IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 000179

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of RODNEY GRIFFIN

Delivered on:	29 July 2016
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	29 July 2016
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Leading Senior Constable Joanne Allen, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of RODNEY GRIFFIN
and having held an inquest in relation to this death on 29 July 2016
in the Coroners Court of Victoria at Melbourne
find that the identity of the deceased was RODNEY GRIFFIN
born on 12 November 1951
and that the death occurred on or about 12 January 2016
at 68 Churchill Avenue, Ararat, Victoria 3377

from:

I (a) FOREIGN BODY ASSOCIATED SMALL BOWEL OBSTRUCTION

in the following circumstances:

1. Mr Griffin was a 64-year-old single man who had a medical history that included moderate intellectual disability, autism, epilepsy, left ventricular failure, hypertension, non-insulin dependent diabetes and anxiety. He was mute but able to communicate his needs and any distress with gestures, and was independently mobile.
2. Mr Griffin was cared for at home by his parents, along with a younger brother and sister, until adolescence when he became difficult for them to manage. Thereafter, given the high level of care he required, Mr Griffin lived in facilities operated under the auspices of the Department of Health and Human Services [DHHS], initially at Kew Cottages, then Aradale Training Centre in Ararat for 18 years, and later in community residential units [CRU] in Ararat.
3. At the time of his death, Mr Griffin had lived at a CRU in Churchill Avenue [Churchill], Ararat, for more than two years. He lived with four other residents with cognitive and/or physical impairments who required varying degrees of assistance and support from the disability support workers on staff all day and sleepover staff at night. Mr Griffin was able to attend to some activities of daily life such as toileting, bathing, dressing and eating with staff support, but he required close supervision because he habitually swallowed foreign objects. He was also supervised at the Mannagums Nursery where he worked each weekday.
4. Mr Griffin's medical needs were coordinated by his general practitioner, Dr Derek Pope, from the Ararat Medical Centre. Dr Pope performed annual general health assessments of Mr Griffiths and saw him as needed in the interim. A range of care plans were developed to assist Churchill staff to manage his nutrition and swallowing issues, diabetes, hypertension, optometry, podiatry, and daily medications.
5. In mid-December 2013, Mr Griffin presented to Dr Pope with vomiting and symptoms consistent with bowel obstruction. X-rays confirmed several foreign objects in the bowel and Mr Griffin was transferred to Ballarat Hospital where a plastic toy was removed

laparoscopically after conservative management had been unsuccessful. He recovered well post-operatively, progress of the other foreign objects through the bowel was followed with serial x-rays performed weekly until they had passed about one month later. Dr Pope noted that radiographs taken in April and June 2014 showed further, different, foreign bodies but Mr Griffin remained asymptomatic with no signs of obstruction.

6. Following his last annual check-up in August 2015 during which some urinary incontinence was noted, Dr Pope referred Mr Griffin to an urologist. The GP was suspicious that a mass detected on ultrasound was a renal carcinoma. However, the urologist diagnosed a benign right renal cyst, noting that the abdominal CT scan revealed multiple foreign bodies in the bowel, including a couple of bolts and glass or plastic fragments. Once again, Dr Pope used serial x-rays to follow the foreign bodies' progress through Mr Griffin's bowel, one passing in October 2015. Mr Griffin remained asymptomatic and his bowels were moving uneventfully when last seen by Dr Pope on 17 December 2015.

7. On 11 January 2016, sleepover staff member, Samuel Seres, noticed that Mr Griffin appeared to be a bit sluggish and, uncharacteristically, had only picked at his dinner whereas he normally had a healthy appetite. He took his nightly medications as usual and was noted to be afebrile. Mr Seres checked on all residents at about 10.50pm before he went to bed and recalled that Mr Griffin appeared comfortable.

8. At about 8.40am on 12 January 2016, Mr Seres went to Mr Griffin's room to wake him. He received no response when he knocked on the door and was unable to open the door due to an obstruction behind it. Peering around the door, Mr Seres saw Mr Griffin lying on the floor on his back, his legs preventing the door from opening fully. Vomit was evident on Mr Griffin's bedding, pyjamas and on the floor around his head. Mr Seres entered the bedroom and ascertained that Mr Griffin was unresponsive, pulseless and cool to the touch. He asked his colleague to call an ambulance and, on arrival, paramedics confirmed that Mr Griffin was deceased.

9. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.[1] However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr Griffin's death was reportable as he was a *person placed in custody or care*[2] of the Secretary to the DHHS. This is one of the ways in which the *Coroners Act* 2008 recognises that people

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[1] See section 4 of the Coroners Act 2008 [the Act] for the definition of "reportable death".

[2] See section 3 of the Act for the definition of a "person placed in custody or care".

in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

10. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[3] this was a mandatory or statutorily prescribed inquest as Mr Griffin was, immediately before death, a person placed in custody or care.[4]

11. This finding draws on the totality of the material the product of the coronial investigation of Mr Griffin's death, contained in the inquest brief compiled by Senior Constable Kelvin Laugesen of the Ararat Police Station. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

12. Mr Griffin's identity, and the date and place of her death were never at issue. <u>I find, as a matter of formality, that Rodney Griffin, born on 12 November 1951, aged 64, late of 68 Churchill Avenue, Ararat, died there on or about 12 January 2016.</u>

13. Nor was the medical cause of death contentious. Forensic Pathologist Dr Paul Bedford of the Victorian Institute of Forensic Medicine conducted an autopsy of Mr Griffin's body, reviewed the police report of death, medical records and post-mortem computer-assisted tomography scans of the whole body [PMCT], and provided a written report of his findings.

14. Among Dr Bedford's anatomical findings were a benign right kidney nodule[5] and a foreign body obstructing the small bowel. No other significant pathology was identified and atenolol and carbamazepine, detected in post-mortem blood samples at levels consistent with their therapeutic use, were considered not to have contributed to the death.

15. Dr Bedford advised that the foreign body he located in Mr Griffin's small bowel was a large quartz-like stone measuring 45mm. He observed that generally foreign bodies pass through the bowel without causing perforation or obstruction. However, in this case, the stone had obstructed the distal small bowel causing it to become distended but not perforated. Dr Bedford noted that this complication can produce vomiting and aspiration or electrolyte imbalances over a longer period.

16. Dr Bedford attributed Mr Griffin's death to foreign body associated small bowel obstruction.

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[3] Section 52(1) of the Act provides that a coroner may hold an inquest into any death that the coroner is investigating.

[4] See section 52(2) and the definition of "person placed in custody or care" in section 3 of the Act. I note that since the insertion of subsection (3A) into section 52 of the Act in November 2014, coroners are no longer required to hold an inquest into the death of a person in custody or care immediately prior to death if the death was due to natural causes. Section 52(3B) outlines the circumstances in which a coroner may consider a death to be due to natural causes.

[5] Consistent with the urologist opinion – see paragraph 6 above.

17. At my request, the Health and Medical Investigation Team of the Coroners Prevention Unit [CPU] reviewed Mr Griffin's clinical management and provided advice about its adequacy. CPU advised:

    a. Mr Griffin had a history of recurrent foreign body ingestion followed by his local doctor with serial x-rays.

    b. In the absence of symptoms of obstruction or perforation of the bowel, observation, serial x-ray and monitoring was appropriate clinical management.

    c. It is unclear whether the foreign body seen previously on x-ray was the one which led to Mr Griffin's bowel obstruction.

    d. Mr Griffin did not show any obvious signs of bowel obstruction or perforation in the period leading up to his death.

18. In light of Dr Bedford's advice, I find that Mr Griffin died as a result of foreign body associated small bowel obstruction. The available evidence supports a finding that this was a result of Mr Griffin's tendency to ingest foreign objects despite supervision and appropriate precautions taken by those who cared for him.

19. Furthermore, the available evidence does not support a finding that there was any want of clinical management or care on the part of Mr Griffin's general practitioner, Dr Pope, or his DHHS carers at Churchill, that caused or contributed to his death.

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

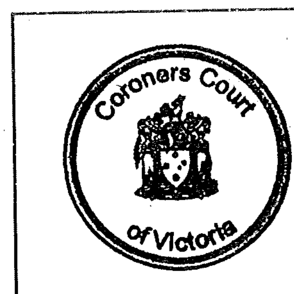
Ms Kay Prior

Ms Susan Johnstone, House Manager, Department of Health Human Services,

Dr Derek Pope, Ararat Medical Centre

Senior Constable Kelvin Laugesen, Ararat Police Station

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 29 July 2016