

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2007 1964

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

*Section 67 of the Coroners Act 2008*

|                                   |                                                                                                                                                                                                                                                                                                                                                                                  |
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| <b>Inquest into the Death of:</b> | DARREN BRETT KINGMA                                                                                                                                                                                                                                                                                                                                                              |
| <br>Delivered On:                 | <br>19 March 2014                                                                                                                                                                                                                                                                                                                                                                |
| <br>Delivered At:                 | <br>Level 11, 222 Exhibition Street<br>Melbourne 3000                                                                                                                                                                                                                                                                                                                            |
| <br>Hearing Dates:                | <br>11 – 13 August 2008<br>27 April 2010<br>13 – 15 December 2010<br>21 December 2010                                                                                                                                                                                                                                                                                            |
| <br>Findings of:                  | <br>CORONER JACQUI HAWKINS                                                                                                                                                                                                                                                                                                                                                       |
| <br>Representation:               | <br>Mr N Papas SC and Ms M Mykytowycz appeared on<br>behalf of Mrs Kingma.<br>Mr JP Constable appeared on behalf of Ms McKay.<br>Ms D Wallis appeared on behalf of Ms Pedelty.<br>Ms J Benson appeared on behalf of the Department of<br>Human Services.<br>Mr J Carmody appeared on behalf of the Ambulance<br>Victoria.<br>Mr J Snowden appeared on behalf of Southern Health. |
| <br>Counsel Assisting the Coroner | <br>Senior Constable R Antolini                                                                                                                                                                                                                                                                                                                                                  |

I, JACQUI HAWKINS, Coroner having reviewed the investigation into the death of  
DARREN BRETT KINGMA

AND the inquest<sup>1</sup> held by Coroner Hendtlass on 11 - 13 Aug 2008, 27 Mar 2010, 13 – 16 and  
21 December 2010 in relation to this death

at MELBOURNE

find that the identity of the deceased was DARREN BRETT KINGMA

born on 29 December 1977

and the death occurred on 26 May 2007

at the Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084

from:

- 1 (a) BRONCHOPNEUMONIA COMPLICATING NECK INJURIES (OPERATED)  
SUSTAINED IN A FALL
- 2 COFFIN-LOWRY SYNDROME

**in the following circumstances:**

#### **SUMMARY OF CIRCUMSTANCES**

1. Darren Kingma<sup>2</sup> was 29 years old when he died on 26 May 2007 at the Austin Hospital after suffering a spinal injury in a fall at the Phillip Street Respite Facility (the respite facility), run by the Department of Human Services.
2. At the age of five, Darren was diagnosed with Coffin-Lowry Syndrome which is characterised by an incapability of speech, severe mental deficiency and muscle, ligament, and skeletal abnormalities.<sup>3</sup> Darren's long term general practitioner was Dr William Gason.
3. Darren's permanent residence was at 22 Roycroft Avenue in Wantirna South where he lived with his mother, Mrs Valerie Kingma, who was also his primary carer. During the evenings, carers from Calgary Silver Circle and Knox City assisted Mrs Kingma to care for Darren.
4. In addition, Darren attended a day program at Knoxbrooke Incorporated (Knoxbrooke) five days per week and occasionally attended the respite facility which provided Mrs Kingma with temporary relief. The respite facility is a Community Residential Unit managed by the Department of Human Services (DHS) and registered under the *Disability Act* 2006.

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<sup>1</sup> This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

<sup>2</sup> For consistency, I have avoided formality and referred to Darren Kingma as Darren throughout the Finding.

<sup>3</sup> *Mosby's Medical, Nursing and Allied Health Dictionary*, Elsevier Science, 9<sup>th</sup> edn, 2013.

### **Summary of the incident at the respite facility**

5. On 20 May 2007, Darren attended the respite facility as Mrs Kingma was going on holiday. At this time, the normal respite facility was being rebuilt and the accommodation was relocated to Camelot Drive in Glen Waverley.
6. Ms Debbie McKay, a disability carer worked the overnight shift on 21 May 2007 which commenced at 4pm. Sometime between 6am and 7am on 22 May 2007, Ms McKay found Darren lying on his side on the floor of his bedroom. She could not see any indication that Darren was injured. Ms McKay observed that the room was still in order and undisturbed.
7. Darren did not comply with Ms McKay's requests to get up off the floor however she believed that this was consistent with previous instances of non-compliance. Ms McKay sat Darren up, dressed him and administered his medication as normal in preparation for his day at Knoxbrooke.
8. At 7.15am, Ms McKay sent a text message to Ms Pedelty, a disability carer who was due to commence work at 8am, requesting her to call back. Ms Pedelty returned the call at 7.30am and was advised that Darren had 'cracked it' and that Ms McKay needed help.
9. Ms Pedelty arrived at the facility at about 8am and was briefed by Ms McKay about Darren and the other resident at the facility. Ms McKay and Ms Pedelty went to Darren's room and found him lying on the floor and not moving. He verbally responded to questions with 'no'. Ms McKay and Ms Pedelty attempted to move Darren to the bed but were unsuccessful and instead propped him up against it.
10. Ms Julie Wilkinson attended the facility at approximately 8.10am to transport Darren to Knoxbrooke. She was taken to his room where he was still on the floor and asked him what was wrong. Ms Wilkinson was sufficiently concerned to advise Ms McKay and Ms Pedelty to ring an ambulance and call his sister, Nadine Jones.
11. Ms Pedelty called Ms Jones and advised her that they had found Darren on the floor and it appeared he did not want to get up or was being uncooperative.
12. Approximately 10 minutes later, Ms Jones arrived at the respite facility. She expressed a view that he was not his normal self and suggested that they call his general practitioner. His general practitioner was unable to attend or provide any assistance so they called an ambulance.

13. Two Ambulance Victoria paramedics attended the respite facility and assessed Darren. They did not find any evidence of injury. They obtained some background information about Darren's disability and how he was found. After physically assessing him, they decided to transport Darren to the Monash Medical Centre.
14. Darren presented to the Emergency Department of the Monash Medical Centre at 9.53am. A large number of assessments and tests were conducted over several hours to determine his diagnosis. An MRI scan conducted at 10pm revealed that Darren had a severe spinal cord injury which rendered him a quadriplegic. He was ventilated and transferred to ICU.
15. On 23 May 2007, Darren was transferred to the Austin Hospital for assessment by a specialist spinal surgical team.
16. On Friday 25 May 2007, after a neurological assessment it was concluded that Darren had a very high spinal cord injury, was unable to breathe spontaneously by himself and was ventilator-dependent. A meeting was held with his family and after his condition was explained to them a decision was made to withdraw respiratory support. Darren died at 2.17am on Saturday 26 May 2007.

## JURISDICTION

17. At the time of Darren's death, the *Coroners Act 1985* (Vic) (the Old Act) applied.
18. On 11 August 2008, the investigation proceeded by way of a mandatory inquest pursuant to section 17(1)(b) of the Old Act<sup>4</sup> as Darren was a person under the care, control or custody of the DHS immediately prior to his death.<sup>5</sup> Therefore the inquest proceeded under the Old Act.<sup>6</sup> However, as my findings are made after the introduction of the *Coroners Act 2008* (Coroners Act) they are deemed to be made pursuant to this Act.
19. The Coroners Court of Victoria is an inquisitorial jurisdiction.<sup>7</sup> Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

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<sup>4</sup> An inquest must be held when the death of a person occurred whilst that person was immediately before death a person placed in custody or care.

<sup>5</sup> Section 3(1) of the Coroners Act 1985.

<sup>6</sup> The Coroners Act commenced operation on 1 November 2009. Schedule 1, section 7 of the Coroners Act states "Subject to clause 10, if the hearing of an inquest has begun under the old Act and the inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the inquest". Clause 10 does not apply to these circumstances.

<sup>7</sup> Section 89(4) of the Coroners Act.

20. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety and the administration of justice.
21. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.<sup>8</sup>

### **ASSIGNMENT OF INQUEST FINDINGS**

22. Coroner Hendtlass retired on 31 December 2013 without making an inquest finding in this investigation. The State Coroner of Victoria, His Honour Judge Ian Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.
23. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements and exhibits. I have read the transcript of the directions hearing and the inquest. I have also viewed video footage of the Inquest.

### **CORONIAL INVESTIGATION AND INQUEST**

24. Coroner Hendtlass commenced an investigation and held an inquest into the death of Darren on 11 – 13 August 2008, 27 April 2010, and 13 – 16 and 21 December 2010.

#### **Witnesses called to give evidence at the Inquest**

25. The following witnesses were called to give *viva voce* evidence at the Inquest:

- Valerie Kingma, mother of Darren
- Nadine Jones, sister of Darren
- Dr Christopher O'Donnell, Director of Radiology, Frankston Hospital
- Catherine Chandler, Ambulance Paramedic, Ambulance Victoria
- Julie Wilkinson, Support Worker, Calvary Silver Circle
- Dr Alexandra Kent, Consultant Anaesthetist, Monash Medical Centre
- Kevin Masci, Executive Manager of Operations, Ambulance Victoria

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<sup>8</sup> Sections 72(1) and (2) of the Coroners Act.

- Professor George Braitberg, Monash University and Director of Emergency Medicine at Southern Health
- Mark Haynes, House Supervisor, Phillip Street, Heathmont
- Monica White, Manager, Disability Accommodation Services, Department of Human Services
- Ruth Pedelty, House Supervisor, Philip Street, Heathmont
- Debbie McKay, Direct Care Worker, Philip Street, Heathmont
- Christopher Jones, Investigator
- Dr Christopher Haw, Senior Orthopedic Surgeon, Western & Sunshine Hospitals.

### **Submissions**

26. Interested Parties were invited to provide written legal submissions at the conclusion of the Inquest. Counsel representing all of the interested parties provided written submissions, which I have considered for the purpose of this Finding.

### **Findings required to be determined by the Coroner**

27. Section 67 of the Coroners Act requires me to find, if possible:
- a) the identity of the deceased
  - b) the cause of death
  - c) the circumstances in which the death occurred.

### **IDENTITY OF THE DECEASED**

28. I find the identity of Darren Brett Kingma was without dispute and required no additional investigation.<sup>9</sup>

### **CAUSE OF DEATH**

29. Dr Noel Woodford, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination on 29 May 2007. Dr Woodford ascribed the cause of Darren's death to:

- 1(a) BRONCHOPNEUMONIA COMPLICATING NECK INJURIES (OPERATED)  
SUSTAINED IN A FALL
- 2 COFFIN- LOWRY SYNDROME.

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<sup>9</sup> Mrs Valerie Kingma confirmed the identity of the deceased in a Hospital Statement of Identification dated 26 May 2007.

30. Dr Woodford noted that “the pneumonia ...developed in the setting of significant high cervical spinal cord injury requiring artificial ventilation.”<sup>10</sup>

***Findings as to cause of death***

31. I accept the cause of death as opined by Dr Woodford and find that Darren Brett Kingma died on 26 May 2007 at the Austin Hospital from:

- 1(a) BRONCHOPNEUMONIA COMPLICATING NECK INJURIES (OPERATED)  
SUSTAINED IN A FALL
- 2 COFFIN- LOWRY SYNDROME.

**CIRCUMSTANCES IN WHICH THE DEATH OCCURRED**

32. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

**Spinal Cord Injuries**

*Coffin-Lowry Syndrome*

33. Darren’s Coffin-Lowry Syndrome is an important contextual factor in the circumstances surrounding his death. An understanding of Coffin-Lowry Syndrome and Darren’s lived experience of it is therefore an essential component to this finding.
34. The Coffin-Lowry Syndrome caused developmental delays in all of Darren’s milestones. Mrs Kingma stated that as Darren got older his disability became more pronounced. In 2003, when Darren was in his twenties he started having ‘startle attacks’ also known as ‘drop attacks’. If Darren was startled by, for example, a sudden noise or someone coming up behind him, he would lose all muscle control and drop instantly to the ground.<sup>11</sup>
35. To alleviate some of the problems associated with these startle reactions and to reduce their frequency, Darren’s neurologist prescribed Clonazepam. However, by late 2005 these drop attacks had increased in frequency and severity and as a result Darren was essentially confined to a wheelchair.<sup>12</sup> Nevertheless, Darren was reasonably independent, could move on and off his wheelchair and could feed himself, however he did require assistance with showering and dressing.

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<sup>10</sup> Exhibit GG – Balance of Inquest Brief – Autopsy Report, p11

<sup>11</sup> Exhibit A – Statement of Valerie Kingma dated 15 July 2007, p2

<sup>12</sup> Exhibit GG – Balance of Inquest brief– Statement of Dr William Gason, p1

36. Darren did not have any particularly challenging behaviour and was generally compliant with a happy and easy disposition. His family and carers describe him as good-natured and playful and noted that he loved attending the respite facility and Knoxbrooke. However, Darren could occasionally be resistant to direction for up to 30 minutes.

*Coffin-Lowry Syndrome and Darren's spinal cord injuries*

37. Darren's Coffin-Lowry Syndrome played an important role in his spinal injuries which ultimately caused his death. Specifically, the nature and severity of these injuries are best understood in the context of the degenerative symptoms associated with Coffin-Lowry Syndrome.
38. Dr Christopher O'Donnell, Radiologist provided an expert opinion on the ante mortem radiological imaging of Darren's spine. He noted evidence of the ligamentum flavum<sup>13</sup> calcification<sup>14</sup> typically found in people with Coffin-Lowry Syndrome. He explained that normally the spinal cord is not held in a rigid position but is bathed in fluid so when the neck moves the cord is free to move in that fluid. However, the calcification tended to compress the spinal cord so that it was held in a rigid position.<sup>15</sup>
39. Dr O'Donnell described two abnormalities on the CT and MRI scans performed at Monash Medical Centre on 22 May 2007 demonstrating injuries to Darren. The first injury noted was a C2/3 lesion, where there was an oedema (swelling) in the cord and the second injury was further down the spinal cord at C5/6. The fractures shown at this point were dislocations of the facet joints which are a typical injury associated with hyperflexion.<sup>16</sup> Dr O'Donnell described both injuries as very serious spinal cord injuries which would have been sustained recently as there was no evidence of healing.<sup>17</sup>
40. Importantly, Dr O'Donnell testified that the CT scan, which was conducted first, indicated an unstable fracture.<sup>18</sup> In such circumstances, a cervical collar should have been applied to prevent movement. However, Dr O'Donnell stated that there was no way to identify that there was damage to the spinal cord with a CT scan and that an MRI scan was needed. This is

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<sup>13</sup> *Ligamentum flavum* means yellow elastic ligaments connecting certain parts of adjoining vertebrae *Mosby's Medical, Nursing and Allied Health Dictionary*, Elsevier Science, 9<sup>th</sup> edn, 2013.

<sup>14</sup> *Calcification* means the accumulation of calcium salts in tissue. *Mosby's Medical, Nursing and Allied Health Dictionary*, Elsevier Science, 9<sup>th</sup> edn, 2013.

<sup>15</sup> Transcript of evidence, p29

<sup>16</sup> Transcript of evidence, p30

<sup>17</sup> Transcript of evidence, p32-33

<sup>18</sup> Transcript of evidence, p54

consisted with Darren's MRI scan being the first evidence of the compression of his spinal cord.<sup>19</sup>

#### *The C 5/6 spinal cord injury*

41. Some of the experts agreed that the injury to Darren's C5/6 vertebrae was a result of a significant hyperflexion injury and were traumatic in origin. Dr O'Donnell explained that hyperflexion is:

when one flexes one's neck. One bends the chin to the chest wall, in a normal way of doing that, one would do it in a slow and deliberate way. Hyperflexion means that it is done in a forceful and much more aggressive way than otherwise would happen, so it tends to go faster and also more dramatically than [it] would otherwise.<sup>20</sup>

42. Dr Christopher Haw provided an opinion that the mechanism of injury would have been an extreme forward flexion combined with rotation and lateral flexion of the head to the left side.<sup>21</sup> Dr Haw testified that force was needed and "it's the acceleration that occurs with the head interfering with the fall... rather than the severity of the blow"<sup>22</sup> that caused the injury.
43. Dr Haw clarified that, while a fall from a height of three metres would normally be required to result in a fracture at the C5/6 level:

falling backwards from an erect position onto a horizontal surface where there is some object that the head can strike that is above the level of the floor surface [had] the potential to produce a severe hyperflexion injury".<sup>23</sup>

44. Dr Haw concluded that this must have occurred in relation to Darren.<sup>24</sup> However, he later conceded that he made assumptions as to how he came to his conclusion. Dr Haw agreed that Darren could have received the injury due to a fall from height, a sudden drop to the ground, a hit to his head as he dropped to the floor or he could even have been assaulted.<sup>25</sup>

#### *C2/3 spinal cord injury*

45. The CT scan showed considerable calcification in the posterior spinal canal. Dr O'Donnell indicated that this compression is likely to have been present for some time and produced a longstanding rigidity on the cord. The spinal cord at this level also showed considerable oedema but no obvious haemorrhage. He stated that the presence of oedema suggested that

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<sup>19</sup> Transcript of evidence, p51-52

<sup>20</sup> Transcript of evidence, p26

<sup>21</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p1

<sup>22</sup> Transcript of evidence, p591

<sup>23</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p1

<sup>24</sup> Transcript of evidence, p596

<sup>25</sup> Transcript of evidence, p601

there had been further recent compression to the spinal cord which caused it to become acutely damaged.<sup>26</sup>

46. The C2/3 spinal cord is responsible for nervous supply to the diaphragm which facilitates breathing.<sup>27</sup> Dr O'Donnell concluded that the oedema at C2/3 is most likely to have been the significant contributor to his breathing difficulties.<sup>28</sup> Dr Haw agreed that the oedema at the C2/3 level together with the intrinsic cord compromise was the major cause of Darren's respiratory failure.<sup>29</sup>
47. Dr O'Donnell indicated that the significant fracture at the facet joints could likely cause the nutcracker effect to occur at the same time, however was unable to be certain it had in this instance.<sup>30</sup>

### *Findings as to spinal cord injuries*

48. I accept the medical evidence and find that Darren had recently suffered injury at the C5/6 level of his spinal cord due to a traumatic hyperflexion injury and that a degree of force was required to cause this injury. However, I am unable to determine the timing and mechanism of this injury.
49. I accept the evidence of the experts and find that Darren had a degree of calcification at his C2/3 level which was most likely caused by his Coffin-Lowry Syndrome and resulted in compression of the spinal cord. Although calcification at this level had been present for a period of time there is also evidence of an acute exacerbation of the injury. However, I am unable to determine whether this occurred at the same time or even proximate to the traumatic injury occurring at the C5/6 level.
50. I am unable to find when the damage to Darren's cervical spine occurred, particularly given that a number of people moved Darren on 22 May 2007 and there was no objective scientific evidence before me which determined the issue with any certainty or precision. However, on the balance of probabilities, I find that the fracture to the C5/6 spine most likely occurred when he fell in his room sometime in the morning of 22 May 2007.

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<sup>26</sup> Exhibit C – Statement of Dr Chris O'Donnell dated 27 May 2008, p2

<sup>27</sup> Transcript of evidence, p27

<sup>28</sup> Transcript of evidence, pp 37 & 46

<sup>29</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p2

<sup>30</sup> Transcript of evidence, p31

### **Appropriateness of the response by individuals and services to Darren's circumstances**

51. Insofar as this Finding considers the circumstances immediately surrounding Darren's death, I have conducted an appraisal of the response by key individuals and services involved with his care and management including:

- Ms Debbie McKay
- Ms Ruth Pedelty
- Ambulance Victoria
- Monash Medical Centre.

52. When making my findings in relation to the circumstances of Darren's death, particularly in relation to the conduct of individuals and organisations, the appropriate standard of proof to apply is articulated in *Briginshaw v Briginshaw*<sup>31</sup> which requires me to be satisfied on the balance of probabilities. The effect of this authority is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

### **Appropriateness of Ms McKay's actions**

53. Ms McKay was employed by DHS as a Direct Care Worker at the respite facility providing care for clients with a disability. She had been working there for five years and knew Darren from his previous stays. Ms McKay had completed a Certificate IV in Disability Studies in 2007. In addition, she had completed 3 to 5 days of induction when she commenced work for DHS in 2001 and had completed some additional courses such as first aid training and manual handling. She had also received on the job training.<sup>32</sup>

54. Ms McKay had not read anything about Coffin-Lowry Syndrome in Darren's Accommodation Service File (ASF)<sup>33</sup>. Her knowledge came from other staff and from previously working with him. Ms McKay indicated that she understood Darren's Coffin-

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<sup>31</sup> (1938) 60 CLR 336

<sup>32</sup> Transcript of evidence, p510-511

<sup>33</sup> Exhibit OP – Accommodation Service File was described in evidence as “where we keep all the relevant documents on any client that accesses respite. You know, we write in it on a daily basis, you know, what they did during the day or where they went out on an outing or they had a fall or any correspondence from the families.” Transcript of evidence, p351 & p513

Lowry Syndrome to involve dizzy spells where he would drop to the floor and was a fall risk.<sup>34</sup> Ms McKay had never seen Darren experience a drop attack before 22 May 2007.<sup>35</sup>

55. She was unaware that Darren's Coffin-Lowry Syndrome was a progressively debilitating condition.<sup>36</sup> It is possible that Ms McKay's lack of understanding with respect to Darren's condition lead to a delay in calling an ambulance and seeking assistance. In particular, there is evidence that Darren could be determined, difficult and uncooperative at times.<sup>37</sup> However, these episodes would not usually last more than half an hour and always occurred in a good-natured way. This informed her assessment of his presentation on 22 May 2007.

#### *Time Darren was found*

56. Ms McKay's evidence in relation to when she believes she found Darren was inconsistent. She initially indicated to Ms Pedelty that she found Darren at 6am. However, subsequent investigations revealed that this was probably not the case and by the time she gave evidence at inquest, her belief was that it was closer to 7am.
57. At the time of the incident, people involved in assisting Darren operated on the basis that he was found at 6am. Ms McKay believes that there may have been a miscommunication in relation to the time in an attempt to veil arrangements about Ms Pedelty taking unauthorised time in lieu. This led to inconsistencies in evidence that have made it difficult to determine an exact chronology of events. Problematically, not one of the versions of events provided by Ms McKay is consistent with all of the objective evidence.

#### *Darren's state when found*

58. Ms McKay's evidence as to Darren's state when she found him included that:
- he was able to respond 'yes' and 'no' and was able to move both of his arms and legs
  - his pants were a little wet but he did not appear ill or injured
  - she did not observe him shivering and he did not have a temperature
  - he was not coughing or sweating and he had no difficulty breathing
  - he was smiling and she did not notice his eyes roll.<sup>38</sup>

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<sup>34</sup> Exhibit BB – Statement of Debbie McKay dated 8 August 2008, p2 & Transcript of evidence, p513

<sup>35</sup> Exhibit BB – Statement of Debbie McKay dated 8 August 2008, p3

<sup>36</sup> Transcript of evidence, p513

<sup>37</sup> Transcript of evidence, pp 3, 61, 184, & 206

<sup>38</sup> Exhibit BB – Statement of Debbie McKay dated 8 August 2008, p10

59. Ms McKay concluded that he probably fell out of bed. She did not believe he was unwell, rather that he was just being difficult in not wanting to get up off the floor and could have been ‘mucking around’.<sup>39</sup>

*Ms McKay’s interactions with Darren*

60. After checking Darren for obvious injuries, Ms McKay changed his clothes<sup>40</sup> and although he was not compliant she testified that he was physically able to assist her and lift his hips.<sup>41</sup>
61. Ms McKay continued to encourage Darren to get up and stated that, if she had believed there was something wrong, she would have made contact with the On Call support or an ambulance.<sup>42</sup> On Call is a service provided by DHS to community residential services staff after hours and on weekends. Staff can access advice, support or direction about different issues including the management of client’s behaviour, injury or illness.<sup>43</sup>
62. Ms McKay’s evidence is that she moved Darren a number of times which included sitting him up, dressing him, laying him down and sitting him up again after Ms Pedelty arrived. While Dr Haw stated that the movement of Darren may have exacerbated his injuries, however it was difficult to determine what effect any particular movement had on his ultimate injuries.
63. In addition, some time after finding Darren, Ms McKay administered his regular medication. Although she was not certain what the medication was for, she was of the belief that it assisted Darren with dizzy spells and it might have helped with the situation at hand.<sup>44</sup>

*Leaving the respite facility*

64. Ms McKay left the respite facility before members of Ambulance Victoria arrived.<sup>45</sup> She indicated that she left because she needed to take the other resident to his placement. She noted that it was the end of her shift and she also needed to take her mother to the doctor.

*Submissions on behalf of Ms McKay*

65. Counsel for Ms McKay submitted that she acted appropriately on 22 May 2007 and within the realms of her knowledge and experience as a carer for Darren. She made an assessment

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<sup>39</sup> Exhibit BB – Statement of Debbie McKay dated 8 August 2008, pp10 & 13

<sup>40</sup> Exhibit BB – Statement of Debbie McKay dated 8 August 2008, p10

<sup>41</sup> Transcript of evidence, p546 & p570

<sup>42</sup> Exhibit BB – Statement of Debbie McKay dated 8 August 2008, p11 & p14

<sup>43</sup> Exhibit U – On Call Folder – Casual Standby folder for Area Six

<sup>44</sup> Transcript of evidence, p568

<sup>45</sup> Transcript of evidence, p554

that he was being uncooperative, and it was reasonable to cajole him into cooperating on the basis that he had no physical sign of injury or blood, did not have a temperature, denied being hurt, the furniture was undisturbed, and he was able to move. Once Ms McKay did become concerned she contacted Ms Pedelty.

***Findings as to the appropriateness of Ms McKay's actions***

66. I am unable to determine the exact time Darren was found due to Ms McKay's inconsistent evidence. Having considered all the evidence and on the balance of probabilities, I find that it was some time between 6am and 7am. However, the time Darren was found does not bear significantly on the conclusions I make as to the appropriateness of Ms McKay's actions.
67. In assessing the appropriateness of Ms McKay's actions, I acknowledge and accept that she only had basic first aid training and was employed as a disability worker not a health practitioner. She appears to have exercised her judgment in accordance with her training and experience, including her knowledge of working with Darren. Specifically, I find that it is not reasonable to expect her to have recognised how serious his condition was. Nevertheless, I find that she should have recognised that Darren was not himself sooner and contacted the On Call service for advice and support.
68. In addition, I find the fact that Ms McKay left the respite facility prior to the arrival of the ambulance officers problematic because it resulted in the ambulance officers experiencing difficulty in obtaining accurate information about the time and condition in which Darren had been found. This critical information may have better assisted in their assessment of Darren's condition, however, I accept that this alone did not significantly impact the ultimate outcome.
69. Finally, although in retrospect, it is evident that providing Darren with his medication was not advisable in the circumstances I find that this would not have been apparent to Ms McKay at the time and make no criticism of her conduct for this.

***Appropriateness of Ms Pedelty's actions***

70. Ms Pedelty had worked as a Care Worker at the respite facility since October 2006 and had cared for Darren a couple of times.<sup>46</sup> She had a Bachelor of Arts in Disability Studies and had worked for DHS for ten years. During employment with DHS, she received first aid and

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<sup>46</sup> Transcript of evidence, p434

fire and emergency evacuation training.<sup>47</sup> Ms Pedelty stated that she had not had any specific training with respect to respite care.

71. Ms Pedelty was aware of Darren's Coffin-Lowry Syndrome and suffered from startle attacks. To her this meant that he could lose all muscle control and drop instantly to the ground.<sup>48</sup>

#### *Knowledge of Darren's situation*

72. Ms Pedelty first became aware of the situation with Darren when she received a text message at 7.30am on 22 May 2007 from Ms McKay which said "call me when you get up".<sup>49</sup> She immediately contacted the respite facility and spoke to Ms McKay who said something like "don't worry, Darren is on the floor, but I think he's just cracked it and I thought I would just let you know".<sup>50</sup> She "took this to mean that Darren had just had a little bit of a hissy fit and was being stubborn".<sup>51</sup> She felt there was no sense of urgency to the message<sup>52</sup> and proceeded to make her way to the respite facility.

#### *Assessment of Darren*

73. Ms Pedelty arrived at the respite facility at approximately 8am. Ms McKay gave her a brief handover relating to the other resident and Darren.<sup>53</sup>
74. Ms Pedelty then checked on Darren and observed the following:<sup>54</sup>
- he looked pale and tired
  - he had some movement in his arms but she did not notice any real movement in his legs
  - he was still able to speak and say yes and no
  - he did not feel particularly cold, was not shivering and had no obvious temperature
  - he was not bleeding and there were no observable signs of injury
  - he was not coughing and had no difficulty breathing
  - he was able to be dressed
  - he appeared normal other than that he was on the floor

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<sup>47</sup> Transcript of evidence, p427

<sup>48</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p2

<sup>49</sup> Transcript of evidence, p439

<sup>50</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p3

<sup>51</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p3

<sup>52</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p3

<sup>53</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p3

<sup>54</sup> Transcript of evidence, p495

*Ms Pedelty's interactions with Darren*

75. Ms Pedelty stated that she and Ms McKay tried to lift him up but he was too heavy. She explained that he had muscle tone. She stated that she tried to encourage him to get up but when there was no response she started to get concerned.<sup>55</sup> Ms Pedelty ultimately considered there was something not quite right with Darren.<sup>56</sup>

*Seeking assistance for Darren and conflicting evidence as to his presentation*

76. Ms McKay and Ms Pedelty were discussing possible action to take when Julie Wilkinson, a carer for Calvary Silver Circle, arrived to take Darren to Knoxbrooke.
77. Ms Wilkinson was familiar with Darren and stated that she had never seen him in a state where he was completely unresponsive to her. She says that when she arrived she noted:
- his eyes roll back into his eye socket, however she did not advise anyone about this<sup>57</sup>
  - that although he had no trouble breathing he was making choking noises as though there was something stuck in his throat<sup>58</sup>
  - that he was very very pale and very very cold<sup>59</sup>
  - that once he was in the recovery position she did not hear any noise from him<sup>60</sup>
  - Darren did not respond when his hand was held<sup>61</sup>
  - she felt concerned that there was something seriously wrong with Darren.<sup>62</sup>
78. Ms Wilkinson suggested that they call Darren's sister Nadine Jones who arrived at approximately 8.20am and found:
- his eyes rolling around the back of his head at times<sup>63</sup> which she described at inquest as happening occasionally<sup>64</sup> or a couple of times<sup>65</sup>
  - his breathing was very laboured<sup>66</sup>
  - he was not really looking at her
  - no visible marks on Darren<sup>67</sup>
  - there were some gurgling noises<sup>68</sup>

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<sup>55</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p4

<sup>56</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p6

<sup>57</sup> Transcript of evidence, p 188 & p189

<sup>58</sup> Transcript of evidence, p194

<sup>59</sup> Transcript of evidence, p196

<sup>60</sup> Transcript of evidence, p198

<sup>61</sup> Transcript of evidence, p201

<sup>62</sup> Transcript of evidence, p200

<sup>63</sup> Transcript of evidence, p57

<sup>64</sup> Transcript of evidence, p63

<sup>65</sup> Transcript of evidence, p86

<sup>66</sup> Transcript of evidence, p58

<sup>67</sup> Transcript of evidence, p59

79. After discussions with Ms Jones and Ms Wilkinson, Ms Pedelty agreed to call an ambulance.

*Decision not to call On Call*

80. The evidence is that neither Ms McKay or Ms Pedelty contacted On Call for advice, support or direction in relation to the management of Darren. Counsel for DHS was critical of Ms Pedelty for not utilising On-Call for advice and support. However, Counsel for Ms Pedelty submitted that with the benefit of hindsight it is easy to say On Call should have been contacted but submitted that such a call was unlikely to have yielded a different outcome.<sup>69</sup>

*Hand over to Ambulance Victoria*

81. By the time the ambulance arrived, Ms McKay and Ms Wilkinson had left the respite facility, leaving Ms Jones and Ms Pedelty to relay all the circumstances surrounding Darren to them. This made it difficult due to the fact that Ms Pedelty was not the person who found Darren. Ms Pedelty conceded that “in hindsight of course...it would’ve been good to have Debbie there.”<sup>70</sup>

82. One of the ambulance officers asked Ms Pedelty why there was a delay in calling the ambulance and Ms Pedelty indicated that Ms McKay thought Darren was just being uncooperative, as sometimes he can be stubborn.<sup>71</sup>

83. Counsel for Ms Pedelty submitted that once the ambulance officers arrived, Ms Pedelty was reliant on their expertise as to how best to manage the situation.

*Time in Lieu*

84. The respite facility had an arrangement in place where employees could apply to the House Supervisor for time in lieu to be taken when staff had worked over their standard hours. Ms Pedelty was second in charge and could authorise this.<sup>72</sup>

85. Ms Pedelty was rostered to commence work at 7am on 22 May 2007 after a week’s annual leave. At approximately 6.30-7.30pm the night before, Ms McKay sent a text message to Ms Pedelty and told her to come in at 8am instead of 7am as time in lieu, as it was her first day back and there were only two clients in residence. Ms Pedelty stated she had planned to

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<sup>68</sup> Transcript of evidence, p70

<sup>69</sup> Legal Submissions on behalf of Ms Pedelty, p8

<sup>70</sup> Transcript of evidence, p465

<sup>71</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p6

<sup>72</sup> Transcript of evidence, p375

organise to take this hour as time in lieu with her supervisor the following day, as she had time owing to her.<sup>73</sup>

#### *Submissions on behalf of Ms Pedelty*

86. Counsel for Ms Pedelty submitted that her actions were entirely reasonable, her care and management of Darren on 22 May 2007 was appropriate and her movement of Darren was not of such significance to contribute to Darren's death. They submitted that it was appropriate for her to contact a family member prior to contacting an ambulance because family members were in a good position to assess Darren.

#### *Findings as to the appropriateness of Ms Pedelty's actions*

87. In assessing the appropriateness of Ms Pedelty's actions, I acknowledge and accept that Ms Pedelty was not medically trained and had basic first aid training. I find that Ms Pedelty exercised her judgment in accordance with her training and experience, including her limited experience working with Darren. Specifically, I find that it is not reasonable to expect Ms Pedelty to have anticipated that Darren had a spinal cord injury or recognise the seriousness of his condition.
88. I find that once Ms Pedelty had assessed the situation and consulted with Ms Wilkinson and Ms Jones, she appropriately called an ambulance and once the ambulance attended she was reliant on their clinical assessment of the situation and handed over care to them as effectively as possible given that Ms McKay had left.

#### **Ambulance Victoria**

##### *Assessment of Darren*

89. At 8.45am, Catherine Chandler and David Murray from Melbourne Ambulance Service (also known as Ambulance Victoria) arrived at the respite facility. They were shown to Darren's bedroom by Ms Pedelty, where they found him lying on the floor. They were told he had been found on the floor earlier in the morning by the night staff.<sup>74</sup>
90. When Ms Chandler introduced herself and her partner to Darren, he responded with facial expressions. Ms Chandler noted that his verbal responses were difficult to understand and Ms

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<sup>73</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p2

<sup>74</sup> Exhibit G – Statement of Catherine Chandler undated, p1

Jones confirmed that this was sometimes the case. She also noted that Darren answered questions with a nod or a shake of his head.<sup>75</sup>

91. Ms Chandler testified that she conducted a top to toe physical assessment of Darren where she put her hands over him to observe whether he responded in any way to indicate discomfort or pain.<sup>76</sup> Ms Chandler took Darren's observations and found his blood pressure and heart rate were within normal parameters, his temperature was centrally and peripherally normal to touch and his pupils were of a normal size and reactive.<sup>77</sup>
92. On assessment of Darren, Ms Chandler stated she was unable to find any evidence of injury and when asked he denied pain, although she noted that he seemed to grimace mildly during some movement.<sup>78</sup>

#### *Provision of incomplete information*

93. It was difficult for the ambulance officers to obtain the necessary information about how Darren was found on the floor because he could not convey the information himself. Efforts to obtain accurate information were frustrated due to the fact that Ms Pedelty was not the first person to find Darren. Ms Pedelty was unable to answer questions about what position Darren was found in, what state the room was in, whether any furniture had been upturned or out of place, when Darren had been found, whether he was conscious and alert at the time and whether there had been any indication of injury.<sup>79</sup>
94. The full history from Ms McKay would have assisted the ambulance officers with their assessment of Darren. Counsel for Ambulance Victoria submitted that first hand information is critical in their ability to make an accurate assessment.

#### *Darren's disability masked the seriousness of his injury*

95. Ms Jones provided information about Coffin-Lowry Syndrome to the ambulance paramedics and how it impacted Darren's motor and cognitive abilities. Ms Chandler had heard of the syndrome but was not aware of how it impacted its sufferers. Ms Jones explained the

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<sup>75</sup> Exhibit G – Statement of Catherine Chandler undated, p1

<sup>76</sup> Transcript of evidence, p138

<sup>77</sup> Exhibit G – Statement of Catherine Chandler undated, p1

<sup>78</sup> Exhibit G – Statement of Catherine Chandler undated, p1

<sup>79</sup> Exhibit G – Statement of Catherine Chandler undated, p1

syndrome to assist Ms Chandler to understand a baseline on which to judge Darren's presenting condition.<sup>80</sup>

96. Although Darren's disability may have impacted the ability of paramedics to assess the situation, Ms Jones made it clear that his presentation was not normal. Ms Jones commented: "I explained to [Ms Chandler] that Darren was not like the way he now presented, that he wasn't just being uncooperative, there was something seriously wrong."<sup>81</sup>

*The use of the 'fore and aft lift'*

97. At the completion of the assessment Ms Chandler decided that Darren should be transported to Monash Medical Centre. Ms Chandler formulated a plan to lift Darren on to the bed which would create space for a wheelchair which could then take him to the stretcher outside. Ms Chandler and her partner then lifted Darren from the floor and onto the bed using a 'fore and aft lift'.<sup>82</sup> Ms Chandler supported him to sit on the bed.<sup>83</sup>
98. Darren was transferred to the wheelchair and then onto the stretcher which was waiting outside. At this time, Darren was noted by both paramedics to be very heavy with little or no ability to assist with the lift because he had no tone at all.<sup>84</sup> Ms Jones also noted that although the ambulance officer was holding Darren while he was taken to the ambulance in his chair, she held his head because it was 'floppy'.<sup>85</sup>
99. Ms Pedelty noted that whilst in the wheelchair, she put her hand on his chest to support him and to keep him from falling forwards. No one was supporting his head.<sup>86</sup>
100. Darren was loaded into the ambulance and Ms Chandler noted that Darren "sat in a semi-recumbent position supporting himself throughout the journey to hospital".<sup>87</sup> Ms Jones testified that she had to hold Darren's head as they went around corners in the ambulance and had sought permission from the paramedics to do so.<sup>88</sup>

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<sup>80</sup> Exhibit G – Statement of Catherine Chandler undated, p1

<sup>81</sup> Exhibit F – Statement of Nadine Jones dated 14 July 2007, p7

<sup>82</sup> A 'fore and aft' lift is where a person positions themselves behind and facing the patient and puts their two hands underneath the patients arms and the second person lifts the patients legs to lift and move the patient.

<sup>83</sup> Exhibit G – Statement of Catherine Chandler undated, p2

<sup>84</sup> Exhibit G – Statement of Catherine Chandler undated, p2

<sup>85</sup> Exhibit F – Statement of Nadine Jones dated 14 July 2007, p7

<sup>86</sup> Exhibit V – Statement of Ruth Pedelty dated 2 July 2007, p7

<sup>87</sup> Exhibit G – Statement of Catherine Chandler undated, p3

<sup>88</sup> Transcript of evidence, p62

101. On transfer from the ambulance stretcher to the hospital bed, Ms Chandler observed a physical decline in Darren. This indicated a deterioration of his condition and she advised the nurse of her concerns.<sup>89</sup>
102. Dr Haw was critical of the use of the fore and aft lift and the way he was transported. His opinion was that “the method of transfer by ‘fore and aft’ lift, as well as the transportation situation where his head and neck were unsupported would have exacerbated his injuries and may have contributed to his death.”<sup>90</sup>
103. In response, Kevin Masci, Executive Manager of Operations, Ambulance Victoria stated that it was reasonable for the patient to be lifted using the ‘fore and aft’ lifting technique. He stated that there was no indication with reference to their training and/or guidelines which required them to immobilise the patient’s spine through the use of a cervical collar and/or the use of a spine board.<sup>91</sup>

*Should the spinal cord injury have been apparent to the ambulance officers?*

104. Ms Chandler’s assessment was that there was no reason to suspect that Darren had a cervical spinal cord injury.<sup>92</sup> She stated that “Darren did not fit into any of the guidelines as stipulated for her to ...suspect a spinal injury. He had not fallen from a height greater than three metres, and the fall was really the only trauma that, at that time, was the possible cause of anything that we now know had occurred.”<sup>93</sup>
105. Mr Masci concluded that on the available information and observations by Ms Chandler it was reasonable not to suspect a spinal cord injury at that time.<sup>94</sup> Further, that it was reasonable to think that the patient’s syndrome was associated with his presentation.<sup>95</sup>
106. Guidelines at the time stated that with a fall of over three metres a cervical collar should be fitted. The circumstances of this situation did not indicate a fall of over three metres therefore the ambulance officers did not believe they needed to fit a cervical collar. However, Dr Haw said the guideline was an advisory document and noted that ambulance officers still

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<sup>89</sup> Exhibit G – Statement of Catherine Chandler undated, p3

<sup>90</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p3

<sup>91</sup> Exhibit M – Statement of Kevin Masci dated 29 May 2008, p1

<sup>92</sup> Transcript of evidence, p153–154

<sup>93</sup> Transcript of evidence, p152

<sup>94</sup> Transcript of evidence, p290

<sup>95</sup> Transcript of evidence, p256

need to make an assessment.<sup>96</sup> Dr Haw was critical of the ambulance officers for not fitting a cervical collar to Darren for transportation. He commented:

I believe that the management of the patient by the ambulance staff was inappropriate as there was clear evidence that there was deterioration in his condition and clear evidence of an altered neurological status that should have alerted them to the possibility of a cervical spinal injury or head injury, indicating the need for immobilisation in a cervical collar, as well as transfer by a stretcher using a spinal board.<sup>97</sup>

107. Ambulance Victoria submitted that there was no evidentiary basis for Dr Haw's conclusions that the paramedics may have contributed to his death and that his comments should be ignored.<sup>98</sup>

*Evidence of improvements made by Ambulance Victoria*

108. On 17 March 2011 Ambulance Victoria amended its Clinical Practice Guidelines covering spinal injuries and provided a copy of the new guidelines with their final legal submissions. The revised guideline sought to accommodate all scenarios that may present to its paramedics and Ambulance Victoria considered that no further recommendations should be made.

*Findings as to the appropriateness of actions taken by Ambulance Victoria*

109. I find based on all of the available evidence that the management of Darren by the ambulance officers was appropriate in the circumstances. I acknowledge that the ambulance officers were presented with a clinically difficult situation, their patient was incapable of verbally explaining what was physically wrong, they were not provided with important first hand information and despite their full physical assessment they could not identify any injury to Darren.
110. Incomplete knowledge about the circumstances of an event makes it difficult for ambulance officers attending a scene to make an accurate assessment. They are reliant on information provided to them from the people that find them and/or a family member saying this was not their normal behaviour. There was nothing in Darren's presentation to make Ms Chandler consider that he had a spinal cord injury. In fact, due to the information that was provided by Ms Jones, Ms Chandler considered that his inability to get off the floor might have been linked to his Coffin-Lowry Syndrome.

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<sup>96</sup> Transcript of evidence, p604

<sup>97</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p3

<sup>98</sup> Ambulance Victoria Submissions, p6.

111. I acknowledge that Ambulance Victoria provided evidence that as a result of Darren's death, they reviewed and amended their clinical guidelines in relation to spinal injuries.

### **Care and management of Darren at Monash Medical Centre**

#### *Triage*

112. At the time that Darren was triaged at the Monash Medical Centre, he was noted to suffer from Coffin Lowry-Syndrome and have been found on the floor that morning with no tone in his arms or legs. Darren had an ineffective cough, was gurgling, had cool and pale skin, and importantly his sister had noted he was unlike his normal self.<sup>99</sup>
113. Dr Haw stated in his opinion that information pertaining to Coffin-Lowry Syndrome should have been acquired at triage by immediate reference to the literature or by contact with the general practitioner, as this would have alerted staff to the increased risk of neurological problems related to cervical pathology in patients with Coffin-Lowry Syndrome.<sup>100</sup> Further, he recommended that it should be part of the emergency department policy that at triage, information pertaining to rare syndromes should be made immediately available by internet access, to the treating residents and registrars.

#### *Inaccurate interpretation of CT Scan*

114. A CT scan was conducted at 4.25pm by Dr James Burnes, Radiologist who interpreted the scan to show old changes only of C5/6 posterior displacement with no cord compression obvious. He suggested that an MRI of the spine was needed if a diagnosis of 'cervical cord injury' was clinically indicated.<sup>101</sup> At this point the collar was removed and an MRI was planned to determine the cause of Darren's neurological findings.<sup>102</sup>
115. Professor Stuckey's interpretation of the radiography images align with those of Dr O'Donnell's, specifically, that the fracture was not appreciated by the radiologist's interpretation of the original CT scan.<sup>103</sup> Dr O'Donnell testified that the original interpretation did not recognise the unstable fracture and that this meant a cervical collar was necessary to prevent further movement and the potential to exacerbate his injuries.

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<sup>99</sup> Exhibit N – Statement of Professor George Braitberg dated 21 July 2008, p1

<sup>100</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p5

<sup>101</sup> Exhibit N – Statement of Professor George Braitberg dated 21 July 2008, p3 & Medical Records, Diagnostic Imaging Report of Dr James Burnes dated 22 May 2007

<sup>102</sup> Exhibit N – Statement of Professor George Braitberg dated 21 July 2008, p3

<sup>103</sup> Exhibit T – Statement of Professor Stephen Stuckey dated 13 December 2010 p1

116. Monash Medical Centre conceded during the course of the inquest that it would have been desirable for the cervical collar prescribed for Darren not to have been removed while he was in the Emergency Department.<sup>104</sup> However, they submitted that there was no substantive evidence to suggest or infer that such removal caused injury to Darren or worsened his pre-existing condition.<sup>105</sup>
117. While the instability of the fracture was not appreciated, the report provided by Dr Burnes did indicate the need for further investigation in the form of an MRI to assess the underlying cervical injury if it was clinically indicated.
118. Dr Haw stated “the reliance on an incorrect specialist report of the CT scan indicat[ed] the absence of a fracture together with the failure to recognise the significance of a 5mm of forward translocation of C5 and C6 resulting in the removal of the cervical collar would have put Darren at further risk of exacerbation of the cervical cord oedema and had the potential for contributing to his death.”<sup>106</sup>
119. However, in evidence Dr Haw agreed with Dr O’Donnell and Professor Stuckey that whilst there was a slight change in presentation from the CT scan to the MRI scan, it was not clinically significant and therefore the removal of the collar did not exacerbate his injuries.<sup>107</sup>

*MRI investigations and consideration of general anaesthetic*

120. An MRI was requested to elucidate the diagnosis, looking for either a traumatic cause, or whether he had a vascular and/or inflammatory cause.<sup>108</sup> Dr Alexandra Kent, Consultant Anaesthetist was contacted by Dr Hamit Aneja, Anaesthetic Registrar shortly after 7pm regarding a request from the Neurology unit to provide a general anaesthetic for Darren in order to facilitate an MRI scan of his head and cervical spine.<sup>109</sup>
121. Dr Kent described that an MRI scan is a high risk procedure. After examining Darren and reviewing his history, Dr Kent was “very concerned that performing a general anaesthetic for this patient would pose an extremely high risk and that other alternatives needed to be considered.”<sup>110</sup> The specific risks associated with Darren related to the safe management of his airway in order to maintain ventilation and oxygenation during induction of general

<sup>104</sup> Transcript of evidence, pp604–613

<sup>105</sup> Southern Health legal submissions, p1

<sup>106</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p4

<sup>107</sup> Transcript of evidence, p608

<sup>108</sup> Transcript of evidence, p236

<sup>109</sup> Exhibit L – Dr Alexandra Kent dated 22 July 2008, p1

<sup>110</sup> Exhibit L – Dr Alexandra Kent dated 22 July 2008, p1

anaesthesia, particularly in the setting of a suspected unstable cervical spine.<sup>111</sup> Ultimately, after considering the specific risks associated with Darren having a general anaesthetic in the MRI scanner, she determined it was inappropriate.<sup>112</sup>

122. Dr Haw provided an opinion that the management of Darren by the anaesthetic department was entirely appropriate and exemplary given the difficult clinical circumstances with which they were presented.<sup>113</sup>

#### *MRI scan*

123. Dr Winston Chong conducted the MRI and provided a report on 22 May 2007. Professor Stephen Stuckey reviewed Dr Chong's report and stated that he considered the report of Dr Chong to be comprehensive and accurate.<sup>114</sup> After the findings of the MRI a cervical collar was reapplied to Darren.

#### *Time it took to diagnose*

124. Professor Braitberg explained that the diagnosis of a spinal cord injury required more time in this case because of Darren's pre-existing medical condition with respect to his neurological function. He commented that it took time to determine new changes from old. Darren was seen by a number of specialists including emergency, radiology, and neurology department staff. He considered that the various consultations with the specialists were appropriate.<sup>115</sup>
125. Dr Haw provided an opinion that the Monash Medical Centre management exacerbated Darren's injuries and may have contributed to his death. Specifically, there was a failure to recognise, following the period of triage, that there was a possibility of a cervical injury responsible for the evident abnormal neurological status with flaccidity of both upper and lower limbs as well as the altered conscious level.<sup>116</sup> Further these clinical findings should have resulted in the early application of a cervical collar.<sup>117</sup> Dr Haw criticised the management of Monash Medical Centre in his report however made many concessions as to the appropriateness of their management at the inquest.

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<sup>111</sup> Exhibit L – Dr Alexandra Kent dated 22 July 2008, p1

<sup>112</sup> Exhibit L – Dr Alexandra Kent dated 22 July 2008, p3

<sup>113</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p6

<sup>114</sup> Exhibit T – Statement of Professor Stephen Stuckey dated 13 December 2010, p2

<sup>115</sup> Exhibit N – Statement of Professor George Braitberg dated 21 July 2007, p3

<sup>116</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p3

<sup>117</sup> Exhibit FF – Statement of Dr Christopher Haw dated 18 September 2009, p4

126. Southern Health submitted that the treatment of Darren by Monash Medical Centre did not worsen, aggravate or increase any injury or disability and did not contribute to his death.<sup>118</sup>

***Findings as to the care and management by Monash Medical Centre***

127. I acknowledge the concession of Southern Health that they did not initially diagnose the fracture from the CT scan which resulted in the removal of the cervical collar and I find that this inaccurate interpretation of the CT scan was unhelpful in providing a differential diagnosis. However, I find that there is no evidence to suggest that this exacerbated Darren's condition.
128. I acknowledge that many clinicians and departments within Monash Medical Centre worked together throughout the day to provide a differential diagnosis of Darren's condition and I find that their efforts were reasonable in the circumstances and did not worsen his condition.
129. Ultimately, a number of factors all linked together, made Darren's condition very difficult to diagnose and treat. I find that once Monash Medical Centre had properly determined that he had a high level cervical collar injury it was appropriate that they referred him off to the expert spinal surgeons associated with the Austin Hospital.
130. I find that Monash Medical Centre's decision to transfer Darren to the Austin Hospital was entirely appropriate in the circumstances given that Darren needed specialist spinal surgery.

**COMMENTS**

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

131. The situation confronting the disability workers, the ambulance officers and the clinicians involved in Darren's care was unusual in that Darren's Coffin-Lowry syndrome was an extremely rare condition which resulted in degenerative symptoms that were unknown even to his family at the time of the incident. The seriousness of his condition was so obscured that even experienced medical practitioners did not appreciate it until extensive diagnostic imaging had been completed. I acknowledge that patients with chronic disability are diagnostically challenging. For this reason, it is important to appreciate the role that family members have in providing essential background information and points of clinical reference for clinicians. Family members have a practical understanding of the person's disability and

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<sup>118</sup> Southern Health legal submissions, p2

medical conditions and can sense when something is wrong before it becomes apparent to clinical staff and this should always be given proper consideration.

132. Staff employed by DHS at the respite facility had a basic understanding of Darren's medical condition. DHS should ensure its staff have meaningful and practical information about their client's disability and medical conditions to enable them to provide individualised care, and practical suggestions on how best to manage them. It is not enough to advise staff to read a client file and gain an appreciation of a complex disability and medical condition without assisting them in acquiring this information. A simple solution to a complex issue such as this could be to have a one page document prepared by the general practitioner on what the person's medical condition is, how it presents to this particular patient, practical suggestions on appropriate management, including advice on when to seek further assistance and in what way.
133. The completion of this finding provides a good opportunity for those individuals and services involved in Darren's care to reflect on the circumstances of his death and ensure their current practices address any identified issues and facilitate continuous improvement. However given the passage of time the utility of making any formal recommendation is limited.

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

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

The Kingma Family

Ms McKay

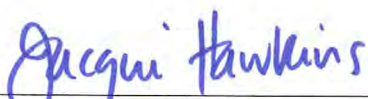
Ms Pedelty

Secretary of the Department of Human Services

Ambulance Victoria

Southern Health

Signature:



JACQUI HAWKINS

CORONER

Date: 19 March 2014

