IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 3747

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Carl Anthony Van Der Kaay
Date of birth:	20 October 1968
Date of death:	18 July 2019
Cause of death:	1(a) Cardiomegaly and ischaemic coronary artery disease
Place of death:	Dandenong Train Station, Foster Street, Dandenong, Victoria

INTRODUCTION

1. On 18 July 2019, Carl Anthony Van Der Kaay (**Carl**), born 20 October 1968, was 50 years old at the time of his death. He is survived by his wife Sharon and they lived together in Pakenham.

2. Carl had a strong maternal history of heart disease and himself had a history of coronary artery stent insertion in tandem with diabetes, hypertension and raised cholesterol. He was also a long-time smoker. His wife said that he had a fall some weeks prior to his death and injured his arm and suffered severe headaches as a result.

3. On 18 July 2019, Carl collapsed on a V/Line train during his commute to work and went into cardiac arrest. Sadly, he could not be assisted and passed away shortly afterwards.

THE CORONIAL INVESTIGATION

4. Carl's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Senior Constable Matthew Hall (**SC Hall**) to be the Coroner's Investigator for the investigation of Carl's death. SC Hall conducted inquiries on my behalf and compiled various materials for consideration by the Court.

8. The Court received correspondence from Mrs Sharon Van Der Kaay and Mr Glenn Porter, a clinical nurse specialist in cardiothoracics who was present at the time of Carl's death. The Court also sought and received correspondence from a representative from Metro Trains, Ms Tilly Loughborough.

9. As part of the coronial investigation, the Coroners Prevention Unit (**CPU**) was also asked to review the appropriateness of the care provided to Carl proximate to his death. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

10. In the later part of the investigation, I sought and received submissions from V/Line's Chief Executive Officer (**CEO**), Mr Matt Carrick.

11. This finding draws on the totality of the coronial investigation into Carl's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. On 18 July 2019 at about 5.44am, Carl was headed to work and boarded a V/Line train at Pakenham Railway Station. As the train arrived at Dandenong Railway Station, he collapsed and went into cardiac arrest.

13. Glenn Porter, an off-duty clinical nurse specialist in cardiothoracics on board the same train at the time, performed cardiopulmonary resuscitation (**CPR**) while another passenger contacted emergency services. He sought a defibrillator from the train conductor however was informed there was not one on board but that an ambulance would meet them at Dandenong Railway Station.

14. Mr Porter and other passengers present managed to contact Carl's wife on his mobile phone. She stated that he had had some chest pain earlier that morning prior to him boarding the train.

15. When the train pulled into Dandenong Railway Station, there was no ambulance present. Mr Porter continued to administer CPR until paramedics arrived about 10 minutes later, at approximately 7.10am. At this stage, resuscitation efforts had been continuing for approximately 30 minutes.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. Paramedics took over CPR for a further 40 minutes and administered defibrillator pads to Carl's chest. Sadly, Carl was not assisted by these efforts and he was declared deceased shortly thereafter.

Identity of the deceased

17. On 18 July 2019, Carl Anthony Van Der Kaay, born 20 October 1968, was visually identified by then Constable Matthew Hall, the Coroner's Investigator.

18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 24 July 2019 and provided a written report of his findings dated 5 December 2019. Dr Dodd also reviewed the Police Form 83, Contact Log, Post-mortem CT scan, and Toxicology and Biochemistry reports.

20. Toxicological analysis of post-mortem samples identified the additional presence of Bisoprolol (~0.08mg/L), used to treat hypertension, and Paracetamol (~5mg/L).

21. Dr Dodd provided an opinion that the medical cause of death was 1(a) Cardiomegaly and ischaemic coronary artery disease. He further opined that there was no evidence to suggest that this death was due to anything other than natural causes.

22. I accept and adopt Dr Dodd's opinion.

FURTHER INVESTIGATIONS

CPU Review

23. As part of this investigation, I requested advice from the CPU to consider whether any prevention opportunities were available. In particular, I sought advice on any data arising from medical episodes encountered on trains and at train stations, and whether the use of a defibrillator was recorded.

24. The CPU identified 15 deaths on a train due to a medical episode between 1 January 2010 and 31 May 2021. A further 34 deaths were identified that occurred in and around a train station. 39 of those deaths were cardiac related and 10 were non-cardiac related.

25. The CPU identified that the use of a defibrillator was found in five of those cases. Given that 45 of the 49 cases were closed with no circumstances identified by this Court, it was difficult to ascertain whether a defibrillator was used and if so, its source.

V/Line Submissions

26. By letter dated 5 November 2021, V/Line were invited to make submissions on my proposed recommendation that all V/Line trains have a defibrillator added to them. By letter dated 6 December 2021, Mr Matt Carrick, CEO, provided a response.

27. Mr Carrick stated that Automated External Defibrillators (**AEDs**) were installed at 29 railway stations in 2018. AEDs have also been installed at strategic metropolitan stations that provide connections to V/Line rail and coach services.

28. He advised that AEDs are currently not installed on V/Line trains. He stated that, in early 2021, V/Line reviewed the feasibility of installing AEDs on trains and conducted risk assessments to determine key issues associated with the initiative. The outcome of this risk assessment was that it is plausible to install AEDs on V/Line trains.

29. Mr Carrick stated that V/Line supports in-principle the installation of AEDs on its trains, noting that the following unresolved issues would have an impact upon the feasibility of the initiative:

    a) funding;

    b) the current configuration of V/Line trains, being four different types of carriages on the regional network; and

    c) the scheduling of installation to ensure timetabled services are not impacted.

FINDINGS AND CONCLUSION

30. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Carl Anthony Van Der Kaay, born 20 October 1968;

    b) the death occurred on 18 July 2019 at Dandenong Train Station, Foster Street, Dandenong, Victoria from Cardiomegaly and ischaemic coronary artery disease; and

    c) the death occurred in the circumstances described above.

31. Having considered the circumstances, I am satisfied that Carl's death was of natural causes.

32. I wish to commend Mr Porter on his proactivity and diligence in his resuscitation efforts of Carl, and his correspondence with V/Line advocating for defibrillators to be installed on their trains.

RECOMMENDATIONS

33. Pursuant to section 72(2) of the Act, I make the following recommendations:

    a) That V/Line install defibrillators on their trains.

34. I convey my sincere condolences to Carl's family for their loss and acknowledge the grief you have endured.

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

    Sharon Van Der Kaay, Senior Next of Kin

    Matt Carrick, V/Line

    Senior Constable Matthew Hall, Coroner's Investigator

Signature:

John Olle
Coroner
Date: 12 July 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.