IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 003799

# FINDING INTO DEATH WITH INQUEST

*Form 37 Rule 60(1)*
*Section 67 of the* ***Coroners Act 2008***

**Inquest into the Death of: Gregory Dean COUTTS**

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| Delivered On: | 15 August 2012 |
| Delivered At: | Coroners Court of Victoria<br>Level 11, 222 Exhibition Street<br>Melbourne 3000 |
| Hearing Dates: | 8 August 2012 |
| Findings of: | Coroner Paresa Antoniadis SPANOS |
| Police Coronial Support Unit | Leading Senior Constable Tracey RAMSEY |

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of GREGORY DEAN COUTTS

AND having held an inquest in relation to this death on 8 August 2012

at Melbourne

find that the identity of the deceased was GREGORY DEAN COUTTS

born on 21 December 1964, aged 46

and that the death occurred on 8 October 2011

at St Vincent's Public Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065

**from:**

1 (a) SEPTIC SHOCK COMPLICATING PNEUMONIA IN THE SETTING OF SPASTIC QUADRIPLEGIA AND EPILEPSY

**in the following circumstances:**

1. Mr Coutts was a 46 year old single man who resided at 9 Stainer Street, Kew, a residential care facility or "group home" operated by the Department of Human Services. Mr Coutts had a number of disabilities with longstanding diagnosis of intellectual disability, spastic quadriplegia and epilepsy, which had proved difficult to control despite daily administration of several anticonvulsants. He also had a significant medical history that included asthma, recurrent urinary tract infections and recurrent aspiration pneumonia due to bulbar dysfunction and the severity of his intellectual disability. As a consequence, Mr Coutts had very limited mobility, was generally bed or wheelchair bound, and required assistance with all the activities of daily living.

2. On 3 October 2011, group home staff asked for a medical review of Mr Coutts, as he had been unwell with a fever, increased coughing and vomiting. Dr Hiran Edirisinghe was the General Practitioner who had been treating Mr Coutts for the preceding twelve months and came to the residence to review him at 4.30pm. He found Mr Coutts clinically unwell, suspected a severe aspiration pneumonia and/or seizure, and arranged a transfer to St Vincent's Hospital for further assessment and treatment.

3. Upon arrival at St Vincent's Hospital, Mr Coutts was unresponsive and hypotensive. Investigations revealed pneumonia and his initial diagnosis was septic shock secondary to aspiration pneumonia. Mr Coutts was treated with aggressive fluid resuscitation and intravenous antibiotics but failed to respond. His family were consulted about further management. In light of his failure to respond to treatment and poor prognosis, the family agreed to withdrawal of active treatment and a palliative approach. Mr Coutts was transferred to the palliative care unit where he was kept comfortable until his death on 8 October 2011.

4. The family objected to autopsy. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (VIFM) conducted a preliminary/external examination in the mortuary, considered the medical records and medical deposition from St Vincent's Hospital and advised that it would be reasonable to attribute Mr Coutts' death to *septic shock complicating pneumonia in the setting of spastic quadriplegia and epilepsy*, without the need for an autopsy.

5. The coronial investigation of Mr Coutts' death included a mandatory inquest as he was a *person placed in custody or care* as defined in section 3 of the Coroners Act 2008.[1] The Act recognises that some people are more vulnerable than others, and affords them protection by requiring that the circumstances of their death are investigated by a coroner, and that as part of that investigation there should be an inquest of formal public hearing.

6. Ms Tonia Lacy, Operational Manager, Inner East, Disability Accommodation Service, Department of Human Services, provided a statement verifying the supports in place for Mr Coutts which included primary health care from General Practitioners Dr Rice and Dr Edirisinghe, regular review by a Neurologist Dr Churchyard, ongoing assessment by Speech Pathologist Hwei-Ming Chin for planning around meal preparation and assistance. A number of plans were in place for Mr Coutts -- a Comprehensive Health Assessment completed February 2011, a Meal Time Profile completed in June 2011 and a Nutrition and Swallowing Checklist completed September 2011.

7. Dr Edirisinghe also provided a statement in which he stated that Mr Coutts had not had any medical procedures since December 2010, apart from routine blood tests, the last in August

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[1] See also sections 52(2) (b) & (3) of the Act.

2011. Mr Coutts had an episode of aspiration pneumonia in July 2011 and was attended for a viral illness in early September 2011.

6. I find that Mr Coutts died from *septic shock complicating pneumonia in the setting of spastic quadriplegia and epilepsy*. I find no evidence that any want of care or clinical management on the part of the staff of the group home where he was resident, Dr Edirisinghe or the staff of St Vincent's Health caused or contributed to his death.

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

The Coutts Family

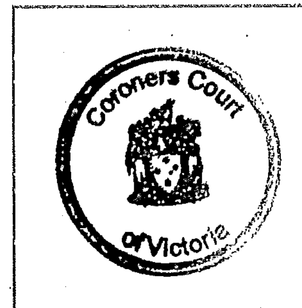
Constable Rasmus Christensen (37223) c/o OIC Fitzroy Police

St Vincent's Health

Dr Hiran Edirisinghe c/o Templestowe District Medical Centre

Ms Tonia Lacy, Operational Manager, Disability Accommodation Service, Eastern Metropolitan Region, Department of Human Services

Signature:




PARESA ANTONIADIS SPANOS
CORONER
Date: **15 August 2012**