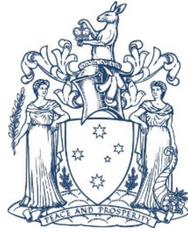


IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2023 003250**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Douglas George Coyle
Date of birth:	28 July 1960
Date of death:	17 June 2023
Cause of death:	1a: Complications of likely sepsis in the setting of a pseudo bowel obstruction in a man with Hirschsprung's disease, intellectual disability and epilepsy
Place of death:	Bendigo Health, 100 Barnard Street, Bendigo, Victoria, 3550

INTRODUCTION

1. On 17 June 2023, Douglas George Coyle was 62 years old when he died in hospital. At the time of his death, Douglas lived at Murdoch Street, a Supported Disability Accommodation (**SDA**) residence in California Gully.

2. Douglas grew up in Heidelberg Heights and was one of six siblings. At the age of eight he was placed into care.

3. Douglas had an intellectual disability and was non-verbal, requiring assistance for all activities of daily living. His medical history also included Hirschsprung's disease, epilepsy, dyslipidaemia and hypothyroidism.

4. Douglas moved to his SDA accommodation in 2017, where he lived with five other men. He attended a day service four days a week and was supported to go out for an evening meal twice a week. He had an active social life and enjoyed bush walks, music, going out for meals, ten pin bowling, dancing and cooking.

THE CORONIAL INVESTIGATION

5. Douglas's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Specifically, Douglas was immediately before his death 'a person placed in custody or care', as he was an SDA resident residing in an SDA enrolled dwelling.[1] The death of a person in care must be reported to the Coroner, even if the death appears to have been from natural causes.

6. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or care. However, As Douglas's death was due to natural causes, I am not required to hold an Inquest.[2]

7. 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

[1] Regulation 7(d) of the *Coroners Regulations 2019* (Vic).
[2] Section 32(3A) of the *Coroners Act 2008*.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Douglas's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Douglas George Coyle 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]

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

Circumstances in which the death occurred

11. Between 10 and 14 June 2023 Douglas was short of breath and had reduced food intake. His demeanour otherwise hadn't changed, and he still appeared happy.

12. On 14 June 2023, support workers booked the next available appointment at his general practitioner which was on 16 June, as they were concerned he was still not eating. They also performed a Covid test which was negative.

13. At around 2:40pm on 15 June 2023, support worker Jesse found Douglas laying on his side in bed with what appeared to be black saliva coming from his mouth. He also had diarrhea. They conveyed him to Bendigo Hospital, arriving at around 3:40pm.

[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.

14. Tests and imaging performed were suggestive of infection and showed a grossly dilated colon. The treatment strategy included fluid resuscitation and electrolyte management, antibiotic therapy and continuing Douglas's regular antiepileptic management. Considering his poor functional baseline and longstanding Hirschsprung's disease, a clinical decision was made that he was only for ward-based management.

15. Douglas's condition continued to deteriorate, and he sadly died at 5:25pm on 17 June 2023.

Identity of the deceased

16. On 17 June 2023, Douglas George Coyle, born 28 July 1960, was visually identified by his support worker, Shane Preece, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Douglas Coyle on 19 June 2023. Dr Ho considered materials including the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from Bendigo Health and provided a written report of her findings dated 22 June 2023.

19. The findings at external examination were in keeping with the clinical history. The CT scan showed bilateral bowel loops but no free gas. There were focal coronary calcifications, increased lung markings with consolidation type changes about the periphery of the right lung, left distal humerus metal fixation, contrast in bladder/kidneys and a right undescended testis.

20. Dr Ho provided an opinion that the cause of death was due to natural causes and ascribed the medical cause of death as 1(a) COMPLICATIONS OF LIKELY SEPSIS IN THE SETTING OF A PSEUDO BOWEL OBSTRUCTION IN A MAN WITH HIRSCHSPRUNG'S DISEASE, INTELLECTUAL DISABILITY AND EPILEPSY.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Douglas George Coyle, born 28 July 1960;

b) the death occurred on 17 June 2023 at Bendigo Health, 100 Barnard Street, Bendigo, Victoria, 3550;

c) I accept and adopt the medical cause of death ascribed by Dr Joanne Ho and I find that Douglas George Coyle, a man with Hirschsprung's disease, intellectual disability and epilepsy died from complications of likely sepsis in the setting of a pseudo bowel obstruction;

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Douglas George Coyle's death was due to natural causes and I find there is no relationship or causal connection between his death and his status as a person placed in custody or care immediately before his death.

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

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

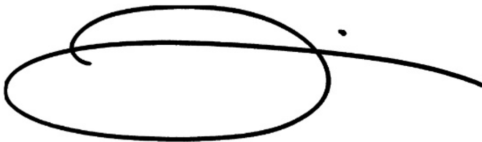
I direct that a copy of this finding be provided to the following:

Dianne Coyle, Senior Next of Kin

Bendigo Health

Senior Constable Jessica Carr, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 21 February 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.