and pneumonia; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Duffy's family 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:

Helen Ann Mausecz, Senior Next of Kin

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Disability Services Commissioner

Signature:

Coroner Leveasque Peterson

Date : 14 November 2022

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.