IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 4752

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**MAXWELL ROWLLINGS**
Date of birth:	**12 September 1949**
Date of death:	**21 September 2018**
Cause of death:	**Complications of Downs syndrome and dementia (palliated)**
Place of death:	**50-52 Crispe Street, Reservoir Victoria 3073**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Maxwell Rowllings was a 69-year-old man who resided in the Department of Health and Human Services supported group accommodation located at 50-52 Crispe Street, Reservoir Victoria 3073 at the time of his death.

2. On 21 September 2018, Mr Rowllings was found deceased in his bed by staff at his supported group accommodation after a period of rapid decline in his health.

3. Mr Rowllings' death was reportable pursuant to section 4(2)(c) of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria and, immediately prior to his death, Mr Rowllings was a person placed in care.

4. Pursuant to section 52(2)(b) of the Act, subject to section (3) and 3(A), a coroner must hold an inquest into a death, if the death or cause of death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care.

5. Pursuant to section 52(3A), the coroner is not required to hold an inquest if the coroner considers that the death was due to natural causes.

6. For this reason, I have not conducted an inquest into the death of Mr Rowllings and instead, make my findings in chambers.

INVESTIGATIONS

Forensic pathology investigation

7. Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Mr Rowllings, reviewed a post mortem computed tomography (**CT**) scan, medical records from "The Clinic", information in the VIFM contact log and referred to the Victoria Police Report of Death, Form 83.

8. Dr Baker commented that the external examination revealed an appearance consistent with Downs syndrome with short stature, typical facial features and flexion deformities of the lower limbs. The post mortem CT scan revealed marked cerebral atrophy with dilated ventricles and a fatty liver. The lung fields were clear.

9. Dr Baker noted that Mr Rowllings' family expressed a preference for no post mortem examination. There were no concerns with the care of Mr Rowllings.

10. Dr Baker ascribed the cause of death as complications of Downs syndrome and dementia (palliated).

Police investigation

11. Upon attending the Crispe Street residence after Mr Rowllings' death, Victoria Police were escorted to Mr Rowllings' bedroom, where he was observed deceased in his bed. Crispe Street staff provided investigating officers with the required information and a coronial investigation was immediately commenced.

12. Senior Constable (**SC**) Gordana Sparrowhawk was the nominated Coroner's Investigator.[1] At my direction, SC Sparrowhawk investigated the circumstances surrounding Mr Rowllings' death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, carers, treating clinicians and investigating officers.

13. During the investigation, police learned that Mr Rowllings was born with Downs syndrome and spent his childhood residing with his parents and older brother, Graeme Rowllings, in the Victorian suburb of Ivanhoe.

14. At the age of 19, Mr Rowllings required fulltime care and was placed into Caloola Mental Health Facility in Sunbury. Mr Rowllings remained in this facility until its closure in 1992. After the facility's closure, Mr Rowllings moved to a facility in Glenauburn Road, Lower Plenty.

15. In 2007, Mr Rowllings moved into the Department of Health and Human Services supported group accommodation located on Crispe Street, Reservoir. "The residence was purpose built to support residents with complex disability needs."

16. His formal diagnosis was an intellectual disability, together with Downs syndrome, Alzheimer's disease, epilepsy (myoclonic and tonic clonic seizures- diagnosed in May of

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

2013) and depression (diagnosed prior to the onset of his Alzheimer's disease). Mr Rowllings was also considered legally blind due to bilateral keratoconus.

17. In addition to his ongoing diagnoses, Mr Rowllings suffered several other chronic health conditions including, moderate oropharyngeal dysphagia with high risk of aspiration, constipation, reflux, urinary incontinence, respiratory infection, mobility issues, weight management, dry eye, pressure care, vitamin D deficiency, vitamin B12 deficiency, sun sensitivity and pain management. "Mr Rowllings had complex communication needs and successfully used augmentative and alternative communication to express his needs and wishes with familiar communication partners."

18. In October of 2015, Mr Rowllings was admitted to hospital for a chesty cough and distended abdomen. He remained an inpatient throughout October and November of 2015 and commenced receiving palliative care support in December of 2015. He was eventually discharged back to his Crispe Street residence for ongoing palliative care through the Melbourne City Mission Palliative Care Unit (**MCMPCU**).

19. Contrary to his medical prognosis, Mr Rowllings' health improved, and he was discharged from MCMPCU's care on 12 July 2016. Mr Rowllings' care was transferred to his treating general practitioner, Dr Dennis Zhou.

20. Dr Zhou or the locum doctor reviewed Mr Rowllings approximately 25 times in the year prior to his death. Mr Rowllings was seen for medication reviews, chesty coughs, poor oral intake, epilepsy management plan reviews, referral for blood and/ or urine testing, vitamin booster shots, pressure care, conjunctivitis, rashes and haemorrhoid management.

21. On 2 September 2018, a meeting between the Crispe Street residence and MCMPCU was held to discuss Ms Rowllings' recent decline in health. Mr Rowllings had become less responsive, was not smiling, was not eating, was suffering from fluid accumulation in the back of his throat and was making "crackling" sounds.

22. On 4 September 2018, Dr Zhou reviewed Mr Rowllings' epilepsy management plan.

23. On 8 September 2018, Dr Zhou reviewed Mr Rowllings for the "crackling" sounds he was making.

24. On 9 September 2018, Mr Rowllings was admitted to Austin Hospital Emergency Short Stay Unit due to a cough, a decline in his general functionality and a twenty minute seizure. At this time, Mr Rowllings was struggling to swallow food.

25. Mr Rowllings was unable to clear the secretions in his upper airway and was prescribed Atropine. Austin Health treating clinicians recommended a palliative approach to his care going forward. Mr Rowllings was discharged and returned to his Crispe Street residence.

26. Upon his return, Dr Zhou made arrangements for Mr Rowllings to commence palliative care through MCMPCU. He was admitted to MCMPCU on 12 September 2018, with the view of having him remain at his Crispe Street residence for "end of life care". In the event that he required admission to a hospital, Mr Rowllings was to be transported to the Northern Hospital Palliative Care Unit.

27. On the same day, 12 September 2018, Graeme Rowllings and Dr Zhou reconfirmed and signed a "Not for Resuscitation Order". Palliative care and management between the Crispe Street residence staff and MCMPCU commenced.

28. On 13 September 2018, speech therapist, Erminia Manzi, undertook an eating and swallowing assessment on Mr Rowllings. Ms Manzi reviewed Mr Rowllings as suffering from severe dysphagia with weak and significantly delayed swallowing reflex. He was also considered to be at high risk of aspiration and not being able to meet his nutritional and hydration needs.

29. Between 13 September 2018 and 21 September 2018, Mr Rowllings' condition deteriorated further. His palliative care was altered appropriately as per his changing presentation. "The focus was on comfort care, to ensure that Mr Rowllings had the right to die peacefully and respectively with dignity in his own bedroom and in the home he loved."

30. On 21 September 2018, Mr Rowllings' breathing was laboured. He was commenced on half hourly observations. At 10.30am, staff member, Yana Dunk, checked on Mr Rowllings and confirmed he was alive.

31. At 11.05am, staff member Kinisimiere Salavuia checked on Mr Rowllings and discovered that he had passed away.

32. No concerns were raised by Mr Rowllings' family as to the quality of care afforded to their loved one.

COMMENTS

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

1. I find the care afforded to Mr Rowllings by the Department of Health and Human Services supported group accommodation located at 50-52 Crispe Street, Reservoir Victoria 3073 was timely and appropriate and did not cause or contribute to Maxwell Rowllings' death.

FINDINGS

1. I find that Maxwell Rowllings, born 12 September 1949, died on 21 September 2018 at the Department of Health and Human Services supported group accommodation located at 50-52 Crispe Street, Reservoir Victoria 3073.

2. I accept and adopt the cause of death ascribed by Dr Melissa Baker and I find that the cause of Maxwell Rowllings' death was complications from Downs syndrome and dementia (palliated).

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

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

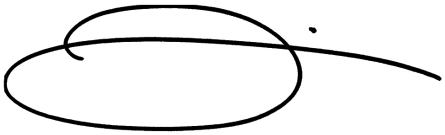
Graeme Rowllings

Shane Beaumont, Department of Health and Human Services

Treasure Jennings, Disability Services Commissioner

Senior Constable Gordana Sparrowhawk

Signature:



AUDREY JAMIESON

CORONER

Date**: 5 August 2020**