Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 0717

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: CRAIG VINCENT DOUTHIE

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	2 July 2020
Delivered At:	Coroners Court of Victoria
Hearing Dates:	2 July 2020
Appearances:	Dr Casey Nottage, Deputy Chief Medical Officer of Bendigo Health
Counsel Assisting the Coroner:	Hayley Challender, Coroners Solicitor

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I, AUDREY JAMIESON, Coroner having investigated the death of CRAIG VINCENT DOUTHIE

AND having held an Inquest in relation to this death on 2 July 2020

at the Coroners Court of Victoria

find that the identity of the deceased was CRAIG VINCENT DOUTHIE

born on 24 October 1965

at Bendigo Health Hospice Unit, 100 Barnard Street, Bendigo, Victoria 3550

from:

1 (a) C 2, 3, 4 SPINAL INJURY SUSTAINED FROM A FALL SECONDARY TO SEIZURES

In the following summary of circumstances:

1. Craig Vincent Douthie was 52 years of age at the time of his death. Mr Douthie suffered from cerebral palsy including spastic quadriplegia[1] and tuberous sclerosis.[2] He also had epilepsy and osteoporosis, a severe intellectual disability and was prone to respiratory infection. Mr Douthie lived in Kyneton, Victoria, at "Sunrise House", a Department of Health and Human Services disability group accommodation.

2. On 10 February 2018, Mr Douthie was in his home. During the day, he had a visit with his brother Brendan Edward Douthie for approximately 45 minutes. Subsequently, at approximately 3.30pm, 5.40pm and 6.10pm, Mr Douthie had seizures. He appeared to recover reasonably well on each occasion.

3. At about 6.10pm, Mr Douthie appeared to recover from the third seizure and took himself to the toilet. Shortly thereafter, Sunrise House staff heard a loud bang from the vicinity of the bathroom and, upon investigation, found Mr Douthie on the bathroom floor. He was conscious and responsive but had no muscle tone. He did not indicate that he was in any pain.

[1] Cerebral palsy distorts messages from the brain to cause increased muscle tension or reduced muscle tension. Spastic cerebral palsy is the most common type of cerebral palsy. Spasticity means stiffness or tightness of muscles, which is most obvious when the person tries to move. Quadriplegia means all four limbs are affected. [https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/cerebral-palsy], accessed 19 June 2020.
[2] A genetic condition; a common characteristic is tuber like growths in the brain and sometimes other organs.

4. Sunrise House staff contacted the on-duty Nurse who put them directly through to Ambulance Victoria; paramedics attended the group home and Mr Douthie was ultimately transported to Bendigo Hospital by ambulance.

5. At 11.45pm, Mr Douthie was admitted to the Bendigo Hospital Emergency Department. During admission, he became progressively drowsier and his body more flaccid. Consequently, medical practitioners booked Mr Douthie in for CT scanning in case of a brain injury and to attempt to identify the nature of any injuries.

6. On 11 February 2018, Mr Douthie underwent CT scanning and medical practitioners identified significant avulsion fractures of the anterior inferior margin of the C4, C2 and C3 spine. Bendigo Health medical practitioners consulted the neurosurgical team at the Austin Hospital in relation to Mr Douthie's prognosis. Due to the nature of his injuries and his pre-existing comorbidities, medical staff ultimately advised Mr Douthie's brother that he would not be a good surgical candidate and Brendan Douthie consented to palliation.

7. Mr Douthie was transferred to the Bendigo Health Hospice Unit for palliation and comfort care. Mr Douthie died at 8.16am on 13 February 2018.

JURISDICTION

8. On 13 February 2018, after Mr Douthie's death, Bendigo Health staff completed an E-Medical Deposition Form (E-Med Dep.) and provided it as a report of death to the Coroners Court of Victoria. Mr Douthie's death was reportable as it was, *inter alia*, unexpected and as a direct result of accident or injury.[3] Additionally, Mr Douthie's death was reportable as he was a person '*in care*' pursuant to section 3 of the Act.

9. Section 52(2)(b) of the *Coroners Act 2008 (Vic)* [the Act] provides that a Coroner must hold an Inquest into a death if the death or cause of death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care. A Coroner is not required to hold an inquest into a death in these circumstances if they find that the

[3] *Coroners Act 2008* (Vic) s 4.

death was due to natural causes.[4] Mr Douthie's death was not due to natural causes and therefore a public hearing by way of inquest is mandated.

PURPOSE OF THE CORONIAL INVESTIGATION

10. The Coroners Court of Victoria is an inquisitorial jurisdiction.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [7]

11. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[8] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9] These are effectively the vehicles by which the prevention role may be advanced.[10]

12. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

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[4] Ibid s 52(3A).
[5] Section 89(4) Coroners Act 2008.
[6] Section 67(1) of the *Coroners Act 2008*.
[7] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[8] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.
[9] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[10] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

STANDARD OF PROOF

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw.[11] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

14. The effect of the authorities 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.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

15. On 13 February 2018, Brendan Edward Douthie completed a statement of identification for his brother Craig Vincent Douthie who was born 24 October 1965.

16. Identity is therefore not in dispute and requires no further investigation.

17. I find, as a matter of formality, that Craig Vincent Douthie, born on 24 October 1965, died in the Bendigo Health Hospice Unit at 8.16am on 13 February 2018.

Medical Cause of Death

Post mortem examination

18. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Craig Vincent Douthie,

[11] (1938) 60 CLR 336.

reviewed a post mortem computed tomography (CT) scan, the E-Med Deposition and referred to the Victoria Police Report of Death, Form 83. Dr Parsons noted that CT scanning conducted at Bendigo Hospital had identified multiple spinal injuries from the C2-C4. Post mortem CT scanning also identified bilateral pleural effusions,[12] right and left pneumothorax,[13] upper left lobe consolidation[14] and displaced C3.

Toxicology

19. Toxicological examination of Craig Vincent Douthie's post mortem blood identified the presence of Acetone,[15] Levetiracetam,[16] Clonazepam metabolite 7-Aminoclonazepam,[17] Nitrazepam metabolite 7-Aminonitrazepam,[18] and Lignocaine.[19]

Forensic pathology opinion

20. Dr Sarah Parsons formulated the medical cause of Mr Douthie's death as C 2, 3, 4 spinal injury sustained from a fall secondary to seizures.

DISABILITY SERVICES COMMISSIONER REPORT

21. The Disability Services Commission (DSC) was established under the Disability Act 2006 (Vic) [the Disability Act]. The DSC is an independent oversight body for the Victorian disability sector. The Minister for Housing, Disability and Ageing (the Minister) has requested that the Disability Services Commissioner inquire into and, at his discretion, investigate any matter relating to the provision of disability services or regulated disability services to a person who was receiving these services at the time of their death. On 19 February 2018, the DSC initiated an investigation into the provision of disability services by DHHS to Mr Douthie under section 128I of Disability Act.

22. On 9 November 2018, the DSC provided its Final Section 128I Investigation Report in relation to Craig Vincent Douthie (the DSC Report) to the Court, pursuant to section 132ZB of the Disability Amendment Act. Upon provision of the report, the

[12] The accumulation of excess fluid in the membranes that line the lungs on the inside of the chest cavity (pleura).
[13] Collapsed lungs caused by pressure from air leaking into the space between the lungs and the chest wall.
[14] Consolidation refers to the alveoli (tiny air sacs at the end of the bronchioles (the tiny branches of air tubes in the lungs) being filled with fluid, cells, tissue or other material.
[15] An organic compound of the human body.
[16] An anti-epileptic used for the control of seizures (available in Australia under the brand name "Keppra").
[17] Clonazepam is used clinically for the treatment of seizures.
[18] Nitrazepam is a sedative/hypnotic drug of the benzodiazepine class.
[19] Lignocaine is a local anaesthetic which is often administered to patients prior to surgery or during resuscitation attempts.

Commissioner requested that I comply with certain conditions for further use and disclosure of the same.

23. The DSC documented issues and made recommendations to DHHS on the basis of their findings about service delivery to Mr Douthie. However, these issues did not have any causal relationship to the circumstances of his death and have been appropriately canvassed by the Disability Services Commissioner's investigation.

CORONIAL INVESTIGATION

24. Leading Senior Constable (LSC) Scott Johnson was the nominated Coroner's Investigator.[20] At my direction, LSC Johnson investigated the circumstances surrounding Craig Vincent Douthie's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Brendan Douthie, House Supervisor at Sunrise House Jodie Duckworth and LSC Johnson.

25. Mr Douthie had lived at Sunrise House since the early 1980s. He had limited verbal communication and was on a variety of medications for his health conditions. Brendan Douthie commented that his younger brother was born with an intellectual disability but that he had begun to suffer from epilepsy in his teenage years.

26. Jodie Duckworth stated that Mr Douthie would have, on average, 15 seizures a month and more than one on any given day. She said that Mr Douthie independently toileted and dressed, he was also able to perform routine chores and would move about the house without assistance. She described him as fiercely independent; Mr Douthie would not allow anyone to hold his hand while he walked.

27. Ms Duckworth stated that it was part of Mr Douthie's normal routine to take himself to the bathroom after a seizure. On 10 February 2018 after his seizure of approximately 6.10pm, Mr Douthie moved from the living area to the bathroom. She stated that an on-duty staff member observed him walk toward the bathroom before resuming their assistance of another resident who was eating a meal.

28. In the Sunrise House Incident Report made after Mr Douthie's death, the staff-member on-duty in the living area stated that Mr Douthie was a little unsteady after his seizure

[20] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

but had recovered well; there was nothing out of the ordinary in his behaviour for a post-seizure period.

29. Upon locating Mr Douthie after his fall, attending staff members believed that he had probably suffered a further seizure. He was responsive, communicated no pain in any of his limbs but had no muscle tone. After contacting Emergency Services, the staff positioned Mr Douthie in the recovery position, as instructed.

30. At approximately 11.45pm, Mr Douthie was admitted to Bendigo Hospital Emergency Department (ED). The nursing assessment and progress notes ["nursing notes"] identify that a DHHS "carer" remained with Mr Douthie throughout his admission. The notes also state, *inter alia*, that the carer would be able to assist with understanding Mr Douthie's baseline health in the context of his existing medical conditions, especially his '*severe intellectual disability.*'

31. At the time of admission to the ED, Mr Douthie was noted to have a Glasgow Coma Scale (GCS)[21] of 11.[22] Bendigo Health staff commented that Mr Douthie appeared to express pain upon movement of his right arm and shoulder. Consequently, an x-ray was booked to identify the nature of any injuries to that area of his body.

32. On 11 February 2018 at about 4.10am, nursing staff noted that Mr Douthie had attended for an x-ray and was seen by the ED Registrar and Intern who were on duty overnight. There were no injuries identifiable by x-ray to his shoulder area and nursing notes state Mr Douthie was likely to be transported back to his home later, as he had been '*medically cleared'* by the ED medical practitioners.

33. At about 8.10am, Mr Douthie was assessed as having a GCS score of 15 and his vital signs were continuously charted. Hospital staff were concerned that he had yet to independently ambulated and had not used the bathroom since his admission. Nursing notes state that Mr Douthie's transport home would be delayed until he was '*more awake and ambulating'*. He was provided his usual medications.

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[21] The Scale was described in 1974 by Graham Teasdale and Bryan Jennett (Assessment of coma and impaired consciousness. A practical scale. Lancet 1974; 2:81-4.) as a way to communicate about the level of consciousness of patients with an acute brain injury.

[22] Generally, a brain injury may be classified as severe (GCS 8 or less), moderate (GCS 9-12) or mild (GCS 13-15) with the Glasgow Coma Scale method.

34. At 8.32am, Emergency Department Intern Dr Melissa Chew noted that Mr Douthie possibly had a soft tissue injury to his right shoulder, which would account for pain he appeared to be expressing. Dr Chew noted that Mr Douthie had been "uncooperative" when staff attempted to assist him with walking. Dr Chew flagged Mr Douthie's non-walking-state to the medical team who indicated that he was not for admission at this time but if he were not able to ambulate within the following 24 hours then they would review him.

35. At 8.34am, Emergency Registrar Dr Christina Goodall-Van Helden took the handover for Mr Douthie's care. She noted that he slept deeply and that she was not able to completely rouse him. Mr Douthie did open his eyes but was non-communicative and uninterested in any inducement to leave his bed. Dr Goodall-Van Helden made a note indicating that his carer reported Mr Douthie would exhibit these behaviours at home, sometimes, and that he would spend the day in bed, only leaving it to use the toilet.

36. At 10.02am, Mr Douthie still had not ambulated nor used the toilet. A bladder scan identified that he had a full bladder. Mr Douthie was unable to stand with the assistance of two others; Dr Goodall-Van Helden noted that his arms and legs were "floppy". She felt unable to perform an accurate neurological examination due to the communication difficulties. She was unsure of his normal baseline. Dr Goodall-Van Helden made a medical management plan to:

    a. Require immediate review by a Medical Registrar;

    b. Conduct blood tests;

    c. Insert catheter;

    d. Administer medication if priapism[23] ongoing subsequent to catheter insertion, and

    e. Conduct a CT scan of the brain and spine.

37. At 2.01pm, a Surgical Urology Registrar assisted Dr Goodall-Van Helden with insertion of a three-way catheter, after there had been significant, documented difficulty with inserting the same. Once the catheter was inserted and his bladder had been drained, Mr Douthie became hypotensive. Intravenous medication and treatment were immediately provided, and his blood pressure improved. At that time, the plan remained for review by the Medical Registrar's and a CT scan was pending.

[23] Sustained, non-sexual erection of the penis.

38. At 5.14pm, CT scanning identified that Mr Douthie had sustained C2-4 avulsion fractures with '*significant narrowing at C3.*'[24] The Medical Registrar's sought the neurosurgical input.

39. At 5.40pm, Dr Goodall-Van Helden made a note to summarise the treatment provided to Mr Douthie that day, she wrote:

> *The notes of today don't do justice to the setbacks that we have experienced during the day.*
>
> *Initially, the first carer didn't express any concerns about his flaccid state of being. Unaware of what his baseline was, I initially wasn't concerned either.*
>
> *However, when I noticed he was in urinary retention as well as that he had priapism, I was concerned and asked for help from G. O Connor / W. Merl and the medical registrar. I knew a CT scan was indicated, however, we were unable to get one as he was restless with his urinary retention. Then we had significant setback with getting a catheter in that was functional. Following that he was to* (sic) *hypotensive to go to CT.*
>
> *He has now been made palliative and had we known the outcome at the start it probably wouldn't have changed our managed* (sic). *However, I feel saddened by the delay of our final diagnosis.*

40. Brendan Douthie stated that he generally did not have any issues in relation to the care and treatment of his brother. However, he did consider that Mr Douthie ought to have been provided pain medication before he was moved by Hospice staff to change the bed sheets.

SUMMARY INQUEST

41. In light of the circumstances of Mr Douthie's death and a lack of evident issues to explore by hearing oral evidence, I determined that this matter would be appropriately finalised by way of a Form 37 Finding into Death with Inquest and to hand-down my Findings at the conclusion of a Summary Inquest. Interested Parties were informed of my determination by way of a Summary Inquest Notice dated 15 June 2020.

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[24] Bendigo Health Medical Records, Craig Vincent Douthie Medical History and Examination Notes, dated 11 February 2018.

COMMENTS

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

1. Section 7 of the *Coroners Act 2008* (Vic) states that it is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officers to, *inter alia*, avoid unnecessary duplication of investigations and to expedite the investigation of deaths. The Coroners Court of Victoria and the Disability Services Commission have a Memorandum of Understanding (MOU) in order to affect that intention.

2. In accordance with the MOU, the DSC provided their investigation report in relation to Mr Douthie's death. The DSC Report did not identify any issues pertinent to the events leading to nor the medical cause of Mr Douthie's death. I sought a coronial brief of evidence examine the immediate surrounding circumstances of Mr Douthie's death, in particular, the medical care and treatment provided to him at hospital.

3. Mr Douthie was not given a CT scan for more than 15 hours after he was first admitted to the ED at Bendigo Hospital. Bendigo Health staff did not have a clear comprehension of Mr Douthie's regular neurological baseline. The investigation has identified that this occurred in the context of his presentation with an initially relatively high GCS score, his intellectual disability and (purportedly) the characterisation of his behaviour at the DHHS group accommodation. Additionally, the administration of CT scanning was further delayed by difficulty in urinary catheter insertion.

4. In light of Mr Douthie's comorbidities, the time frame of his admission to hospital is unlikely to have had an effect on his ultimate clinical course. Similarly, earlier CT scanning is also unlikely to have altered his ultimate clinical course and prevented his death. I accept Dr Goodall-Van Helden's contemporaneous note as an accurate record of the progression of Mr Douthie's care on 11 February 2018, including the setbacks the medical practitioners experienced, as well as an acknowledgement that earlier diagnosis would have been preferred and consistent with good medical practice.

5. Consequently, the investigation has not identified outstanding issues that would warrant the hearing of oral evidence from those involved in Mr Douthie's care at a full inquest. As such, I have held a Summary Inquest to adhere to the provisions of section 52(3)(b),

mandating a public hearing for, *inter alia*, the deaths of persons in care, where their death was not due to natural causes.

6. Finally, I note Brendan Douthie's comment in relation to pain medication. This is a legitimate concern in relation to the final days of his brother's life. As I have determined that this issue was not causal to Mr Douthie's death, I will make no further comment about it; save to say that Bendigo Health should contact Brendan Douthie to discuss that aspect of his brother's care.

FINDINGS

1. I find that the identity of the deceased is Craig Vincent Douthie, who was born on 24 October 1965 and who died on 13 February 2018 at the Bendigo Health Hospice Unit, 100 Barnard Street, Bendigo, Victoria 3550.

2. I find that Craig Vincent Douthie resided in Department of Health and Human Services shared supported accommodation in Kyneton at Sunrise House. As such, I find that he was 'in care' immediately before his death as defined in section 3 of the *Coroners Act 2008* (Vic).

3. I find that Craig Vincent Douthie had seizures at approximately 3.30pm, 5.40pm and 6.10pm on 10 February 2018. I further find that Craig Vincent Douthie went to bathroom unaccompanied after the seizure at about 6.10pm.

4. AND I further find that Craig Vincent Douthie fell while in the bathroom alone, in circumstances where I find that it is not clear whether he fell down subsequent to a further seizure while in the bathroom or due to any unsteadiness stemming from his pre-existing health conditions, in combination with his seizure of approximately 6.10pm.

5. I find that the medical care and treatment provided to Craig Vincent Douthie by Department of Health and Human Services' Sunrise House staff was reasonable and appropriate in relation to the immediate surrounding circumstances of events leading to his death.

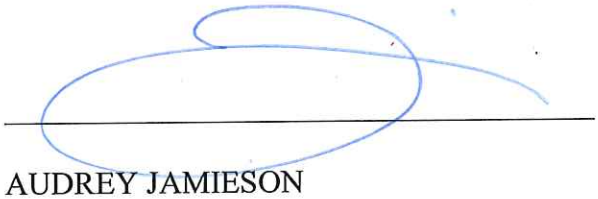
6. I find that diagnosis of Craig Vincent Douthie's injuries by Bendigo Health staff was delayed. I further find that this delay was not causal, nor did it represent a missed opportunity to intervene in the clinical course leading to his death.

7. I accept and adopt the medical cause of death formulated by Dr Sarah Parsons and I find that Craig Vincent Douthie died from C 2, 3, 4 spinal injury sustained from a fall secondary to seizures.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this Finding be provided to the following:
Brendan Douthie
Dr John Turner, Coliban Medical Centre
Stacey Thackrey, Bendigo Health
Leading Senior Constable Scott Johnson

Signature:



AUDREY JAMIESON

CORONER

Date: **2 July 2020**