IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4334

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Rohan GRINDROD
Delivered on:	6 June 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	Inquest on 23, 24, 25, 26 & 27 October 2017 7 December 2017
Findings of:	Caitlin ENGLISH, Coroner
Coroner's Assistant:	Leading Senior Constable Remo Antolini Police Coronial Support Unit
Representation	Ms Jennifer Cowen of Counsel for EW Tipping Foundation, Vista Support Ms Rachel Walsh of Counsel for TAC Ms Eleanor Coates of Counsel for State Trustees

I, CAITLIN ENGLISH, Coroner, having investigated the death of Rohan Grindrod

AND having held an inquest in relation to this death on 23, 24, 25, 26 & 27 October 2017 and 7 December 2017

at Melbourne

find that the identity of the deceased was Rohan Grindrod

born on 13 July 1970

and the death occurred between 16 and 17 November 2011

at 20 Adrian Drive, Pakenham

from:

I (a) Sudden unexpected death in epilepsy

in the following circumstances:

Background & chronology

1. Rohan Grindrod was 41 years old at the time of his death. He died at his home at Adrian Drive, Pakenham sometime after 11.00pm on 16 November and before 4.10pm on 17 November 2011.

2. In March 2007 Mr Grindrod was the driver in a single vehicle collision when his vehicle hit a tree. He had a blood alcohol concentration of 0.19g/100ml. Following the collision, he was in a coma for one month. On his recovery he was diagnosed with an acquired brain injury and frequently suffered from epileptic seizures.

3. In April 2007 Mr Grindrod's claim for compensation was accepted for the statutory No-Fault Benefits from the Transport Accident Commission (TAC).

4. Following his accident, Mr Grindrod separated from his partner, Donna Brereton, and their two-year-old daughter, Kiara.

5. In 2008 he moved to 30 King Street, Pakenham and in late 2010 his friend, Hayden Boloski, moved in with him.

6. On 1 April 2010 State Trustees Ltd (State Trustees) was appointed Financial Administrator over Mr Grindrod's legal and financial affairs.

7. On 5 August 2010 Mr Grindrod was assessed by an occupational therapist and it was arranged for him to have a Personal Emergency Response (PER) Unit[1] supplied by a company called VitalCall. This was paid for by TAC and connected at 30 King Street, Pakenham.

8. On 18 April 2011 the TAC agreed to fund attendant care services[2] for Mr Grindrod.[3] At the time of his death Vista Support (Vista)[4] was providing 7.5 hours per week of personal care and community access support.

9. About early August 2011 Mr Grindrod received an eviction notice and his occupational therapist requested TAC provide case management services to find new premises. This request was accepted and a TAC case manager was appointed to case manage the move to assist Mr Grindrod to find new premises.

10. His TAC case manager assisted Mr Grindrod to gain an extension on his eviction date at VCAT which was extended until 18 November 2011.

11. State Trustees, TAC and Vista were involved with the move and Mr Grindrod secured new premises at Adrian Drive, Pakenham. On 11 November 2011 State Trustees gave TAC a list of Mr Grindrod's utility details so they could be transferred to the new premises. Although arrangements were made for the disconnection and reconnection of utilities and the telephone line to the new address, the VitalCall device was not included in those arrangements.

12. Around 14, 15 or 16 November 2011, Mr Grindrod and his flat mate, Hayden Boloski, moved to the Adrian Drive address. The VitalCall device was physically moved to the new address but not reconnected.

13. On 16 November 2011, in the evening Mr Grindrod and Mr Boloski were watching television at Adrian Drive, Pakenham. At about 11.00pm Mr Boloski went to bed whilst Mr Grindrod stayed up watching television.

14. On 17 November 2011 Mr Boloski awoke and noticed Mr Grindrod's bedroom door was shut. He made a number of trips during the day between King Street and Adrian Drive, still in the process of moving his belongings. At about 4.10pm he noticed Mr Grindrod's door was still closed.

15. Concerned, he opened the door and found Mr Grindrod unresponsive on the floor. Mr Boloski noted the pendant from the VitalCall device was in Mr Grindrod's hand. Mr Boloski tried to

---

[1] For the purpose of this Finding this will be referred to as the 'VitalCall device' unless a witness is directly quoted.
[2] Attendant care services means assistance for people with disabilities to perform tasks they would normally do for themselves. Attendant care focuses on maximising the participant's independence.
[3] Statement of Tegan Stevens dated 11 June 2014, Coronial Brief p 82. In cross examination Ms Stevens clarified 7.5 hours was funded, not 30 hours, as stated in her statement (T 472).
[4] Vista Support is administered by EW Tipping Foundation.

call VitalCall first by using the pendant, and then using the VitalCall handset which was in the kitchen but it was not working. He contacted Emergency Services using his own phone. Emergency Services attended, however Mr Grindrod was declared deceased.

16. On 23 November 2011, Dr Heinrich Bouwer, forensic pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy. He formulated the cause of death as 1(a) Sudden unexpected death in epilepsy (SUDEP).

17. He noted Mr Grindrod's toxicology results for Carbamazepine and Phenytoin (anticonvulsant drugs) were within the therapeutic range, although it is noted the levels were lower than required for optimal therapeutic benefit. Cannabis metabolites detected were consistent with recent cannabis use some time prior to death.

Request for Inquest

18. On 29 November 2011 Mr Grindrod's brother, Brett Grindrod, requested an Inquest into Mr Grindrod's death.[5]

19. His reasons for seeking an inquest concerned the non-activation/reconnection of the VitalCall device at Mr Grindrod's new address. He noted it had saved Mr Grindrod's life some '*30 times prior*' and that he had changed address and Telstra and State Trustees had been arguing over '*turning it on*'. Brett Grindrod noted '*This device was not operational and was never turned on at all at this new address.*'

20. Further, he noted Rohan had been living at his new address for three nights prior to his death. Rohan had told family members at a family get together on 12 November 2011 that State Trustees and Telstra kept '*fucking him around.*' Brett Grindrod stated his '*entire family cannot comprehend how this device wasn't the first item activated.*'

21. In his request for Inquest, Brett Grindrod raised two questions, which formed the basis of formulating the scope of the inquest:

    1) '*Answer could he have had a chance at survival*'; and
    2) '*I feel as the State Government and other Depts have denied my brother basic rights. This may also fall under public interest so no other families can suffer this tragedy.*'

22. On 16 February 2012 Brett Grindrod was advised pursuant to section 52(6) of the Coroners Act 2008 that coronial investigations were continuing.

---

[5] Form 26 Request for Inquest, Exhibit 3.

Coronial investigation

23. I have had the carriage of this investigation following the retirement of Coroner Spooner in February 2014.

24. Mr Grindrod's death was reported to the coroner as it was unexpected and so fell within the definition of a reportable death in the Coroners Act 2008.

25. 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.

26. A coronial brief was prepared which includes statements from VitalCall staff, TAC staff, Vista staff, as well as from the forensic pathologist and the neuropathologist who examined Mr Grindrod after his death.

27. As part of the investigation advice was sought from the Coroners Prevention Unit.

Coroners Prevention Unit review of VitalCall device activations

28. Coroner Spooner requested the Coroners Prevention Unit (CPU)[6] review the circumstances of Mr Grindrod's death.

29. The purpose of the review was to examine the activation history of Mr Grindrod's VitalCall device.

30. Mr Grindrod's VitalCall device had been activated to make an emergency call on 5 April 2011, 9 May 2011, 22 May 2011, 30 July 2011 and 5 September 2011. There are no medical records for 9 May 2011.

31. The corresponding records from Casey Hospital indicated on 27 March 2011 Mr Grindrod attended the Emergency Department following a seizure. Ambulance Victoria (AV) records indicate his six-year-old daughter pressed the VitalCall device.

32. On 5 April 2011 Mr Grindrod was found by his flatmate, thrashing on the floor. Although the AV records do not state who pushed the VitalCall device it is likely his house mate did as AV

[6] 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.

records indicate Mr Grindrod was post-ictal (which means in an altered conscious state following a seizure) when they arrived.

33. On 22 May 2011 Mr Grindrod was found in bed and the AV notes indicate his flat mate activated the VitalCall device.

34. On 30 July 2011 Mr Grindrod attended ED after his flat mate witnessed a seizure. Mr Grindrod was in an altered conscious state when AV arrived. It is likely his flat mate activated the VitalCall device.

35. On 5 September 2011 Mr Grindrod was found by his flat mate in an 'altered state' and the flat mate called an ambulance. It is likely the flat mate activated the VitalCall device as Mr Grindrod was post-ictal.

36. It appears that on each occasion in 2011 (other than 9 May 2011, for which there are no medical records) someone other than Mr Grindrod activated the VitalCall device as on each occasion he was post- ictal.

37. There is no evidence in the medical records that Mr Grindrod ever activated the VitalCall device himself.

38. The activation history of the VitalCall device raised the question of whether there is a causal link between the non-reconnection of the VitalCall device to the Adrian Drive address and Mr Grindrod's death. He was alone in his bedroom on the evening of 16 November 2011when he may have had a seizure. There was no one present to activate the VitalCall device for him, as had occurred on previous occasions.

39. This issue of causation is also affected by Dr Bouwer's advice that in cases of Sudden unexpected death in epilepsy, death may occur with or without a seizure.

Directions Hearing

40. In response to Mr Brett Grindrod's request for inquest, a Directions Hearing was held on 19 May 2016 to canvass the issues to be explored at inquest and witnesses to be called.

41. The two issues for consideration were whether Mr Grindrod would have been able to activate the VitalCall device himself if it had been connected, and secondly, the chain of responsibility with respect to the agencies providing services for Mr Grindrod to ensure the VitalCall device was re-connected to Mr Grindrod's new residence.

42. Although TAC did not attend the Directions Hearing, further statements were requested from TAC, in particular from Ms Penny Mathee, Mr Grindrod's case manager. The staff from Vista

Support who were the carers for Mr Grindrod around the time of his move were also asked to provide statements.

Inquest

43. The matter was listed for inquest on 23 October 2017. The Inquest heard from 13 witnesses over 5 days. The hearing was adjourned for additional statements to be obtained from Mr Grindrod's occupational therapist and from Mr Jibu Paul, and to obtain phone records. Final submissions were heard on 7 December 2017.

44. This finding does not purport to recite all of the evidence heard at Inquest, only that which is relevant to the statutory requirements, namely the identity, cause of death and circumstances as set out in section 67 of the Coroners Act 2008. Circumstances of death must be relevant and proximate to the death. The circumstances include a focus on the two issues forming the scope of the inquiry at inquest.

45. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities.[7]

ISSUE 1. COULD MR GRINDROD HAVE ACTIVATED THE VITALCALL DEVICE?

Mr Grindrod's medical condition

46. As a result of the motor vehicle accident in 2007, Mr Grindrod suffered a brain injury. He was also diagnosed with epilepsy and had frequent, poorly controlled seizures.

47. Mr Grindrod's neurologist, Dr Saman Punchihewa stated that Mr Grindrod was non-compliant with his medication, as revealed by the blood test on 5 September 2011, and that this could increase his risk of seizures and increase his risk of SUDEP.[8] Dr Punchihewa's evidence was that although SUDEP is poorly understood, the heart can stop, completely unrelated to a seizure.

48. Dr Punchihewa advised Mr Grindrod against the use of alcohol and recreational drugs as they are seizure provoking factors.

49. Dr Punchihewa stated that Mr Grindrod told him that on one occasion he got the feeling he was about to have a seizure and so he lay down and someone called for help.

---

[7] This is 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.

[8] T 23.

50. Dr Punchihewa explained that doctors hardly ever see a person having a seizure so most information is gleaned from the person's medical history. On most occasions the record revealed that Mr Grindrod had been found by someone else while he was having a seizure or unconscious.

51. Dr Punchihewa doubted Mr Grindrod would have been able to activate the alarm himself following a seizure.[9]

Cause of death

52. Dr Heinrich Bouwer, forensic pathologist at the Victorian Institute of Forensic Medicine conducted the autopsy and formulated the cause of death as 'I(a) Sudden unexpected death in epilepsy' (SUDEP).

53. Dr Bouwer's Medical Examiners Report was accepted into evidence and formed part of the coronial brief.

54. Dr Bouwer's findings on autopsy included natural disease in the form of mild cardiomegaly and mild fibrosis and hypertrophy of the heart muscles. The lungs were heavy and congested and there was moderate coronary artery atherosclerosis.

55. The low levels of Carbamazepine and Phenytoin in toxicology results confirm Dr Punchihewa's evidence that Mr Grindrod was non-compliant with his medication.

56. In respect to his formulation of the cause of death, Dr Bouwer noted:

'SUDEP is defined as "sudden, unexpected, witnessed or unwitnessed, non traumatic and non drowning death syndrome in patients with epilepsy, with or without evidence of seizure and excluding documented status epilepticus, and which post mortem examination does not reveal a toxicological or anatomic cause of death". The incidence of SUDEP varies from 1 in 100,000 per year through to as many as 1 in 200 per year depending on the community surveyed. The mechanism of death in SUDEP is not clearly established. Hyperventilation and/or cardiac changes occurring during or shortly after the seizure may be such mechanisms but at the present time the precise mechanism is not known.'[10]

57. Dr Bouwer stated that deaths in people with epilepsy may be sudden and unexpected with or without a seizure. There is no specific evidence whether Mr Grindrod had a seizure. There are no specific findings at autopsy that can indicate this.

---

[9] T 19.

[10] Medical Examiner's Report of Dr Heinrich Bouwer dated 24 January 2012, Coronial Brief p 11.

58. Dr Bouwer was also asked to provide his written opinion as to whether Mr Grindrod could have survived if the VitalCall device had been connected.

59. In cases such as this one where the VitalCall device operated 'back to base,' in Dr Bouwer's view it was 'highly unlikely that activation would have had a different outcome, if he did have a seizure, unless someone rapidly came to his assistance'.[11]

60. I accept Dr Bouwer's formulation of the cause of death.

ISSUE 2. CHAIN OF RESPONSIBILITY FOR RE-CONNECTION OF VITALCALL DEVICE

61. In considering this issue the facts to be determined included the following:

- The VitalCall Personal Emergency Response System, and the process involved for transferring and reconnecting it, and the user information provided;
- The roles of the various agencies in Mr Grindrod's life and the move, namely:
  - State Trustees role as his Administrator;
  - TAC's role in providing case management services for Mr Grindrod's move and the services entailed; and,
  - Vista's role and responsibilities in Mr Grindrod's daily life and the move.

Background to Mr Grindrod's move

62. Following his motor vehicle accident in 2007, three agencies were involved with providing services to Mr Grindrod. State Trustees was his Administrator, and responsible for his legal and financial affairs. TAC, as the insurer, approved and paid for services for Mr Grindrod, as recommended by his occupational therapist. Vista Support provided the attendant carers who helped Mr Grindrod with day to day shopping and community access, services funded by TAC. Mr Grindrod also had a piece of specialised equipment, namely the VitalCall device, which was provided by VitalCall and funded by TAC.

63. When Mr Grindrod was served with an eviction notice from King Street, he was required to find a new house. Although his occupational therapist (OT) did not give evidence at the Inquest, it was not in dispute that the OT referred Mr Grindrod for TAC case management services to assist managing the move. In my view this referral recognised the fact that owing to Mr Grindrod's medical conditions following his car accident, a move of premises

[11] Supplementary report of Dr Heinrich Bouwer dated 19 May 2016, Coronial Brief p 13.

represented a need for additional management and co-ordination above and beyond the usual services he received.

Brett Grindrod's evidence

64. Mr Brett Grindrod made the request for an inquest to be held, he made a statement, gave evidence at the hearing, and made some comments at the conclusion of all the evidence. He was the family representative who attended the hearing. Because of the importance of his role in the inquest I will analyse his evidence separately.

65. The responsibilities of the agencies providing services to Mr Grindrod had a number of complex aspects.

66. The complexity of those arrangements is reflected in Brett Grindrod's statement and evidence about his understanding of his brothers' financial and legal affairs, including his recollection of the conversations he had with Mr Grindrod in the days prior to his death.

67. The role and responsibility of each agency involved with providing services for Mr Grindrod was clarified during the evidence at inquest.

68. As Brett understood it, the VitalCall device was organised through TAC and Monash Hospital, funded by State Trustees and controlled by Telstra.[12]

69. The evidence confirmed the VitalCall device was organised for Mr Grindrod on the recommendation of his OT, and funded by TAC. This was unusual, as State Trustees, Mr Grindrod's Administrator, paid for everything else.

70. State Trustees was not involved with organising or funding the VitalCall device. However from August 2010, State Trustees was aware Mr Grindrod had a VitalCall device because they advised Telstra that a telephone connection at Mr Grindrod's home address was necessary for the VitalCall device to function.

71. Owing to a history of Mr Grindrod entering into multiple mobile phone contracts with Telstra, State Trustees had insisted that Telstra deal only with them as Administrator, and not with Mr Grindrod.

72. Brett's evidence was that at a family gathering on 12 November 2011, Rohan told him his new address was 20 Adrian Drive, Pakenham. Rohan told him he was sleeping at the new address and in the process of moving his things over. He told him the VitalCall device was not connected as of 12 November 2011.[13]

---

[12] Coronial Brief p 28.
[13] T 32.

73. On 12 November 2011, the evidence suggests that Rohan was still living at King Street and not at Adrian Drive as Brett had been told. The move to Adrian Drive took place sometime after 14 November 2011. This is supported by evidence of Vista attendant carer Ms Pauline Ogilvy who visited him on 14 November 2011 at King Street and helped him pack boxes, and TAC Case Manager Ms Penny Matthee who spoke to Mr Grindrod on 15 November 2011 and he told her he was still in the process of moving. Ms Matthee agreed to visit him at 20 Adrian Drive on 17 November 2011. Mr Grindrod's flat mate Hayden Boloski stated they moved on 14 November but in evidence could not be sure which was their first night at Adrian Drive, and agreed it could have been 16 November 2011.

74. Brett's evidence was that Rohan told him the power at King Street had been off for '9 days' so he could not vacuum and that he had been locked out of King Street when he still had possessions in that house.[14]

75. The evidence confirms the power was not disconnected at King Street on 3 November 2011 (9 days prior to 12 November 2011) as Brett had been told. Rohan was in the process of moving to Adrian Drive and the power was maintained so cleaning could occur and because the move took place over a number of days. On 14 November 2011 when Pauline Ogilvy was at King Street helping Rohan to pack boxes she stated the utilities were connected. The telephone connection was not transferred until 15 November 2011.

76. Brett's evidence was that Rohan told him he had been to the Telstra office in Pakenham in the days prior (to 12 November 2011) to arrange to have his VitalCall device activated. Rohan said Telstra had advised him to go to the State Trustees to have it activated as they paid for everything.

77. Given the complex relationship between Rohan, Telstra and State Trustees, although this was mistaken advice, it is also quite likely it was given, as Telstra was under instructions to only deal with State Trustees about the provision of Mr Grindrod's telephone services.

78. Brett's evidence was that Rohan complained to him on 12 November 2011 that he was attempting to have the VitalCall device 'activated' and as at 12 November 2011 it was not connected. It is unclear why Mr Grindrod was seeking to have the VitalCall device 'activated' as there is no indication that it was not working whilst Mr Grindrod was still living at King Street. Mr Boloski stated that when they moved into Adrian Drive on 14 November 2011 Mr

[14] T 32-3.

Grindrod had mentioned to him the medical alert phone was not working and that he had to speak to State Trustees for them to turn it on.[15]

79. The VitalCall device appears to have been still connected as at 12 November 2011 as Mr Grindrod was still living at King Street. Both the power and telephone were still connected at that address.[16] Evidence from VitalCall on point could not definitely state the device was working at this time, but aside from Rohan's conversation with Brett, there was no evidence it was not.

80. Brett stated Rohan texted him at 12.10am on 13 November 2011 '*from Rohan's home phone at Adrian drive, the number is 59405099...*'. Brett believed this text was from the Adrian Drive address as he thought he had moved there and that the power was off at King Street.[17] Brett believed the telephone was connected at Adrian Drive, hence he queried why was the VitalCall device was not operational.

81. The number Mr Grindrod texted Brett from (59405099) on 13 November 2011 was the number for both the King Street and Adrian Drive addresses. The telephone line was not transferred between the two properties until 15 November 2011.

82. Brett Grindrod was not aware that if the VitalCall device was moved from one house to another it stopped working. He stated he thought it was like a telephone, '*once you plugged it in, that was the phone, and it all worked.*'[18]

83. Brett gave evidence about the importance of the VitalCall device for Rohan. He said it gave him a sense of hope, and that he felt safe[19] and it was a great relief[20] that he knew he had the VitalCall device.[21]

84. Brett Grindrod's evidence was sincere and authentic. There were complicated aspects to the services provided by the different agencies and the roles and funding of VitalCall, TAC and State Trustees which may have meant it was not clear to either Rohan or Brett who was responsible for what. Some of the information Rohan gave him also appears inaccurate as compared to other witnesses (who had more accurate information available to them).

VitalCall device

---

[15] Coronial Brief p 38.

[16] The evidence from Ms Rasch, VitalCall, was that no signal/activations had been received from the PERS since after a test call on 15 October 2011 however although this does not mean that it was disconnected, neither could she tell whether it was working between 15 October and 16 November 2011 (T 73-74).

[17] T 34.

[18] T 36-7.

[19] T 36.

[20] T 42.

[21] Mr Grindrod's flatmate Mr Boloski also agreed in evidence that Mr Grindrod saw the VitalCall alarm as 'very important' (T 56).

85. Following the recommendation of his OT to TAC, Mr Grindrod received the VitalCall device on 5 August 2010, funded by TAC.

86. The VitalCall device used by Mr Grindrod was called a 'Personal Emergency Response Unit'. It comprised a pendant, worn on a chain, and base unit, which is plugged into a telephone line and power supply. The sensitive microphone and speaker acted similar to a hands-free telephone. When the pendant is pressed, the base unit dials the response centre to notify of a medical emergency. The response centre knows where the call is coming from so the response operator initiates a call, and can address the client by name and assess the emergency. The response operator may contact either a nominated person or the emergency services to attend. In Mr Grindrod's case, when the operator initiated a call for Mr Grindrod, it was placed to Emergency Services.

87. The address on VitalCall's system for Mr Grindrod was 30 King Street Pakenham for the duration of the agreement. VitalCall had no record of being advised Mr Grindrod had moved address.

88. Ms Monique Rasch, VitalCall Operations Manager, gave evidence there were no calls received by VitalCall from Mr Grindrod's VitalCall device after 15 October 2011. Although that did not mean the VitalCall device was not working, Ms Rasch could not confirm if Mr Grindrod's VitalCall device was working on 17 November 2011.

89. The VitalCall customer agreement, clause 4, requires the user to test the device once a month. The test is always conducted by the user. The record produced by VitalCall confirmed Mr Grindrod regularly made a test call on a monthly basis as required, with the last test being on 15 October 2011.

90. Although the original customer agreement for Mr Grindrod was unable to be located by VitalCall,[22] a blank pro forma of the customer agreement was produced which refers to a 'subscriber' and a 'user'. The user is the person who has the device. The subscriber is the agency that pays for the device, which in this case was TAC. Whilst the customer agreement imposes obligations on the subscriber, a copy of the agreement is not sent to the subscriber.[23] The evidence confirmed TAC never received the customer agreement.

91. Despite this, the customer agreement contains obligations on the subscriber, such as not to disconnect the device without advising VitalCall (clause 5(e)) and to advise VitalCall if any

[22] Ms Rasch's evidence was that the VitalCall Customer Agreement provided to Mr Grindrod when he became a client of Vital Call is in offsite archives and could not be located. The copy of the Agreement was not in the archived box it was supposed to be in. Ms Rasch was unable to say if this was a 'one off' or systemic issue (T 92).

[23] Evidence from Tegan Stevens and Sarah Middleton, TAC, confirmed the Agreement was never received by TAC (T 468) nor would TAC agree to perform the functions of a subscriber described therein.

information in the agreement changes (clause 5(g)). Ms Rasch gave evidence that the agreement required TAC to advise VitalCall if Mr Grindrod changed address and confirmed a copy of the customer agreement was not provided to TAC to inform them of these obligations.

92. A user guide[24] and brochure[25] is also provided to the user at the time of installation. The VitalCall User Guide[26], the VitalCall brochure and the VitalCall customer agreement[27] do not specify or warn the user that the device will cease to operate if disconnected from the telephone line or power line.

93. The only warning in the paperwork is at 23(d) of the customer agreement that if the user changes the '*set up at the premises*' it states the device '*may not work in the same way.*'[28]

94. The only other warning is printed on the power plug for the unit, 'DO NOT UNPLUG' in 3 millimetre sized black letters.

95. A VitalCall technician was required to install or relocate a PERS because '*it's not a plug and play unit...it needs professional installation and specific tests to be carried out to ensure that it is installed correctly and installed in the right place.*'[29]

96. In cross examination Ms Rasch was unsure whether the VitalCall device would work if plugged in at a new address and explained that the unit had to be installed correctly having regard to the number of phone extensions in the house, the power supply and the set out of the common areas.[30]

97. Ms Rasch explained that at installation the VitalCall agent tells the user about how to activate the alarm and the connection and disconnection of the unit. They are also told what to do if they are going to change address and she noted the power plug has a warning sticker stating, 'DO NOT UNPLUG.'[31] In re-examination she was equivocal on this point and when asked about information provided to the user about unplugging and moving the unit she answered she '*can't be sure.*'[32]

---

[24] Coronial Brief p 62.
[25] Coronial Brief p 67.
[26] Coronial Brief p 62.
[27] Coronial Brief p 64.
[28] T 85, Coronial Brief p 65.
[29] T 66.
[30] T 67, 69.
[31] T 70.
[32] T 90.

98. Moving the VitalCall device entails a cost for the VitalCall technician to attend, and also requires the power and phone line to be connected at the proposed premises.[33]

99. Ms Rasch confirmed that nothing in the user guide warned the user not to unplug the alarm from the phone line or the power line or explained the consequences of doing so, namely that the unit would cease to work. Aside from the words on the power plug stating 'DO NOT UNPLUG' she agreed the VitalCall user guide contains no warnings about the consequences of unplugging the power or telephone lines, nor does it stipulate not to unplug the telephone line.[34]

100. Further, the customer agreement does not specify the consequences of disconnection of the device from the telephone line or power.

101. Ms Rasch indicated there are a small number of units still in use like Mr Grindrod's, (although she was unable to specify how many) and there are no warnings on them to state that if the power or telephone lines are unplugged they will stop working.

102. Ms Rasch's evidence was that all current VitalCall devices have warnings not to re-locate the device without contacting VitalCall first.[35]

103. Ms Rasch agreed with the suggestion that VitalCall could send a letter to all clients with the same device as Mr Grindrod warning them about the consequences of unplugging the device and giving them a sticker to put on their device as a warning.[36]

104. As the new VitalCall units are GSM (Global System for Mobile Communications) with a SIM and mobile, they have built in reminders to test each week. VitalCall no longer produces the land line device used by Mr Grindrod, although there are still such devices in operation.

105. Ms Rasch indicated VitalCall had some 47 000 clients with PERS. She stated it was still the case that the customer agreements were not provided to the subscriber.[37]

State Trustees – role in Mr Grindrod's life and the move

106. State Trustees was appointed as Mr Grindrod's administrator 1 April 2010 which meant they took control over Mr Grindrod's legal and financial affairs.

107. Ms Rupali Chandra, Personal Financial Consultant, first became aware of Mr Grindrod's VitalCall device on 25 August 2010 from Natalie Brennan at TAC when Mr Grindrod's

---

[33] T 76.
[34] T 82.
[35] T 88.
[36] T 88.
[37] T 93.

telephone line was disconnected for non-payment of a bill.[38] Ms Chandra was aware the device was paid for by TAC but did not know who supplied the device and had no involvement with the contract, payment or how it worked.[39]. All she knew from Ms Brennan at TAC was that it needed an active telephone line to operate.[40]

108. In September 2010 Ms Chandra stated: '*I informed Telstra that he needed to have an active telephone service because of the medical alarm attached to it...the home phone always needed to remain active.*'[41] She believed that meant Telstra put '*a flag on file to say that he had a medical condition for which the phone line needed to remain active, the home telephone line.*'[42]

109. On 14 June 2011, Telstra again disconnected Mr Grindrod's telephone line for the non-payment of the bill however re-connected it on 15 June 2011.

110. On 27 September 2011 State Trustees had a meeting with TAC and Mr Grindrod about his move.

111. Ms Chandra's evidence was that State Trustees' role in the move was to tell Mr Grindrod what he could afford, to provide financial documents so he could make applications for rental properties and arrange for the payments.[43] Ms Chandra agreed her role in the move was '*limited to paying the bond and making sure the rent was able to be paid....and transferring the telephone*'.[44] Ms Chandra only dealt with Ms April Whitelaw from Vista about bond monies.

112. On 11 November 2011 Ms Chandra sought the TAC case manager Ms Matthee's assistance in the transfer of the utilities. She made this request because, from her previous experience of dealing with utility providers, she was aware that the transfer might not happen on time and often when transferring connections by telephone, the utility companies want to speak to the actual account holder.[45]

113. On 14 November 2011 Ms Chandra contacted Telstra in writing to advise that Mr Grindrod's telephone line needed to be moved to a new address.[46] She stated, '*but I didn't think of telling them about the pendant alarm.*'[47]

---

[38] T 88.
[39] T 195-6.
[40] T 198.
[41] T 189-90.
[42] T 190.
[43] T 192.
[44] T 195.
[45] T 193.
[46] T 194.

114. State Trustees had no contact from Mr Grindrod about the VitalCall device, although he was frequently in contact about paying bills on 10 November 2011[48] and on 16 November 2011 seeking money for petrol, food and phone credit.

115. Ms Chandra indicated '*I did not know how the relocation of that service worked.*'[49] Ms Chandra also gave evidence she was unaware the VitalCall device would stop working if it was unplugged and transferred to another house, or that a technician was required if it was to move address.[50]

State Trustees initiatives since Mr Grindrod's death

116. Ms Chandra's evidence was that State Trustees now has a new procedure with new clients. '*...if there is any sort of personal alarm that the represented person is required to use or has connected – if we receive information that there is, we would put what's called a hot note within our system.*'[51]

117. Ms Chandra detailed the State Trustees now has a new process for change of addresses when its clients move. '*...if there's actually a hot note about a personal alarm, and if there is an active alarm, we need to assess how that needs to be changed over to the new address.*'[52]

118. In their submission State Trustees state the 'hot note' will allow State Trustees, '*to act as a "backstop" and remind any relevant parties of the need to ensure that necessary steps are taken for the moving of such alarm system.... not because they consider themselves responsible for the movement of such alarm but for the general benefit of their clients.*'[53]

119. Ms Chandra stated if there had been a 'hot note' active on the system in Mr Grindrod's case: '*...it would have made me aware that that was an additional service that needed to be relocated, and I would have contacted TAC.*'[54]

120. The 'hot note' in relation to personal alarms is something that has been newly developed and is not yet in place.

121. I note State Trustees was aware Mr Grindrod had a VitalCall device and that he needed a connected telephone line for it to work and taken steps to ensure the telephone line was connected.

---

[47] T 204.
[48] T 199.
[49] T 204.
[50] T 207.
[51] T 201.
[52] T 201.
[53] State Trustees Submissions p 10.
[54] T 202.

122. The introduction of a 'hot note' and State Trustees' indication that they can now act as a 'back stop' in cases where people have a personal alarm appears to be an initiative following Mr Grindrod's death. This case appears to have highlighted to State Trustees the need to formalise a process (through the 'hot note') whereby they can remind others agencies to take the steps necessary to move an alarm.

TAC case management services for the move and what the services entailed

123. Evidence from Ms Tegan Stevens estimated about 180 TAC clients have personal alarms, similar to the VitalCall device.

What is case management?

124. Ms Sarah Middleton, TAC team manager, explained that a TAC case manager is allocated when something arises above and beyond what ordinary people involved in the client's care can provide.[55]

125. The TAC case management model is described on the TAC website as a case management process which consists of assessment, planning, facilitation, liaison, identifying and recommending necessary options to address individual needs, maximise independence and achieve quality cost effective outcomes.[56]

126. The case management plan is the document which '*must identify the actions required to work towards the client's objectives...*'.[57]

127. Case management services are typically funded by TAC on an episodic basis. Ms Middleton stated '*A typical example would be if someone was moving home or needed to find alternative accommodation. That would be a typical reason for a case manager to be involved.*'[58]

Request and approval for case management services

128. On 5 August 2011 Tegan Stevens, coordinator at TAC, received a telephone call from Mr Grindrod's OT, Claire Sauvarin, requesting case management services to assist Mr Grindrod '*find a new rental.*'[59] The reasons for the referral included Mr Grindrod's eviction notice and his need for assistance to move out and find another rental property.

---

[55] T 532. Internal case management no longer provided by TAC but the same principles apply to external case managers.
[56] T 532.
[57] T 533.
[58] T 226.
[59] Tegan Stevens File Note of telephone conversation, Coronial Brief p 110-53.

129. Ms Stevens filled in the case management referral, describing it as '*something I would have actioned quite quickly.*'[60] When Ms Stevens completed the 'case management referral', in the section dealing with Client complexity information, she noted Mr Grindrod to have unstable accommodation, an absence of informal supports, complex administration issues and noted he resided in a regional area. The case management required was noted to be high intensity and for less than two months. She noted Mr Grindrod's injury type as moderate brain injury.

130. Asked if she looked at Mr Grindrod's file when preparing the referral, she stated: '*...for something this simple, being that it was just to find new rental accommodation and it seemed a reasonable request, I might not have done an extensive review of the claim file.*'[61]

131. Ms Stevens confirmed in her referral for case management services that no risk assessment was conducted. She stated a support coordinator (such as herself) or case manager, would not make those assessments as they are not part of the 'treating team'. '*We have no forms or processes, to my knowledge, at the time that assessed client safety.*'[62]

132. Although client complexity information was included in the case management referral form (21 issues include: flagged risk client, litigious issues, disputes and/or informal reviews pending, challenging behaviours & other), Ms Stevens made the distinction that the VitalCall device would be regarded as 'equipment', not fall under 'complex home modification issues',[63] and thus was not referred to in the case management referral. Ms Stevens said the case management referral would not include a risk assessment unless it was about staff safety.[64]

133. Ms Stevens was not aware that the VitalCall device would stop working if Mr Grindrod moved from one house to another.[65]

<u>Allocation of a case manager for case management services to Mr Grindrod</u>

134. Ms Penny Matthee was allocated TAC case manager to provide case management services to Mr Grindrod. Her 'general instructions' regarding Mr Grindrod's move were contained in Ms Steven's case management referral.

135. Ms Matthee together with Mr Grindrod developed an individual plan and outcome report (the Individual Plan)[66] for the two goals of Home living and Living independence. The plan also

---

[60] T 470.
[61] T 477.
[62] T 484.
[63] T 485.
[64] T 484.
[65] T 467.
[66] Coronial Brief p 121.

summarised recommendations, actions and allocated responsibilities between the case manager, Mr Grindrod and attendant care workers.

136. The Individual Plan stated one role of the case manager was to '*Liaise with the occupational therapist and attendant care workers on their role in supporting Rohan to review options provided.*' Ms Matthee clarified it was the OT, not herself, who was to advise the attendant care workers from Vista to take Mr Grindrod to open for inspections (in addition to their usual duties such as outings and shopping).[67]

137. There was no mention of the VitalCall device in the Individual Plan and no delegation of tasks regarding the VitalCall device to Vista staff, the attendant care workers.

138. Ms Matthee had a degree of discretion regarding her case management duties and was involved in Mr Grindrod's move in different ways:

- She attended VCAT on 18 October 2011 to assist Mr Grindrod extend his eviction date from the King Street property until Friday 18 November 2011;
- On 4 November 2011 after Mr Grindrod advised her he had found a house to rent at 20 Adrian Drive, Pakenham and planned to move on 12 November 2011, she visited the new house with him, discussed removalist arrangements and liaised with State Trustees regarding payment for a removalist;
- On 7 November 2011 she spoke with April Whitelaw from Vista about Mr Grindrod's move, and communicated with State Trustees regarding payment of the bond and first month's rent;
- 10 November 2011 by email Ms Chandra (State Trustees) asked her to assist to arrange the transfer of utility connections to the Adrian street property;
- On 11 November 2011, she gave Mr Grindrod the details provided by Ms Chandra of the utility providers so that he could transfer the utilities to the new address (although she was not present when Mr Grindrod made the calls). She also attended a GP's appointment with him that day. Discussions at that appointment included management of Mr Grindrod's epilepsy seizures and a referral to a neuropsychologist[68].
- On 15 November 2011 Ms Matthee spoke to Mr Grindrod, who told her he was still in the process of moving, and she agreed to visit him at 20 Adrian Drive on 17 November 2011.
- On 16 November 2011 Ms Matthee had a call from Jibu Paul at Vista that an attendant care worker Ms Ogilvy could not contact Mr Grindrod.

---

[67] T 126-7.
[68] T 106-7.

- On 17 November 2011 Ms Matthee attended 20 Adrian Drive but could not contact Mr Grindrod.

139. Ms Matthee provided advice to Mr Grindrod about the move, suggesting the utilities needed to remain connected at King Street until 18 November 2011 to enable cleaning and the transition of the move.[69]

140. Ms Matthee's evidence was Mr Grindrod never said to her at any time either that he was having trouble with his VitalCall device or that it was not working.[70] She stated if Mr Grindrod had raised any difficulties with her about his VitalCall device she would have called VitalCall and also Vista.[71] Mr Grindrod never asked for help reconnecting the alarm.[72]

141. Ms Matthee stated it was the client and/or their carers who '*had the responsibility regarding activation of the alarm, monitoring the use of the equipment, managing the emergency contacts, ensuring the regular testing of the alarm and notifying the supplier in the event of a move.*'[73]

142. When examined by LSC Antolini about where she obtained this information, Ms Matthee stated:

'*Well I think generally in the community, not every – that's what other people would so um I suppose there's a range of people that have VitalCall from ah, you know, the elderly, the disabled, and that's what, ah would be basically the requirement of any person who had that type of system.*'[74]

143. Ms Matthee stated that although she liaised with Mr Grindrod's OT about Mr Grindrod's move there was no mention of Mr Grindrod's VitalCall device. Nor was there any mention of the VitalCall device with State Trustees[75] or by Mr Grindrod or by the staff at Vista.

144. When asked about her role as case manager to assist a client with finding new accommodation, and whether it was to '*assist them to deal with technical aspects that are beyond their capacity,*' Ms Matthee answered, '*If I'm instructed by an occupational therapist, yes.*' Ms Matthee could not recall speaking with the OT during her period of case management.[76]

---

[69] T 115.
[70] T 119.
[71] T 119.
[72] T 123.
[73] Coronial Brief p 117.
[74] T 128-9.
[75] T 127.
[76] T 168.

145. Her evidence was she took her instructions from the case management referral. Ms Matthee stated that although she would have read Mr Grindrod's TAC file in preparation for her role as case manager she could not recall the reports prepared by the OTs on file. She had no specific knowledge of Ms Sauvarin's report dated 14 October 2011 nor would she expect the report to have been sent to her as '*not all reports... that come through to the support co-ordinator are relevant ...to me as a case manager.*'[77] Beyond the referral for case management services, Ms Matthee could not recall Mr Grindrod's limitations which meant that he required case management assistance. She could not recall if she was aware of an earlier report dating from 2010 detailing Mr Grindrod's cognitive difficulties.[78]

146. Ms Matthee confirmed in the allocation of tasks, there was no reference to the moving of services or the VitalCall device in particular, and she could not say at the time of preparing the Individual Plan whether she was aware Mr Grindrod had a VitalCall device.[79] She did become aware of the VitalCall device (however was unsure when) and was aware the VitalCall device required an active telephone line in order to work, though was not aware it required power to be connected to operate. Ms Matthee confirmed she was aware that VitalCall had to be advised of Mr Grindrod's new address.[80]

147. Ms Matthee was unaware that the alarm could stop working if unplugged from one house and moved to another.[81]

148. Asked to comment on Ms Matthee's evidence, Ms Middleton, a TAC manager, indicated she would have expected that Vista would been made aware of the Individual Plan containing duties for Vista staff and that the summary of recommendations and actions in the Individual Plan would have been prepared with them.

149. Ms Middleton agreed Ms Matthee should have communicated the contents of the Individual Plan to those assigned tasks in the plan and discussed with them.[82]

150. Ms Matthee was asked whether she could have added VitalCall to the list of utilities Mr Grindrod was to ring to transfer, she stated the VitalCall device was equipment not a utility[83]

---

[77] T 134.
[78] T 159.
[79] T 137.
[80] T 141.
[81] T 122.
[82] T 536-7.
[83] This answer is at odds with other 'services' included in the list of utilities to re-connect, such as pay TV and pay Sports.

and that she did not recall considering whether there were other services that also needed to be notified at the same time.[84]

151. Ms Matthee had recorded in her notes about the GP appointment that discussion took place about Mr Grindrod's seizures and his need to have a lodger at home 'for monitoring'.[85] She conceded that the VitalCall device was an important piece of equipment for Mr Grindrod to manage his seizures and to live independently.

152. In hindsight she conceded the VitalCall device was something that needed to be active at all times and specifically co-ordinated to be moved when the telephone was transferred and power was connected.[86]

153. Ms Matthee asked State Trustees to assist with the reconnection of the telephone line because Mr Grindrod was not able to do that himself.

154. Ms Matthee was cross-examined about her evidence that the client and/or their carers had responsibility for the alarm, including in the event of a move. She conceded that she never made a request to Vista staff to assist Mr Grindrod to move his VitalCall device[87] and that the Vista staff were not advised about arrangements or timing regarding reconnection of the telephone line or power at Adrian Drive. Ms Matthee was not aware that Vista workers were not authorised to enter into financial transactions of behalf of clients.

155. When asked about conducting a risk assessment as part of case managing the move Ms Matthee noted she had concerns about the move because Mr Grindrod did not have a great deal of support beyond his flat mate Hayden, but made no mention of risks considered by her when case managing the move.[88]

<u>Vista's role in Mr Grindrod's day to day life and the move</u>

156. Vista is a support agency that provides support workers for people with disabilities. Vista was funded by TAC to provide 7.5 hours of attendant care workers for Mr Grindrod on a weekly basis.

157. The functional independence review prepared by OT Peter Daly[89] was an holistic review of Mr Grindrod's support needs for TAC funding. He also prepared a document 'Carer guidelines' which included advice to Vista carers, including that they check Mr Grindrod was

[84] T 142.
[85] Coronial Brief 141.
[86] T 143.
[87] T 150.
[88] T 169.
[89] Coronial Brief p 110-10.

wearing his VitalCall device each day and that he was reminded to either test the alarm, or document the date on which the next test was required.

158. The report contained no advice to Vista staff about the technical requirements for moving or reconnecting the VitalCall device or that a technician was required to do so.

159. Mr Jibu Paul (manager, Vista) gave evidence of a conversation on 24 October 2011 with the OT regarding Mr Grindrod's move requesting assistance from Vista staff to accompany Mr Grindrod to visit real estate agents to look for a suitable new property.[90] Mr Paul stated this was the only request made to Vista to provide additional support for Mr Grindrod's move.

160. Mr Paul had no calls from either TAC or State Trustees regarding the move.[91]

161. Mr Paul states he was never told Vista staff were to move Mr Grindrod's VitalCall device.[92] Although he was aware Mr Grindrod had some kind of medical alert device, he was not aware who provided it, or who funded it or that it could not simply be plugged and unplugged,[93] or that a VitalCall technician was required for it to be transferred.

162. Mr Paul never had a meeting with TAC about Mr Grindrod's move, nor did he see the Individual Plan prepared by Ms Matthee that designated actions to Vista staff.[94]

163. Mr Paul's evidence was that he was not advised of Mr Grindrod's new address and it was not recorded in the Vista Carelink (Vista's computer system).

<u>Vista staff working with Mr Grindrod around the time of his move - chronology</u>

164. Marianne Aghan had been one of Mr Grindrod's support workers for approximately 12 months. She had a four-hour shift with Mr Grindrod on 11 November 2011. She confirmed the electricity was connected at King Street that day. She did not help pack boxes. There was no indication Mr Grindrod's VitalCall device was not working. She confirmed in the past she had helped Mr Grindrod to check the VitalCall alarm by pressing it.

165. Ms Aghan was not aware that the VitalCall alarm could not simply be unplugged and plugged into at a new house.[95]

166. Ms Aghan's last shift was on 11 November 2011 and Mr Grindrod never expressed any concerns or asked for assistance with his VitalCall device. Ms Aghan never considered it or that it would be her responsibility.

---

[90] Exhibit 22.
[91] T 238.
[92] T 242.
[93] T 249.
[94] T 255.
[95] T 337.

167. When Ms Aghan went to her shift on 18 November 2011 she went to the King Street property to see if Mr Grindrod needed 'help moving some stuff over in my car'[96] as she believed that was the day he was moving to the new address.

168. Another Vista worker, Pauline Ogilvy, met Mr Grindrod for the first time on 14 November 2011. She was filling in for April Whitelaw, who was on annual leave. She also had another shift on 16 November 2011.

169. Ms Ogilvy stated she was given a verbal briefing by Mr Paul about Mr Grindrod prior to her shift on 14 November 2011 and recalled being told Rohan will tell you what he wants you to do,[97] that Mr Grindrod was low needs[98] and she recalls being aware he was at risk of seizures.[99]

170. On 14 November 2011 she helped Mr Grindrod by packing boxes and making at least one, possibly two trips to the new house at Adrian Drive. As at 14 November 2011 she described the Adrian Drive house as having a few boxes, but otherwise empty of furniture as all his furniture was still at the King Street address.

171. At the end of the shift Ms Ogilvy said to Mr Grindrod she would see him on 16 November 2011, expecting him still to be at the old house on her next shift.[100]

172. On 16 November 2011 when Ms Ogilvy attended at the King Street address there was no answer at the front door. She went around the back but it appeared no one was home. She then called Mr Paul who told her to wait a while, which she did for approximately 40 minutes, then left. Mr Paul was not aware of Mr Grindrod's new address.

173. Ms Ogilvy indicated Mr Grindrod expressed to her his stress about the move, but did not ask about or mention his VitalCall device.

174. Ms Ogilvy was not familiar with the VitalCall device and not aware that if it was unplugged from one house and re-plugged at another that it would not work.[101]

175. April Whitelaw was another Vista worker who started working with Mr Grindrod in March 2011. Ms Whitelaw performed 2 shifts per week and was rostered for seven shifts between 24 October and 9 November 2011. She went on annual leave on 12 November 2011. Her last shift with him was 9 November 2011.

---

[96] T 364.
[97] T 381.
[98] T 386.
[99] T 399.
[100] Coronial Brief p 158.
[101] T 386-387.

176. When giving evidence, Ms Whitelaw noted her short, mid-term and long term memory had been affected by an anaphylactic reaction she suffered in 2002.

177. Ms Whitelaw believed she had told Mr Paul of Mr Grindrod's new address.[102]

178. Ms Whitelaw believed Ms Matthee was taking responsibility for changing Mr Grindrod's utility services, with State Trustees' assistance. She stated she had no record of ever being asked to assist with changing over the VitalCall device.[103]

179. Ms Whitelaw was aware Mr Grindrod had the VitalCall device and prompted him to test it, monthly, which was recorded on the whiteboard.[104] She also had to prompt Mr Grindrod to wear his alarm '*many times*'.[105]

180. Ms Whitelaw was not aware the VitalCall device could not simply be unplugged and re-plugged into a new property, stating '*The technicalities for how the alarm worked were not revealed to me... I had no information about how to transfer the unit from one house to the next.*'[106]

181. Ms Whitelaw was asked whether anyone asked her to attend to the VitalCall device. She replied, '*that question is a difficult question because I believe that it was a big nightmare for me.*'[107] She went on to state she believed she received two phone calls on 11 November 2011 from Mr Paul about Mr Grindrod's device.[108] She recalled the date as 11 November because she was going on annual leave that day and had to make the calls after 5.00pm.[109] and she had been rostered on that day, between 9.00am-5.00pm with another client.[110]

182. Ms Whitelaw recalled being asked to investigate some things about the alarm system.[111]

183. She gave evidence of ringing MePACS which she subsequently discovered was the wrong company. Ms Whitelaw stated:

I remember being requested to investigate some things about the alarm system. I rang MePACS alarm system and they couldn't find him on their list. I rang Vista again to confirm Rohan Grindrod's surname spelling and this was confirmed. I rang MePACS again and I don't remember if I got through to MePACS again because it was around 5, 5.30 on a Friday.

---

[102] T 446.
[103] CB 151-005, T 419, T 420-1.
[104] T 410.
[105] T 411.
[106] T 421, 423.
[107] T 243.
[108] T 456.
[109] T 426.
[110] T 427.
[111] T 424.

Obviously, most businesses are closing around that time and their administration department certainly would have been closing. And so it was not possible for me to follow through, (1), because as I've discovered recently since conversations with yourself and Fiona that that the alarm system was actually a VitalCall alarm system so I was even ringing the wrong company. I have absolutely insufficient information, insufficient time and it wasn't my rostered shift and I didn't believe it was my responsibility either. [112]

184. When asked about the purpose of the phone calls made to MePACS on 11 November 2011, Ms Whitelaw stated '*the purpose was to ascertain what needed to be done to transfer Rohan's alarm as best my recollection.*' Ms Whitelaw confirmed this information was not included in her statement nor did she make a note or record of it.[113]

185. Ms Whitelaw was not aware the VitalCall alarm was TAC-funded. But she was aware that '*Rohan was TAC-funded and that State Trustees were controlling his major financial transactions.*'[114] It was clarified she was only recently aware of TAC funding, not at the time she was working with Mr Grindrod.[115] Further, it was only recently that Ms Whitelaw discovered that Mr Grindrod's alarm was a VitalCall device.

186. Mr Paul was recalled on 27 October 2017 to respond to the evidence Ms Whitelaw gave at inquest which was not in her statement. Mr Paul denied making the phone calls to Ms Whitelaw on 11 November 2011. He confirmed his understanding that Mr Grindrod was moving on 18 November 2011, therefore he would not have been making calls about the alarm 7 days prior to the move on 11 November 2011 and he stated, '*I never even thought about that alarm thing...the whole alarm thing didn't you know, come to mind at all – my mind at all.*'[116]

187. Mr Paul was able to say he did not speak in an irate or rude manner to Ms Whitelaw (as suggested by her) but in cross examination could not specifically say whether or not he spoke to Ms Whitelaw on 11 November 2011 as he had no independent recollection or note.

188. When the transcript of Ms Whitelaw's evidence regarding her evidence of the telephone calls on 11 November 2011 with Mr Paul was put to him, Mr Paul specifically denied that any of the calls took place.

189. Further, when it was put to Mr Paul that Ms Aghan had an afternoon shift with Mr Grindrod between 1.30pm-5.30pm on 11 November 2011, Mr Paul confirmed if he had had a query

[112] T 424.
[113] T 431.
[114] T 425.
[115] T 455.
[116] T 556.

about Mr Grindrod's VitalCall device, he would have called the carer with Mr Grindrod at the time.[117]

190. Following Mr Paul's evidence the phone records were obtained from Vista and Ms Whitelaw's phone to ascertain if there was any record of these calls. The records did not support Ms Whitelaw's evidence she received calls on 11 November 2011 from Mr Paul.

191. Ms Whitelaw made no note of her conversations with Mr Paul on 11 November 2011 and did not include reference to it in her statement. Mr Paul had no recollection of the phone calls and denied making them. He stated that although he knew about the alarm he was not aware it was a VitalCall device or any details about it. He stated it never came into his mind.

192. Ms Whitelaw's phone records from 11 November 2011 were checked, as were Mr Paul's, Vista team leaders' and the Vista afterhours service and there was no record matching the calls described by Ms Whitelaw.

193. Indeed another Vista worker, Ms Aghan was Mr Grindrod's carer on the afternoon of 11 November 2011. Given this, it seems unlikely Mr Paul would be contacting Ms Whitelaw rather than Ms Aghan with a task regarding Mr Grindrod.

194. Ms Ogilvy also had a shift with Mr Grindrod on 14 November 2011 which gave Mr Paul an opportunity to follow up the transfer of the Vitalcall device if it was something in his mind to arrange.

195. For these reasons I find Ms Whitelaw's evidence regarding the calls from Mr Paul on 11 November 2011 unreliable and accord it no weight.

196. There is no other evidence (other than Ms Matthee's belief) that Vista was responsible for the transfer of the VitalCall device. It is not in the Carer guidelines and or in the TAC Individual Plan, and there is no evidence of any verbal or written direction for Vista staff to assist.

Summary of TAC witnesses' views on responsibility for the transfer of the VitalCall Device

197. Many of the TAC witnesses offered different views as to who was responsible for the transfer of the VitalCall device. Ms Middleton attributed responsibility for the VitalCall device reconnection to the OT (as trainer of the Vista staff), expanding on Ms Matthee's position that the client and Vista staff were responsible for the re-connection. Ms Canning (who was excused from giving evidence) in her statement indicated it was the client who had responsibility to notify the relevant provider if changing address.[118] TAC witnesses such as Sarah Middleton referred in her evidence extensively to the reports prepared by OTs

[117] T 594.
[118] Coronial Brief p 545.

regarding Mr Grindrod's day to day support needs. These reports with their recommendations were not in dispute. They were historical to this inquiry as they had been accepted by TAC and their recommendations funded appropriately, as illustrated by Mr Grindrod's VitalCall medical alert device and the Vista staff rostered to provide him with assistance.

Findings

ISSUE 1

198. I accept the evidence of Dr Bouwer and Dr Punchihewa and find it highly unlikely Mr Grindrod could have activated the VitalCall device himself, had it been connected.

199. I base this finding on the history of activations which were all performed by third parties (as detailed above in the CPU analysis) and the nature of SUDEP which can occur in the absence of a seizure. If Mr Grindrod had a seizure it is highly unlikely he could have activated the VitalCall device either prior to it occurring or in his post-ictal state without assistance from a third party. Mr Grindrod was alone in his bedroom at the time of his death.

200. Further, I accept Dr Bouwer's evidence that a different outcome was highly unlikely, if Mr Grindrod had suffered a seizure, unless someone rapidly came to his assistance.

ISSUE 2

201. The second issue in this case concerned Mr Grindrod's move and the role of various agencies involved. The move involved a man with a moderate acquired brain injury who had a known medical history of seizures for which he had a VitalCall device which assisted him to live independently. He also had complex arrangements regarding his financial affairs which included a difficult relationship with State Trustees.

202. Case management services were provided by TAC on an episodic basis. These services represented an escalation in assistance for Mr Grindrod. The OT had called TAC requesting case management assistance for Mr Grindrod's move because Mr Grindrod had a moderate severe brain injury and there were complex aspects to managing his move. Neither the TAC coordinator nor case manager were able to say they had read Mr Grindrod's TAC file at least recently regarding the OT reports. I find there was an under estimation by TAC staff of the case management requirements to '*find a new rental*' given Mr Grindrod's particular health challenges. The move was not merely to '*find a new rental*' but, as the goals/objectives in the Individual Plan prepared by the case manager demonstrate, it was to assist Mr Grindrod to live independently. Had there been more active engagement by TAC staff regarding the contents of the reports on Mr Grindrod's file perhaps they would have been more alert to Mr Grindrod's specific needs, in particular his VitalCall device.

203. The reference to the move as '*something this simple*' is revealing and belies why case management services were sought for Mr Grindrod. It was to assist with the complexities of his move, which in my view included a consideration of the transfer and reconnection of his VitalCall device, like the other utilities (including his pay TV subscriptions). Although TAC witnesses stated there was no risk assessment in either the referral for case managing services or in the individual support plan, the client complexity information in the case management referral is similar to a risk management assessment because it is alerting the prospective case manager to things that make the client's case complex. I am of the view that a risk assessment would have identified the VitalCall device as an item requiring attention. This was effectively conceded in hindsight by Mr Grindrod's case manager.

204. The referral form for case management services recognises client complexity information and in my view, specialised client equipment such as a VitalCall device should have been noted either in the referral for case management services or in the Individual Plan.

205. I find the VitalCall device was an intrinsic part of Mr Grindrod's accommodation and ability to live independently, a goal of the Individual Plan, and it should have been flagged by TAC in the case management referral or in the Individual Plan.

206. Further, one of the goals on the Individual Plan prepared by the case manager was that Mr Grindrod live at home and live independently. The VitalCall device was an important piece of equipment that helped enable him to fulfil that goal which is missing from the plan.

207. TAC's contention that Vista staff were responsible to transfer and reconnect the VitalCall device is not supported by the contents of the Individual Plan, which was not communicated to or copied to Vista.

208. I find the case manager's belief that the Vista staff were responsible for arranging the transfer of the VitalCall device to be a construction with the benefit of hindsight. In her evidence she indicated that she gave no consideration to the transfer and re-connection of the device, and that she had no consciousness of it requiring to be moved.

209. The telephone referral for case management services by the OT to TAC did not specifically refer to the VitalCall device. Although the OT had provided reports about Mr Grindrod's needs to TAC, neither the coordinator nor the case manager had read his file recently or the reports. His case manager did not seem to have an appreciation of Mr Grindrod's cognitive difficulties. This illustrates to me they were not fully aware of the complexities his case presented.

210. I accept the case manager was not asked by Mr Grindrod or other agencies such as State Trustees or Vista about transferring the VitalCall device. She never asked Vista to organise its reconnection. It is not referred to in the utilities list provided by State Trustees requiring re-connection. State Trustees and TAC collaborated to transfer utilities, including internet and cable television networks, but not the VitalCall device.

211. The evidence supports that Brett Grindrod and Rohan's flat mate Hayden Boloski were the only people to whom Mr Grindrod communicated his difficulties regarding the re-connection of the VitalCall device.

212. State Trustees was aware Mr Grindrod had a VitalCall device and had organised the Telstra reconnection of the phone line connection as a priority because of the VitalCall device.

213. I find TAC as provider of case management services to manage Mr Grindrod's move, was the best placed agency to assist him to transfer his VitalCall device from King Street to the new address at Adrian Drive. Enquiries with VitalCall would have revealed requirements to transfer the device.

214. However I note there was no warning on the VitalCall device about the dangers of disconnection other than a small notice stating 'DO NOT UNPLUG' on the power plug.

215. Mr Grindrod took his VitalCall device seriously. Records show the alarm was regularly tested monthly as required. Ms Aghan stated he wore the alarm 90% of the time, and the date to test the alarm was noted on the whiteboard.

216. One unexplained part of the evidence at inquest was why Mr Grindrod said to his brother on 12 November 2011 the VitalCall device was not working and he had been to Telstra to try and have it re-connected.

217. Mr Boloski's statement confirmed the VitalCall device was not connected as at 14 November 2011 at Adrian Drive.

218. Mr Grindrod had ample opportunity to ask any of the carers or his case manager about the VitalCall device. One likely scenario is that, like everyone who gave evidence at the Inquest, he believed that once the power and phone line were transferred or connected to the new premises, he could unplug the unit from King Street and re-plug it at Adrian Drive. If he moved on 14 November 2011 after Pauline Ogilvy's attendance or on 15 November 2011, there were no Vista staff rostered on for him to speak to.

219. The evidence of all witnesses from agencies providing services to Mr Grindrod, and including his brother Brett, was that no-one was aware of the consequences of disconnection to re-plug

at a new location or that a technician was required to transfer the device. The fact Mr Grindrod took the VitalCall device and unit to Adrian Drive suggests he might have thought the same.

220. I find there are not appropriate warnings on the VitalCall unit itself and no warnings in the User Guide or brochure provided by VitalCall.

221. The customer agreement which states that the device, if moved, may not work in the same way, was never provided to TAC and it is unclear whether Mr Grindrod received a copy. In any event the customer agreement was an inadequate warning.

222. The small script on the power plug stating 'DO NOT UNPLUG' is a patently insufficient way of warning as it is difficult to see and no consequences are specified or directions included about the importance of calling VitalCall to organise for the transfer of the device.

223. Whilst I find TAC was best placed to assist Mr Grindrod to transfer the VitalCall device, even if this had occurred, I find there was no causal link with Mr Grindrod's death because of my findings on Issue 1.

224. I am of the view there was no intention to overlook the transfer of the VitalCall device and that all workers involved with supporting Mr Grindrod were committed in their efforts.

COMMENTS

225. Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

TAC - initiatives

226. As a result of Mr Grindrod's death, TAC is now aware of the risk that a VitalCall device might fail to operate if it is transferred to another address without assistance from a VitalCall technician. On 9 October 2017 TAC wrote to VitalCall and other providers of similar alarms and recommended warning labels or stickers be placed on the unit to warn users to call the provider company (supplier) before unplugging the device.

227. TAC also advised it is identifying current clients who may have an alarm such as the VitalCall device in order to contact them and advise them of the risk.

228. Ms Middleton noted TAC could not comply with the VitalCall customer agreement and that TAC had written to VitalCall on 9 October 2017 advising that TAC did not consider itself a subscriber of the service as it could not fulfil obligations specified in customer agreement.

Other initiatives

229. Vista has indicated it has implemented a flag warning system on Carelink, its internal computer system that indicates if a client has a personal alarm device.

230. State Trustees now has a 'hot button' on its internal computer system if a client has a personal alarm similar to Mr Grindrod's.

231. TAC indicated it could consider implementing a system to trigger an assessment of how an alarm should be moved if a client tells TAC that they are moving to a new house. However, TAC noted in submissions it considers the treating team is better placed to conduct risk assessments.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:

232. That VitalCall contact all users with a device similar to Mr Grindrod's, clearly stating and warning that if the unit is disconnected from either the telephone line or the power source, the unit may cease to operate and advising that a VitalCall technician is required for transfer of the unit.

233. That VitalCall, when it writes to users with a similar device to Mr Grindrod's, provide stickers to be applied to units which clearly state they are not to be disconnected from either the telephone line or the power source, and if that occurs the unit may not operate. It should also advise to contact VitalCall to transfer the unit.

234. That all the VitalCall literature provided to users for devices similar to Mr Grindrod's include clear warnings about the consequences of disconnection to the telephone or power lines and the need for a VitalCall technician to transfer the device. The VitalCall user guide and information brochure should be updated to contain this essential information.

235. That TAC writes to all clients who are users of VitalCall devices such as Mr Grindrod's, if it has not done so already, warning them about the dangers of disconnecting the device from the telephone or power supply and advising a technician is required to transfer the unit.

236. That TAC when providing case management services (either internal or outsourced) for TAC clients include or require that a risk assessment is performed regarding the potential risks involved in the task requiring case management.

237. That TAC implements a 'hot note' warning or flag on their electronic systems, such as that implemented by Vista and State Trustees, if it has not done so already, as an alert that a client has a Personal Emergency Response device.

238. That TAC, State Trustees, and Vista conduct a review, if they have not done so already, to ensure that all clients with lifesaving equipment such as Mr Grindrod's are recorded appropriately on their electronic systems so the equipment is identified as a risk requiring evaluation in the event of any change to the client's circumstances, such as when moving address.

Pursuant to section 73(1) of the Coroners Act 2008, I order this finding be published on the internet:

I direct that a copy of this finding be provided to the following:
Mr Brett Grindrod, Senior Next of Kin
Senior Constable Michael Simon, Coroner's Investigator
TAC
State Trustees
Vista Community Support, c/o Lander & Rogers
VitalCall
Monash Health
Dr Saman Punchihewa
Ms Penny Matthee
Ms April Whitelaw

Signature:

CAITLIN ENGLISH
CORONER
Date: 6 June 2018