IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003890

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Wayne Duncan Miller
Date of birth:	27 March 1968
Date of death:	17 July 2023
Cause of death:	1(a) Multiorgan failure and septic shock complicating parasitic gastrointestinal infection in a man with multiple medical comorbidities
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria
Keywords:	In care; SDA resident; natural causes

INTRODUCTION

1. Wayne Duncan Miller (**Wayne**) was 55 years old when he passed away in hospital on 17 July 2023 following a short illness.

2. At the time of his passing, Wayne lived in a Specialist Disability Accommodation (**SDA**)[1] residence in Glen Waverley operated by Aruma Disability Services (**Aruma**), with two other participants. This arrangement was funded through Wayne's National Disability Insurance Scheme (**NDIS**) plan.

3. Wayne was the eldest of five siblings born to parents Carole and Laurence Miller. He was a well-loved member of a close-knit family, highlighted by the evidence in the Coronial Brief and the beautiful photos and video shared with the Court by his family.

THE CORONIAL INVESTIGATION

4. Wayne's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). The death of a person in care or custody[2] is a mandatory report to the coroner, even if the death appears to have been from natural causes.

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

6. 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.

7. Victoria Police assigned Leading Senior Constable Dennis Li to be the Coronial Investigator for the investigation of Wayne's death. The Coronial Investigator conducted inquiries on my

[1] Specialist disability accommodation (**SDA**) is a range of housing designed for people with extreme functional impairment or very high support needs. SDA dwellings have accessible features to help residents live more independently and allow other supports to be delivered better or more safely.

[2] See the definition of '*reportable death*' in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *'person placed in custody or care'* in section 3(1) of the Act. Regulation 7(d) of the *Coroners Regulations 2019* provides that the definition of '*person placed in custody or care*' includes a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling.

behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Wayne Duncan Miller including evidence contained in the coronial brief and advice from the Coroners Prevention Unit (**CPU**)[3]. 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.[4]

BACKGROUND

9. During his childhood, Wayne was diagnosed with a severe intellectual disability and developmental delay, which was believed to have occurred due to oxygen deprivation when he was born.

10. In 1974, Wayne's parents learnt of the Doman-Dellacardo rehabilitation program involving physical and mental stimulation through repetitive exercises to stimulate and retrain the neurological pathways in the brain. They travelled to the United States of America with Wayne to learn the program. Through the implementation of this treatment over the next two years, Wayne was able to walk with assistance, chew his food, and hold and pick up a glass to drink unassisted. However, Wayne continued to require ongoing assistance with all of his activities of daily living and remained non-verbal.

11. When he was 25 years old, Wayne moved into supported residential care at Glen Waverley, which was initially operated by Churches of Christ Community Care, and later Aruma. His family regularly visited him and would bring him home for weekly family dinners and special occasions.

12. Wayne attended day programs five days a week run by the Waverley Adult Training Centre for Intellectually Handicapped Persons (**WATCH**),[5] a not-for-profit community organisation.

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[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[4] 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.

[5] Now called Watch Disability Services Inc, an NDIS Registered Provider. Further information about Watch Disability Services is available via their website: https://www.watchdisabilityservices.com.au/.

WATCH was jointly established in the mid-1980s by Wayne's parents and other parents in similar situations to enable people with disabilities to learn and be in company with others.

13. Through WATCH, Wayne was able to participate in meaningful and enjoyable individual and group activities, including creative art, music, games, park and cooking activities. Wayne also enjoyed attending swimming lessons and going on weekly excursions to watch the planes land with the other residents at his home.

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

Circumstances in which the death occurred

14. On Saturday 15 July 2023, at about 6.15am, Wayne was found by his support worker banging his forehead against his bedhead. The support worker observed blood coming out of Wayne's mouth and he appeared to be in pain. Following advice from the Aruma After Hours service, the support worker called 000 to request an ambulance for Wayne.

15. In the initial call to 000 at 6.30am, the support worker explained the situation but was informed that an ambulance would not be dispatched, but that a nurse on call would call back. However, in the intervening period, Wayne continued to bang his head harder on the bookshelf. The support worker intervened to prevent Wayne from continuing to bang his head and contacted 000 again to request an ambulance given Wayne's escalating behaviour and due to concerns he was distressed and in pain.

16. An ambulance was subsequently dispatched and attended the residence at approximately 7.00am. The attending paramedics initially experienced difficulty in assessing Wayne as he refused to allow them near him. However, they were eventually able to check his vital signs, which were in normal limits. Wayne was administered paracetamol, and the paramedics advised the support worker to call the on-call doctor for advice and take him to his general practitioner (**GP**) on Monday if he had not improved.

17. At approximately 9.00am, a second support worker called Waverley General Practice and made an appointment for Wayne to attend the clinic later that morning.

18. At approximately 11.50am, Wayne was seen by GP Dr Tamara Jones at the Waverley General Practice. On examination, Dr Jones observed that Wayne had a small laceration to his inner right upper lip. Dr Jones prescribed regular paracetamol over the next few days, and advised the support workers to avoid acidic foods, use a topical antiseptic gel or saline mouthwash for

the laceration if able, and to bring Wayne back to the clinic for review if there were any concerns.

19. Support workers at the residence continued to monitor Wayne over the following day. He remained unwell and refused to eat or drink anything.

20. On the afternoon of Sunday 16 July 2023, Wayne's condition deteriorated further, and he had an episode of diarrhoea with worms identified in his stool. His support workers again sought advice from the Aruma After Hours service. Following their advice, the support workers immediately called 000 to request an ambulance for further assessment.

21. At about 4.30pm, the National Patient Transport (**NPT**), a non-emergency patient transport service, attended the residence and conducted an initial assessment of Wayne's vital signs. They found Wayne had an increased heart rate (tachycardia) and was hypotensive. Due to their concerns about Wayne's condition and need for treatment, they arranged for a phone assessment with Ambulance Victoria and paramedics were dispatched to the residence shortly afterwards.

22. At about 5.48pm, Mobile Intensive Care Ambulance (**MICA**) paramedics arrived at the residence and found Wayne in an altered conscious state. The paramedics administered fluids and medications to manage Wayne's hypotension and transported him to Monash Medical Centre Emergency Department (**ED**) via ambulance, in the company of his father and brother.

23. On admission to the ED, Wayne was diagnosed with sepsis of unknown origin, possibly due to a protozoal diarrheal infection. He was administered broad spectrum antibiotics. However, Wayne did not show any signs of improvement and his condition continued to deteriorate with evidence of multiorgan failure.

24. Following discussion with Wayne's family, a decision was made to transition Wayne to palliative care consistent with his goals of care and comfortable end-of-life care was commenced. Wayne passed away peacefully surrounded by his family at 3.40am on 17 July 2023.

Identity of the deceased

25. On 17 July 2023, Wayne Duncan Miller, born 27 March 1968, was visually identified by his father, Laurence Miller.

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

Medical cause of death

27. Senior Forensic Pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Wayne's body on 18 July 2023 and provided a written report of his findings dated 19 July 2023.

28. The post-mortem examination was consistent with the reported circumstances. Examination of a post-mortem computed tomography (**CT**) scan showed bilateral patchy pulmonary consolidation and bilateral basal ganglia calcification.

29. Dr Lynch provided an opinion that the medical cause of death was *multiorgan failure and septic shock complicating parasitic gastrointestinal infection in a man with multiple medical comorbidities.* He opined that the death was due to *natural causes*.

30. I accept Dr Lynch's opinion as to medical cause of death.

CPU REVIEW

31. As part of my investigation and to ascertain whether Wayne's death was preventable, I obtained advice from the Health and Medical Investigation Team (**HMIT**) of the CPU regarding the appropriateness of the care and treatment provided.

32. HMIT reviewed the coronial brief, medical records and information provided by Aruma and the National Disability Insurance Agency (**NDIA**) as part of their review.

33. It was noted that Wayne had been unwell from 15 July 2023 with reduced oral intake. His condition deteriorated rapidly on 16 July 2023, and he was taken by ambulance to Monash Medical Centre where he was diagnosed with septic shock and evidence of multi organ failure.

34. HMIT could not identify any evidence of neglect in Wayne's care and management, and noted that Wayne's family considered that he was well cared for. HMIT considered that Wayne's pre-existing and co-occurring morbidities may have led to his rapid demise in the setting of a severe infection. Ultimately no concerns of care or intervention opportunities were identified.

35. I accept the advice of the CPU on this matter.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Wayne Duncan Miller, born 27 March 1968;

    b) the death occurred on 17 July 2023 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria from multiorgan failure and septic shock complicating parasitic gastrointestinal infection in a man with multiple medical comorbidities; and

    c) the death occurred in the circumstances described above.

37. Having considered the available evidence, I am satisfied that Wayne died of natural causes.

38. I have not identified any concerns in relation to the care provided to Wayne in the period proximate to his death. Further, I am satisfied that support staff at Aruma took appropriate steps to escalate their concerns and seek medical advice and treatment for Wayne when he became unwell, and his condition deteriorated.

39. I convey my sincere condolences to Wayne's family, friends and carers for their loss. I acknowledge Wayne's care team at Aruma Disability Services and WATCH, who were described by Carole as having *well loved and cared for* Wayne.

ORDERS

40. 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.

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

Carole & Laurence Miller, Senior Next of Kin

Kat Taylor, Aruma Disability Services

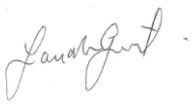
Kate Macdermid, Monash Health

Dr Wendy Barton, Waverley General Practice

Nick Abarno, National Disability Insurance Agency

Leading Senior Constable Dennis Li, Victoria Police, Coronial Investigator

Signature:



Coroner Sarah Gebert

Date: 12 July 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.