IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4360

FINDING INTO DEATH WITHOUT INQUEST

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

I, PETER WHITE, Coroner having investigated the death of GEORGE MAVRAGANIS

without holding an inquest:

find that the identity of the deceased was GEORGE MAVRAGANIS

born on 24 June 1965

and the death occurred on 26 August 2015

at the Northern Hospital, 185 Cooper Street, Epping, Victoria

from:

1 (a) COMPLICATIONS OF UROSEPSIS IN THE SETTING OF T3/4 PARAPLEGIA

Pursuant to section 67(1) of the *Coroners Act 2008* I make findings with respect to the following circumstances:

1. George Mavraganis was a 50 year old man who was a resident at Yooralla Shared Supported Accommodation Service in Thornbury. He became a T3 paraplegic in 1966 as a result of a knife wound to the thoracic region when he was 9 months old.
2. His doctor of 25 years, Dr Toscano reported that Mr Mavraganis was fiercely independent and lived at home with no attended care for a number of years. His deteriorating respiratory status forced him to move to Yooralla Thornbury in early 2015. Mr Mavraganis also experienced severe psoriasis, had a permanent in-dwelling catheter and suffered from recurrent urinary tract infections.
3. Dr Toscano last saw Mr Mavraganis at the Thornbury residence on 24 August 2015. Mr Mavraganis had a urinary tract infection and Dr Toscano prescrived antibiotics and arranged to review him again in two days' time.
4. Later that day, Mr Mavraganis began to complain of shortness of breath. He received oxygen and was attended to by the on-site nurse. He was then transported by ambulance to the Northern Hospital where he was admitted to the Intensive Care Unit with a diagnosis of pneumonia, urosepsis and a chest infection.

5. On 26 August 2015 at approximately 5am, Mr Mavraganis was checked on by a doctor who found him unresponsive. Mr Mavraganis had passed away.
6. Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine performed a post mortem medical inspection. Dr Lynch provided me with a report of his findings. The post mortem CT scan showed kyphoscoliosis and metal in the spine and both femora. He further noted that the external examination and findings were consistent with the history reported. Dr Lynch concluded that the cause of Mr Mavraganis' death was 1(a) complications of urosepsis in the setting of T3/4 paraplegia. I adopt Dr Lynch's findings in relation to the cause of death.
7. As part of my investigation, First Constable Chloe Antonelli provided me with a coronial brief of evidence (the brief). The brief contains statements from the Acting Group Manager of Yooralla Residential and Residential Support and the doctor from the Northern Hospital who found Mr Mavraganis deceased. I also received a statement from Dr Toscano detailing Mr Mavragnais' history. I have relied on the totality of the evidence before me in setting out this finding.
8. On the basis of the material before me, I am satisfied that Mr Mavraganis' death was due to natural causes.

Pursuant to section 73(1B) of the Coroners Act 2008 I order that this finding be published on the internet in accordance with the rules.

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

Mr Mavraganis' family

First Constable Chloe Antonelli, coroner's investigator

Signature:

PETER WHITE
CORONER
Date: **15 March 2016**