IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002785

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Robert Thoai Dao
Date of birth:	9 December 1949
Date of death:	25 May 2023
Cause of death:	1(a) Complications of cervical fractures and spinal injury (operated), sustained in a fall
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	Ambulance; Accidental Fall

INTRODUCTION

1. On 25 May 2023, Robert Thoai Dao was 73 years old when he died at the Austin Hospital. At the time of his death, Robert lived at 4 Little Street, Deer Park, Victoria with his wife, Thi Kim Chi Truong.

2. Robert was born in the city of Hue, Vietnam and later emigrated to the United States after serving alongside the US in the Vietnam War. Dao met his wife, Kim, in late 2002 through extended family members and ultimately moved to Australia in July 2003, marrying Kim in August 2003. Robert joined Kim's existing family and raised her three children as his own. On moving to Australia, Robert worked as a machine operator for approximately ten years, retiring in 2014.[1] Friends described Robert as hard-working and well-liked by his bosses and colleagues.

3. Robert suffered from a number of chronic health conditions, including Type 2 Diabetes, ischaemic heart disease, hypertension, obstructive sleep apnoea and liver cancer, for which he underwent surgery in May 2023.[2] Robert's regular general practitioner, Dr Huy Ho, stated that Robert attended regular check-ups and was prescribed medication for his conditions, but was generally stable and the cancer was considered to be in remission.[3] Robert's cardiac health was managed from 2009 onwards by a cardiac specialist, Dr Swee Seow.[4]

4. Family described Robert as well-loved and respected wherever he went. From colleagues in the workplace to his friends and neighbours, he enriched the lives of those around him. He was an excellent cook, an avid gardener, and enjoyed keeping many pets.

THE CORONIAL INVESTIGATION

5. Robert'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.

6. 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

[1] Coronial Brief, statement of Kim Truong, p.13.
[2] Coronial Brief, statement of Kim Truong, p.14.
[3] Coronial Brief, statement of Dr Huy Ho, p.36.
[4] Coronial Brief, statement of Dr Swee Seow, p.38.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. 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.

8. Victoria Police assigned Senior Constable Reilly Shaw to be the Coroner's Investigator for the investigation of Robert's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Robert Thoai Dao 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.[5]

10. In considering the issues associated with this finding, I have been mindful of Robert's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

11. On 7 May 2023 at approximately 10:30 am, Robert and Kim attended their local McDonald's in St Albans to have breakfast. They ordered coffees and shared a breakfast McMuffin. The couple went to leave the restaurant at around 11:30 am, and Robert held the door open for Kim, who noticed it had been raining. As Robert began to walk out of the restaurant, he slipped on the wet external tiles and fell heavily, flat onto his back, also striking his head.[6]

[5] 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.

[6] Coronial Brief, Exhibit 3, CCTV footage No.2.

12. CCTV footage captured the incident. A small yellow sign that appears to be a slip hazard warning is depicted in the footage, lying flat on the anti-slip area where Robert lost his footing. It is not known why the sign was lying flat, instead of being positioned upright, but from its position it appears possible that it had been knocked over by the inclement weather or passing pedestrians.[7]

13. Upon falling, Robert moaned and appeared to be in pain, and told Kim he was unable to roll onto his side because his body was numb. Bystanders from inside the restaurant came to assist and Robert was helped to sit up. After a short time, the CCTV shows him looking unsteady while sitting, and he returns to a supine position on the ground.[8] A McDonald's staff member called for an ambulance.

14. At approximately 11:52 am, Ambulance Victoria paramedics arrived and Robert initially reported right shoulder pain and numbness to his hands.[9] The CCTV footage shows Robert being lifted by the shoulders and supported by a paramedic to sit up while the initial assessment occurs, then being lifted under the arms by the paramedics to a crouching stand, before collapsing front-forward across the stretcher, and finally having his legs lifted onto the stretcher and being manoeuvred into a straighter supine position.[10] Once loaded into the ambulance, Robert complained of midline neck pain and loss of sensation and movement in his lower limbs, with weakness in his upper limbs, with progression to complete loss of movement in his left arm.[11] A cervical spine collar was recorded as placed at 12:17pm.[12] On further assessment, Robert presented in an altered conscious state and was bradycardic and hypotensive.[13] He was conveyed to the Royal Melbourne Hospital Emergency Department, arriving at 12:50 pm.[14]

15. On arrival at the Royal Melbourne Hospital (**RMH**), Robert was assessed as awake and alert (GCS 15), with significant weakness in all four limbs and hypotension. A full body computed tomography (**CT**) scan was performed and showed a widened disc space at C4/C5, with an impression of a large central disc protrusion and an unstable 'chalk stick' fracture at T6/T7. The CT showed no evidence of intracranial trauma.[15] Robert was intubated and a full spine

[7] Coronial Brief, Exhibit 2, CCTV footage No. 1.
[8] Coronial Brief, Exhibit 3, CCTV footage No.2.
[9] Coronial Brief, statement of Courtney Gatt, p.23.
[10] Coronial Brief, Exhibit 2, CCTV footage No. 1. See also statement of Kim Truong, p.15.
[11] Coronial Brief, statement of Courtney Gatt, p.23.
[12] Coronial Brief, statement of Dr Chinh Dam Nguyen, p.31.
[13] Coronial Brief, statement of Courtney Gatt, p.23.
[14] Coronial Brief, statement of Kim Truong, p.15.
[15] Coronial Brief, statement of Dr Chinh Dam Nguyen, p.32.

MRI performed. RMH clinicians diagnosed Robert with *'[cervical] spine and [thoracic] spine fractures and neurogenic shock after a reported fall from standing height, requiring urgent operative management at the Austin Hospital*.'[16]

16. At approximately 2:30am on 8 May 2023, Robert was transferred to the Austin Hospital for surgery, which was performed the same day.[17] Following surgery, Robert was admitted to the Intensive Care Unit and remained sedated and intubated. He continued to require vasoactive medication to support his blood pressure and developed ventilator associated pneumonia. Sadly, his condition continued to deteriorate despite intensive medical management.

17. In the period 15 to 22 May 2023, the Austin Health treating team met with Robert's family several times to discuss Robert's condition and care goals. By 22 May 2023, the treating team considered that further medical intervention would be futile and unable to achieve a quality of life consistent with Robert's wishes.

18. On 25 May 2023, following end of life care discussions with Robert's family, he was extubated and transitioned to comfort care. He passed away a short time later with his loved ones by his side.

Identity of the deceased, pursuant to section 67(1)(a) of the Act

19. On 25 May 2023, Robert Thoai Dao, born 9 December 1949, was visually identified by his stepdaughter, Jacqueline Duong.

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

Medical cause of death

21. Specialist Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 26 May 2023 and provided a written report of his findings dated 26 May 2023.

22. The findings at post-mortem computed tomography (**CT**) scan included:

    a) cervical spine injury, with absent C4 vertebral body and osteosynthesis;

    b) ossification of the occipital region of the skull;

[16] Ibid.
[17] Coronial Brief, statement of Dr Chinh Dam Nguyen, p.34.

c) no skull fracture;

d) ascites;[18]

e) surgical clips of the posterior aspect of the liver;

f) coronary artery calcifications;

g) consolidation of the lower lobe of the right lung;[19]

h) increased bilateral lung markings;[20] and

i) bilateral pleural effusions.[21]

23. The findings upon post-mortem external examination were consistent with the circumstances and clinical history described above.

24. Having regard to these findings, Dr de Boer provided an opinion that the medical cause of death was 1(a) complications of cervical fractures and spinal injury (operated), sustained in a fall and I accept Dr de Boer's opinion.

CORONERS PREVENTION UNIT –HEALTH AND MEDICAL REVIEW

25. After careful review of the available evidence and the CCTV footage obtained from St Albans McDonalds, I directed independent practitioners in the Health and Medical Team of the Coroners Prevention Unit (**CPU**)[22] to review the proximate Ambulance paramedic treatment provided to Robert in the circumstances of this case.

26. To gain a fuller picture of the care and treatment provided to Robert, I directed that further information be obtained from Ambulance Victoria and the attending paramedics. The Court subsequently received the following materials from Ambulance Victoria:

[18] Fluid collection in spaces within the abdomen.
[19] A condition where the air in the small airways of the lungs is replaced with a fluid, solid, or other material, caused by conditions like aspiration, pneumonia, and lung cancer.
[20] Increased or prominent bronchovascular markings indicate that the vessels of the lungs are filled with fluids.
[21] The build-up of too much fluid between the layers of pleura around the lungs, commonly caused by heart failure.
[22] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

a) a statement from Mr Stuart Reid, Acting Director of Patient Safety and Experience dated 25 February 2025;

b) Ambulance Victoria In-depth Case Review Report dated 24 November 2024; and

c) Ambulance Victoria Clinical Practice Guidelines/Standards for Spinal Injury SPG, Patient Assessment Standards and Clinical Approach CPG.

Ambulance Victoria In-depth Case Review

27. The In-depth case review identified several '*contributing factors'* which affected the outcome of the services rendered by attending paramedics to Robert on 7 May 2023. These factors included:

a) A misunderstanding by the attending paramedics that Robert's experienced a simple fall instead of a potential trauma. The CPU commented that available Ambulance Victoria case sheet however documents that the case was referred to the paramedics as "*Falls: possibly dangerous body area (Public Place).*"[23] It is unclear from the review how the misunderstanding that this was a simple fall instead of a potential trauma occurred;

b) The '*CPG A0101 Clinical Approach'* guideline was not followed, "*the attending crew did not assess, gain a medical history or complete mechanism of injury, assess, consider risks and patient safety, consider differential diagnosis, plan, implement or reassess. This approach ensures all patients receive a structured and comprehensive assessment of their health status that leads to their health care needs being addressed.*"[24] The guideline represents the minimum standards of assessment that paramedics are expected to follow.

c) The '*CPG A0805 Spinal Injury'* guideline was not followed, the attending paramedics did not follow this guideline until Robert was moved into the ambulance. The review note that, '*Self-extrication*[25] *attempted despite patient unable to remain sitting without physical support. Neurological exam checklist that identifies signs and symptoms consistent with acute spinal cord injury and supports decision making at point of care*

[23] *Coronial Brief*, Statement of Courtney Gatt.
[24] Ambulance Victoria In-depth Case Review dated 24 November 2024.
[25] In this context 'self-extrication' means that the patient was requested/expected to move or to assist with the move from ground to trolley.

not applied as the minimum standard of neurological assessment required for spinal clearance prior to extrication…Extrication commenced prior to initial assessment…The guideline supporting spinal cord clearance is detailed and a checklist exists to support point of care decision making, however inadequate knowledge, exposure, and recognition of mechanism of injury in elderly patient led to movement of the patient prior to complete assessment".[26]

d) A lack of teamwork was noted a contributing factor as '*shared care decision making did not occur'*. The lead paramedic appeared to be distracted by Kim answering questions and did not complete his assessment. The second paramedic in attendance was excluded from the assessment process because the lead paramedic spoke in Vietnamese with Kim despite both Kim and Robert understanding English as a second language.

e) The lack of complete assessment meant that critical patient medical history was missed given that Robert had an extensive history of cardiac disease, cancer, diabetes, hypertension and high cholesterol. The review noted that "*these pre-existing illnesses increase the risk of occult injury in patients >65 years of age".*[27]

f) Another contributing factor identified in the review was cognitive bias of attending paramedics and their premature diagnostic closure arising from the description of the injury as 'slipped over' leading to a perception of low risk for serious injury and Robert appearing to be well on arrival. This is despite the case being given as "*Falls: possibly dangerous body area*".[28]

Review of Mr Reid's statement

28. Mr Reid, the Acting Director of Patient Safety and Experience from Ambulance Victoria provided a statement to the Court outlining a response to questions about the care and treatment provided to Robert by attending paramedics on 7 May 2023. Mr Reid confirmed the following:

[26] Ambulance Victoria In-depth Case Review dated 24 November 2024.
[27] Ibid.
[28] *Coronial Brief*, Statement of Courtney Gatt.

a) that the attending paramedics treated the incident as a '*slip and fall'* and conceded that the initial assessment of Robert prior to extrication was brief and incomplete including the assessment of his neck at the time of their initial attendance;

b) a neurological examination was not performed to ascertain whether Mr Dao had any weakness or reduced sensation in his legs or arms prior to extrication;

c) there was no shared care decision making as the second paramedic was not present for the initial assessment and the treatment options available were not discussed and explained to Robert and his wife; and

d) a safe and effective care plan for Robert was not formulated and agreed before the extrication and informed consent was not obtained from Robert.

29. Mr Reid noted that the contributing factors to the incomplete assessment done by the attending paramedics were that it had started to rain which in turn influenced the paramedic's decision to move Robert to the ambulance in the interests of providing comfort and privacy. There were also cars lined up behind the ambulance waiting to get through which contributed to the paramedics feeling pressured to move the ambulance out of the way.

30. Paramedics would generally have priority assigned to their vehicles at emergency scenes and would be accustomed to their vehicles causing traffic disruption. It is concerning that a mere queue of cars outside McDonald's is reported to have caused them 'to feel pressured' to such a point where they neglected to follow basic guidelines.

31. Whilst the attending paramedics concern for patient comfort (rain) is admirable, one would reasonably anticipate that experienced paramedics would be accustomed to adverse weather and alternatives to hastily moving the patient, such as continuing to use umbrellas and a '*space blanket'* to shelter Robert, (as bystanders had already done and were present at the time of paramedics arrival) as actions that could have been taken within the scope of their training and decision making.

CPU Conclusion

32. The CPU formed the view that whilst the attending paramedics mishandling of Robert contributed to the worsening of his injuries, it was unclear whether the failure to suspect a spinal injury would have altered the outcome in an elderly person with Robert's other co-morbidities. The CPU noted that the practice adopted by the attending paramedics is

concerning given the potential to cause disability or death in a person who might not otherwise experience these outcomes if spinal care to the expected standard was applied in the first instance.

33. CPU further expressed their views that it was disappointing that an experienced paramedic failed to exercise the bare minimum and essential care standards which are incorporated in the spinal injury clinical guidelines designed to protect patients with potential spinal injuries.

34. Although the In-depth Case Review concluded that the care provided to Robert was deficient and not compliant with Ambulance Victoria clinical guidelines, there were no specific learnings and systems recommendations arising from the review.

35. The CPU confirmed that Ambulance Victoria has detailed written protocols in place with a view to providing optimal patient care and every Ambulance Victoria paramedic has access to these written protocols and has participated in continuing education to reinforce the standard to meet the best care framework. The written guideline supporting spinal cord clearance has a checklist to support point of care decision making and there is also a neurological examination checklist that identifies signs and symptoms consistent with acute spinal cord injury and supports decision making at point of care.

36. The CPU noted concerns that the review did not identify any need to update the written protocols and checklists that should have been applied in the care of Robert noting that both paramedics were interviewed during the review and self-reflected on this case and the omissions that occurred.

37. I agree with the concerns and advice expressed by the CPU and intend to refer the relevant paramedics to the Paramedicine Board of Australia and the Australian Health Practitioner Regulation Agency (**AHPRA**) for their consideration of these circumstances.

FINDINGS AND CONCLUSION

38. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[29] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made

[29] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

39. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

    a) the identity of the deceased was Robert Thoai Dao, born 9 December 1949;

    b) the death occurred on 25 May 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084, from complications of cervical fractures and spinal injury (operated), sustained in a fall; and

    c) the death occurred in the circumstances described above.

40. Having considered the circumstances, I am satisfied that Robert's death occurred in the circumstances so described. I find that the actions and decision making of attending paramedics fell short of the expected standards of care that ought to have been provided in the circumstances of this case and in consideration of Ambulance Victoria's own practice standards and guidelines.

41. That being said, I cannot be satisfied to the same standard that these shortfalls independently caused Robert's death, given his age and other comorbidities.

42. I will refer this case to the Paramedicine Board of Australia and the Australian Health Practitioner Regulation Agency (**AHPRA**) for their consideration and review.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I convey my sincere condolences to Robert's family for their loss.

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

Thi Kim Chi Truong, Senior Next of Kin

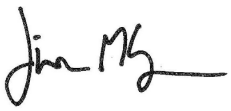
Noemi Baquing, Austin Health

Andrew Mariadason, Royal Melbourne Hospital

Stuart Reid, Ambulance Victoria

Senior Constable Reilly Shaw, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 30 September 2025

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.