IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004319

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Wayne Daniel Holland
Date of birth:	29 May 1963
Date of death:	28 July 2024
Cause of death:	1a : urosepsis in the setting of chronic suprapubic catheterisation in a man with congenital rubella and other medical comorbidities
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	In care – natural causes, Specialist Disability Accommodation

INTRODUCTION

1. On 28 July 2024, Wayne Daniel Holland was 61 years old when he died in hospital from an infection associated with a long-standing suprapubic catheter (**SPC**).

2. At the time of his death, Wayne lived in Specialist Disability Accommodation (**SDA**) funded through the National Disability Insurance Scheme (**NDIS**).

3. Wayne had significant disability associated with congenital rubella. Wayne was deaf and blind and had an intellectual disability.

4. In 2019, Wayne had a spine infection causing incomplete quadriplegia. The long-term SPC was inserted the same year which was complicated by recurrent urinary tract infections.

5. Wayne attended a day program in Thornbury five days a week and enjoyed the sensory experiences of wind, sun, rain, and the vibration of loud music through speakers.

THE CORONIAL INVESTIGATION

6. Wayne's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, being a person who was an SDA resident living in an SDA enrolled dwelling.[1]

7. 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.

8. 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.

9. Coroner Katherine Lorenz, (as she then was), initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024.

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

10. 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.

11. This finding draws on the totality of the coronial investigation into the death of Wayne Daniel Holland. 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.[2]

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

Circumstances in which the death occurred

12. On 26 July 2024, at about 8pm, a carer noticed Wayne to be agitated, pulling at his SPC, and reduced urine output. An ambulance was called who conveyed Wayne to hospital.

13. At about 11:39pm, Wayne arrived at Emergency Department (**ED**) at the Austin Hospital where the SPC was changed in the ED under conscious sedation.

14. Wayne continued to deteriorate and remained agitated. While being transported for a CT scan his blood pressure dropped. This did not respond to intravenous fluids and so a metaraminol infusion was commenced.

15. The CT scan showed infection of the bladder and consolidation in the right lower lungs possibly representing infection or aspiration.

16. Previous discussions with Wayne's family in the medical record indicated a ceiling of care as ward-based care and not for resuscitation or admission to the Intensive Care Unit (**ICU**). To keep receiving medications for blood pressure support such as metaraminol, Wayne would have to be transferred to the ICU.

17. Clinicians discussed this concern with Wayne's mother and sister who confirmed that they wished for ward-based care as the ceiling of care. The metaraminol infusion was ceased, and Wayne was transitioned to palliative care.

[2] 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.

18. Wayne was transferred to the palliative care unit and passed away peacefully in the early hours of 28 July 2024.

Identity of the deceased

19. On Wayne Daniel Holland, born 29 May 1963, was visually identified by a long-term carer at his accommodation, who completed a statement of identification.

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

Medical cause of death

21. On 29 July 2024, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination and provided a written report of the findings.

22. External examination and postmortem CT scan showed changes in keeping with the clinical history.

23. Dr Francis provided an opinion that the medical cause of death was *1(a) urosepsis in the setting of chronic suprapubic catheterisation in a man with congenital rubella and other medical comorbidities*.

24. Dr Francis also provided an opinion that the death was from natural causes.

25. I accept Dr Francis' opinion.

FINDINGS AND CONCLUSION

26. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Wayne Daniel Holland, born 29 May 1963;

    b) the death occurred on 28 July 2024 at the Austin Hospital from *urosepsis in the setting of chronic supracpubic catherterisation in a man with congenital rubella and other medical comorbidities*; and,

    c) the death occurred in the circumstances described above.

27. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at the SDA dwelling, or staff at the Austin Hospital, which caused or contributed to the death.

28. Having considered all the available evidence, I find that Wayne's death was from natural causes and I am satisfied that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act to not hold an inquest into the death and to finalise the investigation in chambers.

I convey my sincere condolences to Wayne's family for their loss.

Pursuant to section 73(1B) of the Act, this finding is to be published on the Court's website in accordance with the rules.

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

Glenys Holland, Senior Next of Kin
Austin Health

Signature:

Coroner Dimitra Dubrow

Date: 17 August 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.