FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2574/08

Inquest into the Death of GARY ALLAN CARRICK

Delivered at: Coroners Court of Victoria, 436 Lonsdale Street, Melbourne
Delivered on: 13 April 2010
Hearing dates: 13 April 2010
Findings of: JOHN OLLE
Representation: N/A
Place of death: Repatriation General Hospital

SCAU: Seargent Dimsey

In the Coroners Court of Victoria at Melbourne
I, JOHN OLLE, Coroner

having investigated the death of:

Surname: CARRICK
First name: GARY
Address: 2 Canopy Avenue, Kew, Victoria 3101

AND having held an inquest in relation to this death on 13 April 2010 at Coroners Court of Victoria, Melbourne, find that the identity of the deceased was Gary Carrick and the death occurred on 16 June 2008, at the Austin Repatriation, Studley Road, Heidelberg, Victoria 3084

from
1a. BRONCHPNEUMONIA

in the following circumstances:

1. Gary Carrick was aged 45 years at the time of his death. He lived in a supported residential unit at 2 Canopy Avenue, Kew.

2. A comprehensive coronial brief has been prepared. In addition, the file was referred to the Clinical Liaison Service (CLS)[1] for review.

[1] The Clinical Liaison Service (CLS) assists the Coroners Court of Victoria in ensuring that the true nature and extent of deaths caused during specialised clinical provision are fully elucidated and that any remedial factors are identified to prevent any future occurrences.

3. CLS was provided with the following documents:

- The medical records from the Austin Hospital and DHS Accommodation Services file;
- A photocopy of the medical record from the GP;
- Pathology report;
- Police Circumstances Form 83;
- Family letter dated 27 March 2009 (addressed to DHS), 18 June 2009, 4 July 2009; and
- Sworn statements from Judith Carrick (next-of-kin), Dr Alan Rice (GP), Dr Josephine Stewart (Palliative Care Consultant, Austin Hospital).

A summary of health issues

4. Mr Carrick's medical history included Down Syndrome, Tourette Syndrome and severe progressive cervical myelopathy leading to a functional decline.

5. He resided in supportive residential services under the care of the Department of Human Services (DHS). Mr Carrick was in care his entire life. He was unable to speak, but able to use sign language. He could dress and feed himself. Previously, he attended daily learning sessions.

6. In January 2008, Mr Carrick began to have difficulty walking and was intermittently incontinent of urine. On 6 February 2008, planned X-Rays of the left hip and cervical spine were cancelled as he was unco-operative and would require sedation to perform the X-Rays. His GP made an urgent referral to a neurologist and an appointment occurred on 26 March, 2008.

7. The neurologist determined the need of an MRI scan under general anaesthetic. At this time Mr Carrick could walk with assistance.

8. On 20 April 2008, Mr Carrick was moved from his current place of residence (Kew Residential Services) into a community residential unit (CRU).

9. On 14 May 2008, a physiotherapist authorised for a wheelchair and sling to assist with Mr Carrick's mobilisation.

10. On 16 May 2008, an MRI scan of the brain and cervical spine was performed which showed moderately severe cervical myelopathy with secondary cord thinning, ongoing cord compression and mid and lower cervical spondylosis.

11. In a letter to Mr Carrick's GP, dated 4 June 2008, the neurologist stated that the report underestimated the severity of the syndrome, and the appearance would suggest a long term problem, possibly some degree of cord compression over many years.

12. Mr Carrick was now unable to weight bear. He needed assistance with feeding, and was permanently incontinent of urine.

13. The neurologist had a meeting with Mrs Carrick on the 4 June 2008 to discuss the MRI results. He recommended against surgery, and suggested that management should be focused on providing appropriate nursing care.

14. On 5 June 2008, Mr Carrick was seen by the podiatrist. Ulcers on his buttocks and elbows were treated with (silversalazine) ointment and dressed. Regular pressure care was recommended.

15. On 6 June 2008, Mr Carrick was seen by his GP and oral antibiotics were commenced (staphylex). Bay Royal District Nursing Service (RDNS) referral for assessment and wound care management was made.

16. On 9 June 2008, Mr Carrick was transferred to the Austin Repatriation Hospital for worsening pressure ulcers to the elbows and sacrum, and necrosis to the toes. On admission to the emergency department, he had an elevated WCC (13.5) suggesting inflammation. He had extensive areas of deep ulceration that were infected. It was acknowledged that management of the ulcers were difficult as he tended to position himself prone. A surgical review determined that, given his medical history, he was not a candidate for surgical intervention.

17. A Not For Resuscitation (NFR) Order was obtained from Mrs Carrick.

18. On 11 June 2008, Mr Carrick was transferred to the Palliative Care Unit. He was given a trial of intravenous antibiotics and administered palliative pain relief. He was certified deceased on the 16 June 2008.

Letters of Concern raised by Mrs Carrick

19. I am satisfied that the issues raised by Mrs Carrick have been fully addressed.

20. I have reviewed a report of Dr Chris O'Donnell, Forensic Radiologist, Victorian Institute of Forensic Medicine. Dr O'Donnell provided a report which confirmed very severe spinal cord pathology. This indicates long standing (many years) compressive effect. It indicated the results were not specifically associated with Down Syndrome.

The final CLS Review Meeting was conducted in November 2009

21. Chaired by a coroner, CLS considered that the medical management appeared reasonable.

22. Mr Carrick had a chronic and severe condition that was investigated as an outpatient. If managed as an in-patient in hospital, an earlier diagnosis of his neurological symptoms may have been made. It is unlikely however, that an earlier diagnosis would have changed the medical management (i.e. no surgery, conservative treatment).

23. The timing and investigations seemed adequate given the co-morbities and complex needs of Mr Carrick. An MRI scan may have been performed earlier, however, once again the timing of the investigations would not have changed the medical management.

24. Mr Carrick appeared to have a sudden deterioration in his condition which was difficult to manage at both his place of residence, and whilst in hospital.

DHS

25. Mr Carrick may have needed a higher level of care than provided. CLS suggested this be followed up by appropriate personnel at DHS.

26. Importantly, however, the cause of death at autopsy was Bronchopneumonia with no contributing factors.

27. I have read DHS correspondence to Mrs Carrick, dated 7 January 2009, and 24 June 2009, from the former and current regional director.

28. I am satisfied that Mrs Carrick's concerns have been thoroughly considered and reviewed and appropriately responded to by DHS.

29. I am satisfied, with assistance of the CLS review, the response of DHS and upon analysis of all material, that further investigation is not warranted.

Letter to the coroner from Mrs Carrick, dated 24 February 2010

30. Mrs Carrick has urged that I consider making recommendations in respect to DHS policy. For the reasons outlined above, in particular, what I consider to be appropriate, considered and thorough responses by DHS, I do not propose to make the recommendations sought.

31. I note with appreciation the following comments of Mrs Carrick;

1) DHS acknowledge they could have managed her son better than they did (letters of DHS referred to above); and

2) "I would like to acknowledge and express my appreciation to the many dedicated and caring staff members who have cared for Gary during his life."

32. Whilst acknowledging the appropriate response of DHS to Mrs Carrick's concerns and having satisfied myself that the medical management generally has been thoroughly reviewed by CLS, there were lessons to be learnt.

33. I urge DHS to ensure that shortcomings identified by it in response to issues of concern raised by Mrs Carrick continue to be vigilantly addressed.

Post Mortem Medical Examination

34. On the 19 June 2008, Associate Professor David Ranson, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy.

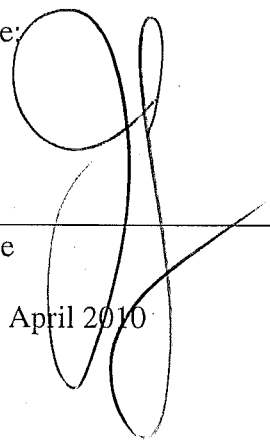
35. Associate Professor Ranson commented:

> "The autopsy revealed evidence of very significant natural disease in the form of severe bronchopneumonia with extensive tracheobronchitis. In addition to the lung infection there was evidence of pressure sores to the toes and to the region of the right and left elbows."

36. Associate Professor Ranson found the cause of death to be bronchopneumonia.

37. I am satisfied that the cause of death of Gary Carrick is Bronchopneumonia and so find.

Signature:



John Olle
Coroner
Date: 13 April 2010