IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 005057

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ROBERT EDWARD CURRY

Delivered On:	10 September 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	8 August 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Police Coronial Support Unit:	Leading Senior Constable Amanda MAYBURY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of ROBERT EDWARD CURRY

AND having held an inquest in relation to this death on 8 August 2012

at Melbourne

find that the identity of the deceased was ROBERT EDWARD CURRY

born on 23 January 1971, aged 38

and that the death occurred on 24 October 2010

at Community Residential Unit, 7 Lara Crescent, Mount Evelyn, Victoria 3796

from:

1 (a) END-STAGE RESPIRATORY FAILURE

1 (b) KYPHOSCOLIOSIS

CONTRIBUTING FACTORS

2 CEREBRAL PALSY, INTELLECTUAL DISABILITY6

in the following circumstances:

1. Mr Curry was a 38 year old single man who resided at 7 Lara Crescent, Mount Evelyn, a Community Residential Unit, managed by Melba Residential Services (Melba), on behalf of the Department of Human Services. Mr Curry had a significant past medical history that included profound intellectual disability, cerebral palsy with severe scoliosis, rickets, cataracts, asthma, aspiration pneumonia, recurrent chest infections and depression. He required full time high level care and assistance with all the activities of daily living. Mr Curry had been in care since he was about seven years old and had resided at Lara Court for about twelve years before his death. His mother Vivian took an active interest in his life and visited him regularly until her death some nine years ago.

2. Mr Curry's medical care was provided by Dr Gurcharan Singh Ubhi, from Lilydale Medical Centre, who gave him a full medical check-up once a year and attended to any illnesses as they arose. Mr Curry's health had been stable for many years, with no particular medical issues in the months immediately preceding his death, except conjunctivitis of the left eye which responded to eye drops and washes. His regular medications were administered by Melba staff, from a "Webster" pack prepared by the pharmacy. They were Caltrate, Colfen, Losec, Iron Plus, Megatrol and Zyprexa.

3. On 23 October 2009, after he had left for his day placement, one of the Melba staff members noticed that Mr Curry's Webster pack still contained that morning's medications. The medications were taken to the day placement centre and administered to Mr Curry. Upon reflection, the staff member thought it was possible that she had administered another resident's medications to Mr Curry at about 7.00am that morning by mistake, prior to his departure for the day placement centre. The other resident's medications were Kepra, Tegretol, Rivotril, Aldactone and Coloxyl/Senna. The incident was reported but Melba were unable to verify whether the mistake had in fact occurred.

4. There was nothing about Mr Curry's behaviour to raise concerns for his welfare or safety. He appeared a little sleepy on his return from day placement but this was not uncommon for him. Mr Curry had dinner and was put to bed at about 8.00pm as usual. He was checked later in the evening and appeared to be sleeping peacefully, as he was when last checked at 12.15am on 24 October 2009. At about 12.45am, however, one of the nightshift carers checked on Mr Curry and found he wasn't breathing. She called "000" and commenced cardiopulmonary resuscitation until ambulance officers arrived a short time later. Mr Curry was unable to be revived.

5. The coronial investigation of Mr Curry's death included a mandatory inquest, as he was a *person placed in custody or care* as defined in section 3 of the Coroners Act 2008.[1] The Act recognises that some people are more vulnerable than others, and affords them protection by requiring that the circumstances of their death are investigated by a coroner, irrespective of the medical cause of death, and by mandating that as part of that investigation there should be an inquest or formal public hearing.

6. An autopsy was conducted by Senior Forensic Pathologist Dr Shelley Robertson from the Victorian Institute of Forensic Medicine (VIFM), who reviewed the circumstances as reported by the police to the coroner and considered the available medical records. Dr Robertson attributed the cause of Mr Curry's death to *end-stage respiratory failure secondary to kyphoscoliosis* and noted as indirect contributing factors *cerebral palsy and intellectual disability.* Dr Robertson made the following comments in her autopsy report regarding her findings and the toxicologist's report – "... *Robert Curry, died from natural causes with evidence of end-stage respiratory disease. He had a past history of intellectual disability,*

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[1] See also sections 52(2) (b) & (3) of the Act.

cerebral palsy and gross kyphoscoliosis. This had produced severe compromise of his respiratory system with gross distortion of thoracic cavities. Toxicological analysis showed the presence of drugs at levels consistent with therapeutic usage. These would not have contributed to death."

7. Toxicological analysis of post-mortem samples revealed Carbamazepine ("Tegretol", an anticonvulsant) ~6mg/L, Olanzapine ("Zyprexa", an antipsychotic also used for mood stabilisation) ~0.7mg/L and a trace of 7-aminoclonazepam, a marker for Clonazepam ("Rivotril", a benzodiazepine with sedative and anticonvulsant properties). These results confirm the medication error suspected by Melba staff to have occurred on 23 October 2009.

8. I asked Professor Olaf Drummer, Head of Forensic Scientific Services at VIFM and a Toxicologist, to comment on the likelihood that the medication error, which occurred on the morning of 23 October 2009, caused or contributed to Mr Curry's death. He advised that the levels of Carbamazepine and Clonazepam detected, while consistent with normal therapeutic use, *would cause at the very least significant sedation* in Mr Curry if he was not accustomed to them and potentially could contributed to his death given that his compromised underlying medical condition. Professor Drummer could not be more precise, but indicated that Mr Curry's clinical state in the hours following the medication error would be important in assessing the impact on the drugs.[2]

9. In Dr Robertson's absence, Professor Stephen Cordner, Director of VIFM, provided a supplementary report addressing the medication error outlined above confirmed by the results of post-mortem toxicological analysis. He agreed with Professor Drummer's advice to the effect that it was *"possible that drowsiness associated with the ingestion of the drugs has tipped an already quite ill man over the edge…that it cannot be reasonably excluded that the ingestion of the drugs may have played a contributory role in this man's death. I do not think it can be concluded that the drugs necessarily contributed to this man's death."*[3]

10. The records provided by Melba indicated that Mr Curry was sleepy on arrival at the residence after his day placement on 23 October 2009, which was not unusual for him. Relevantly, observations made on 22 October 2009, were consistent, that is, he had returned from his day placement sleepy, indeed *"very sleepy"* that day as well.

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[2] Email report to Coroner dated 29/11/2011.

[3] Email report to Coroner dated 03/08/2012.

11. At the inquest, Ms Penny Kendall,[4] Manager, Community Living Support Services, Melba Residential Services, gave evidence about Mr Curry's general level of functioning and confirmed that their records indicated no appreciable change in his behaviour following the medication error. She also explained how the medication error had occurred on the morning of 23 October 2009 and its significant impact on the staff member involved. It should be noted that the staff member involved had been employed at the residence for several years and that unfamiliarity with Mr Curry or with the procedures at the residence appeared to have played no part in the error occurring.

12. Ms Kendall testified that there are no "minimum qualifications" for staff employed at the residence, although some have a Certificate 4 qualification. What Melba look for is a person who has a good attitude for working with people with disabilities.[5] Apart from orientation and induction, after they had been employed for some time, staff members were expected to attend one of the half day training session in the administration of medication which were held up to three times a year. In the event that a training session is not scheduled for some time, or if agency staff are employed, they are instructed in the administration of medication on the job, and are required to accompany another trained/experienced staff member on four medication rounds before being allowed or required to administer medication independently.[6]

13. I find that Mr Curry died from *end-stage respiratory failure secondary to kyphoscoliosis* and note as indirect contributing factors *cerebral palsy and intellectual disability.* While I am satisfied to the appropriate standard of proof that the medication error occurred on the morning of 23 October 2009, the evidence does not support a positive finding that the medication probably contributed to his death. Neither does the evidence support exclusion of this as a possibility, that is that the medication error may have contributed to death by increasing Mr Curry's drowsiness thereby compromising his already compromised respiratory function.

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[4] No relation to the police investigator LSC Darren Kendall.

[5] Transcript page 15.

[6] Transcript pages 16-17.

COMMENTS

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

1. Mr Curry was a person under the control, care of custody of the Secretary to the Department of Human Services, and as such a person placed in custody of care as defined in the Coroners Act 2008. He had profound physical and intellectual disabilities and required assistance with all the activities of daily life, including assistance in accessing medical attention and treatment. He was entirely dependent on his carers for the administration of medication.

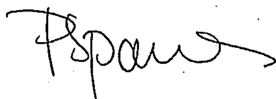
2. While I have made no finding that a medication error probably contributed to his death, the evidence allows of this possibility.

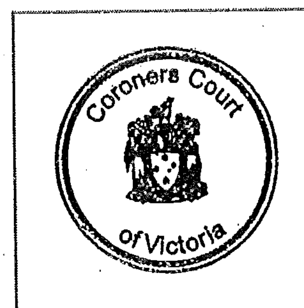
3. The circumstances surrounding Mr Curry's death and the medication error in particular, highlight the need for carers in a Community Residential Unit setting to be competent in the administration of medication, for there to be carefully enforced procedures around administration of medication, and ongoing training in this regard.

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

The family of Mr Curry
Leading Senior Constable Darren Kendall (22800) c/o O.I.C. Mooroolbark Police
Dr Gurcharan Singh Ubhi c/o Lilydale Medical Centre, 351 Main Street, Lilydale
Ms Penny Kendall, Melba Residential Services
Office of the Senior Practitioner, Disability Services Division, Department of Human Services

Signature:





PARESA ANTONIADIS SPANOS
CORONER
Date: 10 September 2012