IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005107

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

I, Coroner Leveasque Peterson, having investigated the death of Lucio Chiussi and, without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (Vic):

a) the identity of the deceased was Lucio Chiussi, born 23 March 1931;

b) the death occurred on 14 September 2020 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria from 1(a) septicaemia due to infected groin wound, 1(b) femoropopliteal bypass in a man with multiple co-morbidities, with contributing factor decubitus ulcer, diabetes mellitus, ischaemic heart disease; and

c) the death occurred in the circumstances described below.

1. Lucio Chiussi (**Lucio**) was 89 years old at the time of his death. He was born in Italy and immigrated to Australia in the 1950s with his wife, Nives Chiussi. In 1967, they had one daughter together, Ingrid. Lucio was a mechanic by trade and retired in November 1991. Just prior to his hospitalisation and eventual passing, he lived with his wife in Coburg North.

2. Lucio was admitted to hospital in June 2020 due to an exacerbation of congestive heart failure and underwent left femoral popliteal bypass surgery. On 10 August 2020, he was admitted to Plumpton Villa Aged Care Facility (**PVACF**) for ongoing care. On 8 September 2020, staff at PVACF identified bruising and redness in Lucio's left groin area. A wound chart was commenced, however no dressing was required. Lucio's general practitioner, Dr Robert Hoffman, was informed.

3. The following day, staff noted the bruising and redness had developed into a blister, resulting in a 1cm deep wound. Allevyn dressing was applied, and Dr Hoffman conducted a telehealth consultation and prescribed oral antibiotics and antifungal cream.

4. On 11 September 2020, staff noted the blister had burst. Dr Hoffman advised staff to continue with the antibiotics. While the progress notes state *"dressing was applied",* the wound chart does not support that any dressing change occurred that day. On 12 September 2020, the dressing on Lucio's left groin area was *"soaked, cleaned and redressed as per regime".* The regime requires Allevyn dressing to be applied.

5. On 13 September 2020, staff noted Lucio had a decreased appetite. The Royal Melbourne Hospital (**RMH**) Residential In-Reach Team were contacted to review him and they noted *"?sepsis, purulent discharge and abscess noted".* They recommended Lucio be brought to hospital for further treatment and this occurred later that evening. He passed away the following day.

6. Lucio had a past medical history of dementia, peripheral vascular disease, congestive cardiac failure, possible ischaemic cardiomyopathy, previous coronary artery bypass grafts x 2, ischaemic heart disease, type 2 diabetes mellitus, hypertension and hypercholesterolemia.

7. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 16 September 2020 and provided a written report of her findings dated 17 September 2020.

8. Dr Baber provided an opinion that the medical cause of death was *'1(a) septicaemia due to infected groin wound, 1(b) femoropopliteal bypass in a man with multiple co-morbidities, with contributing factor decubitus ulcer, diabetes mellitus, ischaemic heart disease'*.

9. On 23 December 2020, Dr Frances Crotty (**the complainant**), a doctor at the RMH Residential In-Reach Team, filed a complaint with the Aged Care Quality and Safety Commission (**ACQSC**) alleging that, in essence, PVACF did not manage Lucio's left groin wound properly.

10. The ACQSC conducted a comprehensive investigation. They concluded that, given the sudden change and complexity of the wound located on 11 September 2020, it would have been appropriate that PVACF staff seek further advice from a wound consultant on both 11 and 12 September 2020.

11. In response to the concerns raised by the complainant and the referral to ACQSC, PVACF arranged for the following training for their staff:

    a) on 9 December 2020, all nurses at the PVACF will participate in an online wound management seminar, hosted by Smith and Nephew;

    b) on 17 December 2020, Smith and Nephew deliver face-to-face wound management education;

    c) on 2, 4, 7, 10 and 15 December 2020, all Clinical Care Coordinators at PVACF will be providing education to staff on recognising and responding to clinical deterioration, and accuracy in documentation; and

    d) on 25 February 2021, a wound consultant from Broadmeadows Health Service will attend PVACF and deliver education on wound management, dressing products, and understanding the signs of clinical deterioration of wounds and wound sites.

12. The ACQSC proceeded to finalise the complaint. The complainant was satisfied with the response and measures taken by PVACF.

13. I accept and adopt Dr Baber's opinion. I am also satisfied by the preventative measures taken by PVACF in response to the ACQSC's investigation.

Following a review of all the available evidence, I am satisfied that Lucio's death may have been preventable in the context of earlier diagnoses and treatment, however I also acknowledge the review and changes in training brought about by this event.

To enable compliance with section 73(1A) of the *Coroners Act 2008* (Vic), I direct that these findings be published on the internet.

I convey my sincere condolences to Lucio's family for your loss and acknowledge the grief you have endured.

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

a. Nives Chiussi, Senior Next of Kin

b. Richard Lauder, Northern Health, Other Applicant

c. Andy Price, Aged Care Quality and Safety Commission, Other Applicant

d. Jane Lohrey, Aged Care Quality and Safety Commission, Other Applicant

e. Senior Constable Clare Hamer, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date: 23 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.