IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 005416

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Lorinda Stacey Ruff
Date of birth:	11 June 1964
Date of death:	5 October 2019
Cause of death:	1(a) Complications of metastatic colorectal carcinoma
Place of death:	McCulloch House, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria

INTRODUCTION

1. On 5 October 2019, Lorinda Stacey Ruff was 55 years old when she died at McCulloch House, Monash Medical Centre. At the time of her death, Ms Ruff resided in a group home in Chadstone and was receiving National Disability Insurance Scheme (**NDIS**) funded and regulated support through Life Without Barriers. Ms Ruff's disability support services transferred from the Department of Health and Human Services (**DHHS**) to the NDIS on 31 March 2019.

2. Ms Ruff's medical history included a moderate intellectual disability, bipolar affective disorder (schizophrenia), lymphedema and osteoporosis.

3. Ms Ruff experienced recurrent 'up' and 'down' cycles due to her bipolar affective disorder, which affected the level of support she required with day-to-day living. Throughout her 'up' cycles, she was largely independent and required minimal assistance. Throughout her often debilitating 'down' cycles, however, Ms Ruff became unresponsive and uncommunicative, and required additional support for eating and toileting. Irrespective of the behavioural cycle she was experiencing, Ms Ruff had difficulty expressing pain or discomfort unless prompted by care staff. Care staff noted that Ms Ruff had a high tolerance for pain.[1]

4. From 9.00am to 3.00pm each weekday, Ms Ruff participated in a supported day service offered by Burke & Beyond.[2]

5. In accordance with her health plan, Ms Ruff underwent regular reviews every three months and a more comprehensive review every 12 months. In June 2018, she returned a negative faecal occult blood (bowel cancer screening) test. Ms Ruff's last comprehensive review occurred in March 2019 and routine blood tests identified only mild anaemia but normal iron levels.[3]

THE CORONIAL INVESTIGATION

6. Ms Ruff's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Ms Ruff's death was reportable as she was in care of the State immediately before the time of her death.[4] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their

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[1] Statement of Anne Mundy dated 21 April 2020.
[2] Statement of Kylie Peele dated 4 February 2020.
[3] Statement of Dr Elvera Stow dated 29 January 2020.
[4] Section 4(2)(c).

deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

7. 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.

8. 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.

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

10. This finding draws on the totality of the coronial investigation into the death of Ms Ruff including evidence contained in her medical records and a review conducted by the Disability Services Commissioner (**DSC**). 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.[5]

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

Circumstances in which the death occurred

11. On 29 July 2019, Ms Ruff consulted her treating general practitioner Dr Elvera Stow, accompanied by a carer. Dr Stow was advised that Ms Ruff experienced a loss of appetite over the previous three days and exhibited body language that caused her carers to suspect abdominal pain. On examination, Ms Ruff was found to have low blood pressure and pulse, and abdominal tenderness. Dr Stow referred Ms Ruff to Dandenong Hospital emergency

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[5] 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.

department (**ED**), where she was subsequently admitted to the intensive care unit (**ICU**) on 30 July 2019.[6]

12. On admission to ICU, Ms Ruff was treated for septic shock and a lower bowel obstruction. A computed tomography (**CT**) scan revealed evidence of colon cancer.[7]

13. On 31 July 2019, Ms Ruff underwent surgical evacuation and removal of the colon and rectum (proctolectomy/sigmoidoscopy), and a stoma bag was fitted. An ultrasound of her liver revealed that the cancer had metastasised.[8]

14. Ms Ruff's ongoing treatment at Dandenong Hospital was complicated by bacteraemia (bacteria in the bloodstream) and breakdown of the surgical wound. These complications were treated with intravenous antibiotics and vacuum-assisted closure (**VAC**) dressing, respectively.[9]

15. Discussions took place between Ms Ruff's treating clinicians and her family in relation to her poor prognosis, and a decision was made not to undergo chemotherapy but to provide supportive care. On 30 August 2019, Ms Ruff was transferred to the Kingston Rehabilitation Centre.

16. Ms Ruff became acutely unwell on 30 September 2019 with abdominal pain and faecal vomiting.[10] A nasogastric tube (**NGT**) was inserted and Ms Ruff was transferred back to Dandenong Hospital. She subsequently became highly agitated and intolerant of the NGT. Further discussions took place between her treating team and family and a decision was made to withdraw active treatment and commence measures for comfort. Ms Ruff was transferred to the McCulloch House inpatient palliative care unit for end-of-life care and subsequently died at 10.25am on 5 October 2019.[11]

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[6] Statement of Dr Elvera Stow dated 29 January 2020.
[7] Statement of Dr Thang Chlen Nguyen dated 4 March 2020.
[8] Statement of Dr Thang Chlen Nguyen dated 4 March 2020.
[9] Statement of Dr Thang Chlen Nguyen dated 4 March 2020.
[10] Statement of Dr Thang Chlen Nguyen dated 4 March 2020.
[11] Statement of Dr Thang Chlen Nguyen dated 4 March 2020.

Identity of the deceased

17. On 5 October 2019, Vanessa Weekes visually identified the deceased as her sister, Lorinda Stacey Ruff, born 11 June 1964.

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

Medical cause of death

19. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 7 October 2019 and provided a written report of his findings dated 8 October 2019.

20. Dr Lynch consulted a post-mortem CT scan, which revealed fluid within the peritoneal cavity and lungs bilaterally, and bilateral lung markings.

21. Toxicological analysis was not performed.

22. Dr Lynch provided an opinion that the medical cause of death was 1(a) Complications of metastatic colorectal carcinoma, and considered that Ms Ruff's death was due to natural causes.

23. I accept Dr Lynch's opinion.

REVIEW OF CARE

24. Following Ms Ruff's death, Life Without Barriers undertook a review of their disability support services and reported to the DSC the results of their review. Life Without Barriers identified opportunities for improvement in its service review, including improved communication between the group home and the day services. The DSC also invited Life Without Barriers to consider reviewing the quality of recordkeeping utilised by the group home in relation to residents' file notes. Life Without Barriers indicated a commitment to educating its staff on the importance of written communication between the house and day services.

25. The DSC ultimately considered that no further action was required as the services delivered by Life Without Barriers was in line with the *Disability Act 2006* (Vic). I am satisfied with this course and I am also satisfied that the care provided by Life Without Barriers to Ms Ruff in the period proximate to her death was reasonable and appropriate.

26. As noted above, Ms Ruff's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Ruff died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into her death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Lorinda Stacey Ruff, born 11 June 1964;

    b) the death occurred on 5 October 2019 at McCulloch House, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, from complications of metastatic colorectal carcinoma; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Lorinda's family 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:

Vanessa Weekes, Senior Next of Kin

Disability Services Commissioner

Lanii Birks, Monash Health

Peter Ryan, Monash Health

Senior Constable Allison Ramselaar, Coroner's Investigator

Signature:

Coroner David Ryan
Date:21 July 2021

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.