FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4494/09

Inquest into the Death of JOHN ALAN HEMINGWAY

Delivered On:	6th October, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	28th September, 2011
Findings of:	CORONER KIM M W PARKINSON
Place of death:	Monash Medical Centre
Representation:	Mr P Halley on behalf Yooralla Society
PCSU:	Leading Senior Constable Greig McFarlane

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

Court reference: 4494/09

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: HEMINGWAY
First name: JOHN
Address: 25 Third Street, Clayton, Victoria 3168

AND having held an inquest in relation to this death on 28th September 2011 at Melbourne

find that the identity of the deceased was JOHN ALAN HEMINGWAY and death occurred 14th September, 2009

at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria 3168

from
1a. BRAIN SWELLING ASSOCIATED WITH CEREBRAL INFARCTION
1b. DRAINAGE ACUTE ON CHRONIC SUBDURAL HAEMORRHAGE
1c. HEAD INJURY

In the following circumstances:

1. An inquest was conducted into the death of Mr John Hemingway on 28 September 2011. Two witnesses gave evidence in the proceedings. The police investigator, Senior Constable Rob Bartlett and Ms Joanne Hine, Regional Manager North West Loddon Hume, Yooralla Society.

2. Mr Hemingway was a 62 year old man with a medical history of cerebral palsy, hydrocephalus, hypertension, epilepsy, incontinence and recurrent urinary tract infections. Mr Hemingway had a speech impediment as a result of epilepsy, however was able to communicate. His cousin, Ms Hazel Edwards, was his guardian and was actively involved in his life. He was a recipient of disability services pursuant to the *Disability Services Act* (2006) and resided in supported accommodation provided on behalf of the Department of Human Services by Yooralla.

3. On 13 August 2009, Mr Hemingway was returning to his residence after attending a medical appointment. He had been driven by a Yooralla employee, Mr Januarius Rembrand. Mr Rembrand, was an international student and worked on a casual basis for Yooralla. He was the holder of an international drivers license, but did not hold a Victorian Drivers Licence.

4. The vehicle, which was a white Toyota Hi-ace van, included a hoist lift for loading and unloading of wheelchair bound residents. The vehicle was parked in the driveway of the premises and Mr Hemingway had been assisted in exiting the vehicle in his wheelchair by the driver. He was positioned on the driveway footpath at the boundary of the property, slightly to the left of the rear of the vehicle. The driver then left Mr Hemingway on the pavement and returned to the vehicle to move it forward into the driveway, so as to allow sufficient room for the wheelchair to enter the carport and the doorway to the premises.

5. The driver then exited the vehicle, without engaging the handbrake. The vehicle commenced to roll backwards and struck Mr Hemingway causing his wheelchair to overturn and resulting in his sustaining injury. An ambulance was called and Mr Hemingway was transported to the Monash Medical Centre. He had sustained a subdural haematoma or haemorrhage on the brain. He was also identified to have a fracture to the neck of femur, which was thought to be historic, but may have been attributable to the collision. Mr Hemingway was managed conservatively.

6. On 27 August 2009, he was discharged from the hospital to continuing care at his residence. The facility staff had expressed concern as to their ability to be able to manage Mr Hemingway's needs, however had been reassured that his medical status had not significantly altered since prior to the collision.

7. On 3 September 2009, his General Practitioner, Dr Helene Owzinsky, was called to the residence as a result of carers concerns that they were unable to manage his pain. Dr Owzinsky noted that Mr Hemingway was severely dehydrated and required hospitalisation.

8. He was readmitted to the Monash Medical Centre Intensive Care Unit. Neurosurgical Registrar Dr Leon Lai and the Director of General Medicine, Professor Donald Campbell, reported on the clinical course. A CT was performed which showed an increase in the subdural haemorrhage with mass effect. Mr Hemingway was admitted for burr hole draining of the subdural haemorrhage. After the surgical procedure he developed status epilepticus and required re-intubation. Subsequent CT scans showed bilateral posterior cerebral artery infarction. There was a generalised slowing of activity on EEG. Following this deterioration there was a meeting between the medical team and the family and palliative measures were instituted. Mr Hemingway died on 14 September 2009.

9. An autopsy was performed by Dr Michael Burke, Senior Forensic Pathologist of the Victorian Institute of Forensic Medicine. Dr Burke reported that the cause of death was:

1 (a) Brain Swelling Associated with Cerebral Infarction
1 (b) Drainage acute on chronic subdural haemorrhage
1 (c) Head Injury

10. The matter was not reported to the police on 13 August 2009, by either the facility or by the driver and consequently there was no initial investigation undertaken of the scene or circumstances of the accident. On 18 August 2009, a report was made to police by Ms Mary Murphy, Acting Area Manager, Yooralla. Senior Constable Bartlett undertook an examination of the location and a reconstruction of the circumstances of the collision from the statement made by the driver and his examination of the vehicle and the wheelchair. Police concluded that the vehicle rolled backwards as it was parked on a slight incline and the vehicle hand brake had not been engaged. There did not appear to be any mechanical fault with the vehicle.

11. I am satisfied having regard to the available evidence that no further investigation is required. I find that the collision occurred as a result of the failure of the driver to engage the handbrake on the vehicle and that this failure contributed to the death. I find that the procedures for unloading Mr Hemingway from the vehicle, involving as they did, leaving him unattended in his wheelchair, at the rear of the motor vehicle, contributed to the death.

12. I find that Mr John Hemingway died on 14 September 2009 and that the cause of his death was Brain Swelling Associated with Cerebral Infarction, Drainage acute on chronic subdural haemorrhage, which arose as a result of the head injury sustained in a motor vehicle collision (pedestrian).

Comments:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

13. A number of internal reviews of the incident and the facility processes and procedures were undertaken. Ms Hine's evidence was that the initial facility response was not regarded as satisfactory and that there required to be new procedures implemented to avoid such an incident occurring again. These procedures include annual auditing of service sites, including review of the site occupational health and safety plan.

14. The organisation has developed a comprehensive vehicle management plan, including site specific procedures for the loading and unloading of passengers from vehicles. Licensing of drivers required to be local licensing and not reliant upon international drivers license status. All casual staff are now subject to oversight supervision by the Casual Bank Manager, a newly created position. That manager has responsibility for the oversight of engagement practices, induction and education and training relating to casual employees. This means that all labour hire agencies utilised by Yooralla comply with regulatory and Yooralla Service standard requirements and that the casual staff are included in induction and training in the processes and procedures of the organisation and that they participate in mandatory occupational health and safety training.

Changes made at the particular residential site

15. The specific safety issues arising from this collision are:

(1) That the vehicle driver did not engage the handbrake before he exited the vehicle; and
(2) That Mr Hemingway was removed from the vehicle and left unattended in the wheelchair behind the motor vehicle.

16. As to these matters, the organisation has instituted a number of procedural changes. The new safety procedure for vehicles instruct that a client is never to be left in the wheelchair in proximity to a vehicle, but is to be removed from the vehicle and taken inside the premises before the vehicle is moved.

17. The site specific instructions now require that the vehicle be reversed into the driveway so that the vehicle is parked on a flat surface and to ensure that there is sufficient room to utilise the hoist and to subsequently access the front doorway. Training and supervision measures have also been upgraded.

Driving skills, knowledge of local road rules and driver training of employee drivers

18. Section 61 of the *Road Safety Act 1986*, requires that a driver report a motor vehicle collision where a person is injured. That did not occur in this case.

19. On one view of the matter it is an obvious point that a driver of a motor vehicle when exiting the vehicle should engage the handbrake. The Victorian Road rules (r.213) require that action of a driver upon exiting the vehicle. Whether inadvertent or not a part of the drivers original training, it is a serious concern that such a basic driving procedure was not applied. The driver of the vehicle was licensed on an international drivers license. He stated that he had driven in his country of origin for 18 months prior to coming to Australia.

20. The international license holder is not required to engage in testing for road skills before the driver commences to drive on Victorian Roads. It appears that no distinction is drawn between tourists and longer term student visa holders. All persons who hold temporary visas are entitled to continue to drive on an international license without obtaining a Victorian license or undergoing any testing as to driving capacity or knowledge of local road rules.

21. This is in contrast to persons who come from interstate or New Zealand, who are required to obtain a local license three months after arrival and taxi license holders who are required to hold a Victorian license, together with other accreditation, in order to be able to transport passengers.

22. Whilst it may be a practical and convenient approach for tourists present for a short time, to be able to drive on an international license in combination with their country of origin license, it appears counter intuitive that the usual standards applicable to drivers licensed in Victoria, would not be required of all persons who are in fact employed to drive for occupational purposes, and whose duties include transporting passengers.

23. In this case I have been advised by counsel for Yooralla, on instructions taken during the course of the proceedings, that Yooralla is now to require that all of its drivers hold a local drivers license and that an international drivers license will no longer be acceptable for the purpose of driving Yooralla clients. In those circumstances I make no recommendations in relation to that organisation. I note the extensive efforts made to address the health and safety issues arising from the circumstances of Mr Hemingway's death.

24. I do however consider that the licensing regulator ought to review the question of whether it is appropriate for people to be able to be employed by private or public organisations, to drive a motor vehicle and convey passengers, relying solely on a license from country of origin and an international drivers license and without meeting local Victorian license testing standards.

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

25. That the licensing regulator VicRoads, review the question of whether a person who is not the holder of a Victorian Drivers License ought be entitled to be engaged or employed to drive a motor vehicle and convey passengers, relying on a country of origin license and international drivers license, and without meeting local licensing testing standards.

26. I direct that a copy of this finding be provided to the family, the interested parties, the Honourable Terry Mulder, Minister for Roads; the Secretary VicRoads; the Chief Commissioner of Police.

Signature:

Kim M W Parkinson
Coroner

6th October, 2011