IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4506

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JOHN OLLE, Coroner having investigated the death of RODNEY SOFFER
without holding an inquest:
find that the identity of the deceased was RODNEY SOFFER
born on 21 January 1955
and the death occurred on 7 October 2013
at Austin Hospital, 145 Studley Road, Heidelberg VIC 3084

from:

1(a) ISCHAEMIC BOWEL

1(b) CHRONIC MEGACOLON IN THE SETTING OF CONSTIPATION, HYPOTHYROIDISM AND RUBINSTEIN TAYBI SYNDROME

Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) there is a public interest to be served in making findings with respect to the following circumstances:

BACKGROUND AND CIRCUMSTANCES

1. Rodney Soffer was born on 21 January 1955 and was 57 years old at the time of his death. He had a medical history of Rubinstein Taybi Syndrome, high riding left hemidiaphragm, constipation, urinary incontinence, intellectual disability, blindness, right herniorrhaphy, hypertension, left elbow with haemarthrosis, psychosis, rectal bleeding, and hypothyroidism.[1]

2. Mr Soffer was, immediately before death, a person placed under the care of the secretary to the Department of Human Services ('DHS'). He was a resident of a DHS group home for

[1] Oriel Road Medical Centre medical records of Rodney Soffer, Coronial brief, 10.

people with a disability in Bellfield. He had moved into this home on 25 July 2005, however had been residing in high level care for a number of decades.

3. On 30 September 2013 house supervisor, Paul Campbell, observed on Mr Soffer's bowel chart that he had not had a bowel motion for a few days. Picoprep powder was administered as per Mr Soffer's treatment sheet. During that afternoon Mr Soffer appeared unsettled and had at least three bowel motions. Consequently Mr Campbell administered PRN paracetamol and Mr Soffer settled at approximately 8.35pm.[2]

4. On 1 October 2013 Mr Soffer was admitted to Austin Hospital in the context of decreased appetite and a distended abdomen. He underwent a CT scan which showed a widely dilated bowel suggestive of gastric volvulus. An attempt was made to diagnose and decompress a potential sigmoid volvulus and a subsequent CT scan showed little improvement. Mr Soffer also had a lower respiratory tract infection. A referral was made to the Colorectal Surgery Unit and a request was made for a flexible sigmoidoscopy, which was performed in the afternoon of 3 October 2013. Dilated bowel was observed but no source of obstruction and no evidence of volvulus was found. A recommendation for palliative treatment was made, if Mr Soffer's condition deteriorated. On 4 October 2013 Mr Soffer was discharged home, into the care of his general practitioner with a treatment plan and Community Palliative Care input.

5. On 5 October 2013 Mr Soffer returned to the Austin Hospital Emergency Department and was readmitted on 6 October 2013 with further abdominal distension. He was provided analgesia. Ischaemic bowel was considered as a possible cause, as there appeared to be ischaemic areas on the sigmoidoscopy at the time of the insertion of a rectal tube for symptom management. Intravenous analgesia/sedation was commenced to keep Mr Soffer comfortable and he passed away on 7 October 2013.[3]

POST-MORTEM EXAMINATION

6. A post-mortem examination and report was undertaken by Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Lee reported that the autopsy revealed megacolon with focal infarction of the sigmoid colon.

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[2] Statement of Paul Campbell, Department of Human Services, Coronial brief, 7.

[3] Statement of Mr Ian Michell, Surgeon, Austin Health, Coronial brief, 16.

7. Toxicological analysis of blood detected midazolam and morphine, which were used for palliation. Antipsychotic medications risperidone and olanzapine were detected. Metoclopramide was also detected. The antipsychotic medications were within therapeutic post mortem range.

8. Dr Lee reported that individuals with Rubinstein Taybi Syndrome are at increased risk for different types of tumours and clinical history included life-long constipation. Hypothyroidism slows the actions of the digestive tract resulting in constipation. Mr Soffer had a clinical history of hypothyroidism, and lymphocytic thyroiditis was seen at autopsy.

9. Ischaemic sigmoid colon was confirmed histologically and no thrombi were found in the adjacent mesenteric arteries. The mesenteric veins had scattered early thrombi and apparent vasculitis. Dr Lee reported that these findings may have been secondary to compression of the mesentery by the markedly dilated sigmoid colon.

10. There was no evidence of any injuries which may have caused or contributed to death.

11. Dr Lee reported that she is of the opinion that Mr Soffer's death is due to natural causes, and that the death is due to 1(a) ischaemic bowel and 1(b) chronic megacolon in the setting of constipation, hypothyroidism and Rubinstein Taybi Syndrome.

FINDING

12. I am satisfied, having considered all of the evidence before me, that no further investigation is required. I am satisfied that there is no evidence of the involvement of any other person in this death.

13. I find that the death was due to natural causes.

14. I find that Rodney Soffer died on 7 October 2013 and that the cause of his death is 1(a) ischaemic bowel and 1(b) chronic megacolon in the setting of constipation, hypothyroidism and Rubinstein Taybi Syndrome.

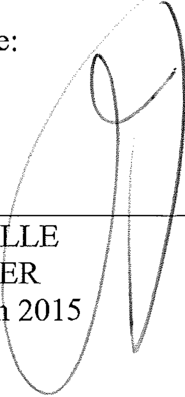
I direct that a copy of this finding be provided to the following:

The family of Rodney Soffer;

Investigating Member, Victoria Police; and

Interested parties.

Signature:



JOHN OLLE
CORONER
25 March 2015