IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004003

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Grant Douglas Griffiths
Date of birth:	17 April 1958
Date of death:	14 July 2024
Cause of death:	1(a) Complications arising from the combined features of HIV infection, multiple cerebrovascular accidents, progressive cognitive decline/dementia, malnourishment and marked weight loss on palliative care regime
Place of death:	1/9 Gertrude Street, St Albans, Victoria
Keywords:	In care; Natural causes; Specialist Disability Accommodation

INTRODUCTION

1. On 14 July 2024, Grant Douglas Griffiths was 66 years old when he passed away at his Specialist Disability Accommodation (**SDA**) in St Albans.

2. At the time of his death, Grant resided in an SDA dwelling enrolled under the National Disability Insurance Scheme (**NDIS**) at 1/9 Gertrude Street, St Albans, Victoria. Grant received funded daily independent living support due to his medical conditions, which was provided by disability service provider, Yooralla. The supports provided to Grant included assistance with personal care, food preparation and feeding, assistance with communication, and planning appointments with health professionals.

Background

3. Grant grew up in Wodonga and later moved to Melbourne in his late twenties where he had various jobs including gardening and working in a department store. Grant was an avid gardener in his younger years and had a strong interest in plants.

4. In 2008, Grant suffered a stroke. He suffered a second stroke in September 2015 which impacted his mobility and cognitive function.

5. Grant had a complex medical history including human immunodeficiency virus (**HIV**), type 2 diabetes, hypertension, dyslipidaemia, cognitive impairment, incontinence, and pressure ulcers. Despite his significant health issues, Grant would commonly refuse medical treatment.

6. Throughout his life, Grant kept his family at arm's length and was not close to them. At the time of his death, Grant was estranged from his four surviving siblings. It is unclear from the material provided in the statements to the Court as to the origin of this estrangement, however, this distance characterised all reports of what is known about Grant's life.

7. Prior to March 2022, Grant lived independently at his home in Yarraville. NDIS-funded support workers attended once a week to assist him with shopping and bill management and he attended a group on Saturdays for social excursions. Bolton Clarke assisted Grant with medical administration.

8. On 31 March 2022, Grant was admitted to the Alfred Hospital due to functional decline. Shortly after, he was transferred to the Caulfield Hospital where he had a prolonged admission

until 30 January 2023. Despite ongoing attempts by staff, Grant was disengaged with care, rehabilitation or discharge planning whilst in hospital.[1]

9. On 30 January 2023, Grant was discharged from Caulfield Hospital and transitioned into full-time 24-hour care at an SDA dwelling in St Albans where he received Supported Independent Living (**SIL**) supports. Grant was unable to walk and was dependent on others to complete daily tasks.[2]

10. During his time at the SDA dwelling, Grant declined to sit out of bed and became permanently bedbound. He also frequently refused medical and nursing intervention, and other general supports. As a result, Grant's health further deteriorated including progression of his HIV.[3]

11. Grant was able to communicate verbally. However, his cognitive function fluctuated from day to day and on some days, he was not willing or able to communicate properly.

12. In March 2023, the Victorian Civil and Administrative Tribunal (**VCAT**) made an order appointing the Office of the Public Advocate (**OPA**) as Grant's guardian and the State Trustees as Grant's administrator. Previously, Grant's sisters, Ruth and Kaye, were appointed as his guardian and administrator respectively in July 2022, however Grant expressed a clear preference for his family not to have any decision-making powers and did not wish them to receive information about his personal matters.[4]

13. On 5 March 2023, Grant was admitted to Sunshine Hospital due to a worsening pressure wound on his right hip and a decreased conscious state. While in hospital, Grant continued to refuse medical and nursing intervention and his physical condition significantly declined due to inadequate oral intake and progression of his illness. Grant was discharged from hospital and transitioned back into his SDA accommodation on 30 October 2023.

THE CORONIAL INVESTIGATION

14. Grant's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an

[1] Neuropsychological Assessment Report of Clinical Neuropsychologist Dr Michelle Coleman dated 16 June 2022.
[2] Caulfield Hospital Care Plan dated 13 January 2023.
[3] Coronial Brief, Statement of Sally Lincoln, Yooralla Service Manager.
[4] Application to VCAT to revoke or reassess guardianship or administration order dated 22 February 2023.

SDA enrolled dwelling immediately prior to his death.[5] Deaths in care are reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of people in care and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

15. 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.

16. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

17. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Grant's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

18. In July 2025, I assumed carriage of the investigation into Grant's death from then Coroner John Olle for the purpose of finalising the case and making findings.

19. This finding draws on the totality of the coronial investigation into the death of Grant Douglas Griffiths including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[6]

[5] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

[6] 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.

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

Circumstances in which the death occurred

20. On 11 April 2024, VCAT revoked Grant's guardianship order. Grant's guardian had recommended that there was no further need for a guardian because of Grant's desire for end-of-life treatment and no resuscitation. These instructions remained consistent throughout the order, and any future decisions regarding services and medical treatment could be resolved through less formal means.[7]

21. In May 2024, Grant was showing significant signs of deterioration. He was less alert and refusing all medication, hydration and food. The Yooralla team contacted the Mercy Palliative Care team and, in a context, where Grant had made plans for end-of-life care. Comfort measures were put in place on 21 May 2024.

22. On 12 July 2024, Grant was placed on a syringe driver containing morphine and anti-nausea medication. Grant was being monitored at home by his support workers, and he passed away peacefully on 14 July 2024.[8]

Identity of the deceased

23. On 14 July 2024, Grant Douglas Griffiths, born 17 April 1958, was visually identified by Yooralla Service Manager, Sallyanne Lincoln.

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

Medical cause of death

25. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 16 July 2024 and provided a written report of his findings dated 23 July 2024.

26. The post-mortem examination revealed that Grant was underweight and had several pressure sores.

27. Dr Beer provided an opinion that the medical cause of death was *"1(a) Complications arising from the combined features of HIV infection, multiple cerebrovascular accidents, progressive*

[7] Report of the guardian to the Victorian Civil and Administrative Tribunal dated 15 March 2024.
[8] Victoria Police, Police report of death for the coroner, dated 14 July 2024.

cognitive decline/dementia, malnourishment and marked weight loss on palliative care regime".

28. I accept Dr Beer's opinion.

CORONERS PREVENTION UNIT REVIEW

29. The Coroners Prevention Unit (**CPU**) reviewed the care and management provided to Grant and advised that Grant's death was expected due to his multiple comorbidities which were voluntarily untreated for numerous years.[9] The CPU considered that the care provided by Yooralla was reasonable and appropriate for Grant's high support needs during his deterioration, and that Grant's care was consistent with his wishes to refuse treatment.

FINDINGS AND CONCLUSION

30. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Grant Douglas Griffiths, born 17 April 1958;

    b) the death occurred on 14 July 2024 at 1/9 Gertrude Street, St Albans, Victoria, from *complications arising from the combined features of HIV infection, multiple cerebrovascular accidents, progressive cognitive decline/dementia, malnourishment and marked weight loss on palliative care regime*; and

    c) the death occurred in the circumstances described above.

31. Having considered all the available evidence, I find that Grant's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Grant's death in chambers.

32. I note that Grant made several choices about his treatment and care at the end of his life. This included the right to accept and refuse care and treatment. The witness statements made as part of my investigation indicated that not only were his choices respected, but that he had

[9] 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.

continuing support and care, to the extent of his wishes, as his illness progressed and he passed away.

I convey my sincere condolences to Grant's friends, family and carers for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Kaye Griffiths, Senior Next of Kin

First Constable Matthew Taliana, Coronial Investigator

National Disability Insurance Scheme

Signature:

Coroner Therese McCarthy

Date: 06 July 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.