IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 2543

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: RODNEY DAVID KEEGAN

Hearing Date:	10 October 2012
Findings of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Leading Senior Constable Nadine Harrison
Delivered On:	26 October 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000

I, AUDREY JAMIESON, Coroner having investigated the death of **RODNEY DAVID KEEGAN**

AND having held an inquest in relation to this death on 10 October 2012

At Melbourne

find that the identity of the deceased was **RODNEY DAVID KEEGAN**

born on 13 August 1969

and the death occurred on 12 July 2011

at Maroondah Hospital, Davey Drive, Ringwood East 3135

from:

1 (a) CARDIOMYOPATHY IN A MAN WITH AN ACUTE ABDOMEN.

in the following circumstances:

1. Mr Rodney Keegan was 41 years of age at the time of his death. He had a history of intellectual disability, epilepsy and psychosis. He had undergone cardiac surgery in the past for a congenital heart condition and had right sided paralysis subsequent to a stroke. He was treated with a number of medications including the anticoagulant, Warfarin. Mr Keegan lived in a Department of Human Services Community Residential Unit (CRU) at 5 Mitchell Road, Mount Albert North.

2. On 6 July 2001, Mr Keegan was admitted to Maroondah Hospital following a fall at the CRU. On admission he was found to have an elevated INR[1] of 7.5 which was treated and reversed to 1.8. A CT scan of the brain showed no evidence of haemorrhage.

3. On 9 July 2011, Mr Keegan developed abdominal pain, distension and tachycardia. A CT Scan of the abdomen identified free fluid but no cause was found. At 8.00pm a Code Blue was

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[1] The target range for INR in anticoagulant use (e.g. warfarin) is 2 to 3. In some cases, if more intense anticoagulation is thought to be required, the target range may be 2.5-3.5.

called for an episode of apnoea. He was transferred to the Intensive Care Unit and later suffered an electro-mechanical dissociation (EMD)[2] arrest. He was intubated and Cardiopulmonary Resuscitation (CPR) was performed for 13 minutes before the return of spontaneous circulation. It was suspected that he had aspirated during intubation attempts.

4. Mr Keegan's condition failed to improve in the following days. The possibility of abdominal surgery was discussed with Mr Keegan's family, however, a decision was made not to prolong his suffering.

5. On 11 July 2011, Mr Keegan was extubated. He died at 12.08am on 12 July 2011.

6. The death of Rodney David Keegan was reportable as immediately before his death he was *a person placed in custody or care* as it is defined in the *Coroners Act 2008.*[3]

Investigation

7. Dr Noel Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a preliminary examination of the body of Rodney Keegan, reviewed a post mortem CT scan and the medical records and reported to the Coroner that the cause of the intra-abdominal fluid identified on the ante mortem CT scan was not entirely apparent. He advised that only a full post mortem examination would provide clarity to the acute medical issues surrounding Mr Keegan's death. However, as Mr Keegan's family had expressed an objection to an autopsy being performed and having regard to Mr Keegan's significant medical issues over a prolonged period, Dr Woodford stated that a reasonable cause of death that accounted for the terminal circumstances could be attributed to cardiomyopathy in a setting of acute abdomen.

8. The Police investigation did not identify any suspicious circumstances. No issues with regard to the care or medical management of Mr Keegan were identified.

9. An Inquest was held pursuant to section 52(2)(b) *Coroners Act 2008.*

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[2] Pulseless Electrical Activity (or Electro-Mechanical Dissociation - EMD) is present when the ECG shows a rhythm normally associated with an output but with no detectable central pulse.

[3] Section 3 – *person placed in custody or care* means – (d) a person under the control, care or custody to the Secretary to the Department of Human Services or the Secretary to the Department of Health

10. Leading Senior Constable Nadine Harrison provided a summary of the circumstances to the Coroner. No witnesses were called to give evidence.

Finding

I accept and adopt the medical cause of death as identified by Dr Woodford and find that Rodney David Keegan died from natural causes being cardiomyopathy in a setting of an acute abdomen. The exact cause of the acute abdomen was not however identified.

AND I further find that that there is no causal relationship between the cause of Mr Keegan's death and the fact that he was *a person placed in custody or care.*

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the Finding be published on the internet.

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

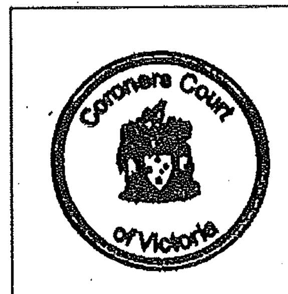
Mrs Anne Keegan

Secretary to the Department of Human Services

Constable Samara Jones, Ringwood Police Station, Investigating Member

Eastern Health

Signature:



AUDREY JAMIESON
CORONER
Date: **26 October 2012**