IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001795

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Andrew Peter De Julia
Date of birth:	31 August 1961
Date of death:	6 April 2023
Cause of death:	1(a) Ischaemic heart disease in the setting of aspiration pneumonia in a man with Prader-Willi syndrome
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128
Keywords:	Death in care; natural causes

INTRODUCTION

1. On 6 April 2023, Andrew Peter De Julia was 61 years old when he passed away at Box Hill Hospital. At the time of his death, Mr De Julia lived in specialist disability accommodation in Kew, Victoria.

2. Mr De Julia had a complex medical history which included Prader-Willi syndrome, hypotension, depression, intellectual disability, transient ischaemic attack, multiple myocardial infarctions, chronic kidney disease, ischaemic heart disease, type two diabetes mellitus, epilepsy, bipolar disorder, and previous lower-limb skin cellulitis.

3. For most of his life, Mr De Julia lived with his father, Ivan De Julia and his second wife, Olga De Julia, who was like a mother figure to Mr De Julia and his siblings. His mother lived interstate for much of his childhood and passed away from cancer in 2004. He attended a school for people with disabilities, followed by Urella Finishing School in Kew for one year.

4. Mr De Julia worked at the Shelter Workshop for over 20 years where he had many good friends. He was married twice in his lifetime and returned to live with his father when those relationships ended. Mr De Julia had a passion for music and regularly travelled by train to see his aunt at her nursing home where they listened to music together. He enjoyed playing pool with his friends and travelled to a friend's house in Lilydale each week for pool matches.

5. Mr De Julia moved to Mount Eliza with his father and stepmother in 2014, but found it was too difficult to visit his friends in Melbourne. Three years before his death, he moved into the specialist disability accommodation in Kew. His father stated that the "*care facility was fantastic, and Andrew loved living there.*" He described his primary carer, Willian De Kaste, as "*amazing with Andrew*". Mr De Julia was described by his father as having "*a very good and longer than expected life*" and "*a happy person who loved his work and his friends*".

6. Mr De Julia lived a full, happy, and independent life and had few care needs. Mr De Kaste stated, "*Andrew was a gentleman and was very self sufficient*." Regarding his care needs "*he mainly required help managing his medication and food*." However, in 2021 and 2022 he suffered heart attacks and required stents, the most recent occurring in December 2022. As a result, his physical health deteriorated, and he required a walker to assist with mobility. His physical health continued to decline despite appropriate medical treatment. By 2023, he had severe heart failure and was being investigated for gastrointestinal issues.

THE CORONIAL INVESTIGATION

7. Mr De Julia's death was reported to the Coroner because it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).[1] The sole reason for the report was that Mr De Julia was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as he was "*a prescribed person or a person belonging to a prescribed class of person*" due to his status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr De Julia's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Andrew Peter De Julia including evidence contained in the coronial brief. 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.[3]

---

[1] Section 4(1), (2)(c) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received information that Mr De Julia resided at an address where the residents meet these criteria.

[3] 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.

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

Circumstances in which the death occurred

12. On 27 March 2023, Mr De Julia was taken for review to his GP due to vomiting and recent weight loss. The GP ordered blood tests. Mr De Julia's condition did not improve and on 31 March 2023, Mr De Julia was taken from his home to Box Hill Hospital (**BHH**) with vomiting, loose stools, and a cough. He was diagnosed with aspiration pneumonia and was admitted under the general medicine team. He received antibiotic therapy, however his condition deteriorated with hypotension, he was unresponsive to fluids and was admitted to the Intensive Care Unit (**ICU**) for blood pressure support.

13. In the ICU, Mr De Julia received noradrenaline and milrinone and despite some initial improvement to his circulatory function, his condition did not improve. He deteriorated further on 5 April 2023, and an electrocardiogram demonstrated a new right bundle branch block. The ICU and cardiology teams consulted with Mr De Julia's father, and jointly decided to redirect his care. Mr De Julia was provided with palliative and comfort care and passed away peacefully in the ICU on 6 April 2023.

14. As part of the coronial investigation, statements were obtained from Mr De Julia's treating clinicians at Box Hill Hospital. No concerns were raised about his care. It was noted that on admission Mr De Julia had a history of unintentional weight loss and functional decline in the preceding months and was awaiting investigations for a positive faecal occult blood test which may have indicated gastrointestinal cancer. His heart failure was noted, and that he had acute on chronic kidney disease. Treating clinician, Dr Amy Wilson noted that in her opinion, "*Andrew's death was not unexpected. Andrew was a co-morbid gentleman with significant pre-existing severe heart failure on the background of ischeamic heart disease since at least 2014. He was referred to the Coroner as he was a resident of an SRS, and not due to any concern in the medical history or around his cause of death*."

Identity of the deceased

15. On 6 April 2023, Andrew Peter De Julia, born 31 August 1961, was visually identified by his carer, William De Kaste.

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

Medical cause of death

17. Forensic Pathologist Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 10 April 2023 and provided a written report of her findings dated 11 April 2023.

18. The post-mortem examination revealed findings consistent with the reported history.

19. Examination of the post-mortem CT scan showed no skull fracture or intracranial haemorrhage. There was a small left frontal supra-cortical round hyperdensity suggestive of a meningioma, subcutaneous oedema with a small volume of ascites, a large right pleural effusion, and a small left pleural effusion in keeping with cardiac failure. There was left lower lobe consolidation and right lower lobe calcification and collapse.

20. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

21. Dr Glengarry provided an opinion that the medical cause of death was "*1(a) Ischaemic heart disease in the setting of aspiration pneumonia in a man with Prader-Willi syndrome*" and that the death was due to natural causes.

22. I accept Dr Glengarry's opinion.[4]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Andrew Peter De Julia, born 31 August 1961;

    b) the death occurred on 6 April 2023 at Box Hill Hospital 8 Arnold Street, Box Hill, Victoria, 3128, from ischaemic heart disease in the setting of aspiration pneumonia in a man with Prader-Willi syndrome; and

    c) the death occurred in the circumstances described above.

Pursuant to s 73(1B) of the *Coroners Act 2008* I direct publication of this Finding on the website of the Coroners Court in accordance with the rules.

[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

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

Ivan De Julia, Senior Next of Kin

Eastern Health

First Constable Rebecca Goldsworthy, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 19 April 2024

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.