IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 1477**

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Inquest into the death of WAYNE MYHILL

Delivered On:	3 FEBRUARY 2022
Hearing date:	8 NOVEMBER 2021
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK, VICTORIA
Findings of:	CORONER PHILLIP BYRNE
Date of death:	BETWEEN 23 AND 24 MARCH 2019
Counsel Assisting the Coroner:	MS RACHEL QUINN, CORONER'S SOLICITOR

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

I, PHILLIP BYRNE, Coroner having investigated the death of WAYNE MYHILL

AND having held an inquest in relation to this death on 9 November 2021 at Southbank, in the State of Victoria:

find that the identity of the deceased was WAYNE MYHILL

born on 13 October 1964

and the death occurred between 23 and 24 March 2019

at 4 Alexandra Avenue, Ararat, Victoria, 3377

from:

1 (a) NECK INJURIES SUSTAINED IN A FALL

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

Background

1. Wayne Myhill, aged 54 years at the time of his death, lived at 4 Alexandra Avenue, Ararat, Victoria where had he resided for 22 years. The home was a residential accommodation service managed by the Department of Families Fairness and Housing **(DFFH)**, formerly known as the Department of Health and Human Services **(DHHS)**.
2. On 23 June 2019, after Mr Myhill's death, the management of the residential accommodation service transferred from the department to Possability, a disability service provider.
3. Mr Myhill had a medical history of cerebral palsy, an intellectual disability in addition to Lennox Gastaut Syndrome, which resulted in epilepsy. Mr Myhill's epilepsy was managed by Neurologist Dr Thomas Kraemer, however Mr Myhill continued to experience regular seizures, often resulting in falls. Mr Myhill was also under the care of a dietician, occupational therapist, exercise physiologist and saw his general practitioner regularly.

4. In 2001, Mr Myhill had surgery to fuse vertebrae in his neck. This prevented him from moving his head backwards. From 2001, Mr Myhill experienced multiple fractures, including fractured vertebrae in 2018.

5. The facility had a care plan in place to assist Mr Myhill, which included strategies to minimise the risk of falls. Mr Myhill also wore a protective soft padded helmet, including if he rose during the night to use the toilet.

6. At the time of his death, Mr Myhill was under the care of the Secretary of the department.

BROAD CIRCUMSTANCES SURROUNDING DEATH

7. According to staff at 4 Alexander Avenue, Mr Myhill was assisted to bed each evening between 8 and 9pm. Staff would then check Mr Myhill around 10.30pm and again the following morning around 6.30am.

8. On the evening of 23 March 2019, disability support officer, Samantha Schwab assisted Mr Myhill to bed. She states that she ensured Mr Myhill was in the middle of the bed. She returned to check on him around 10.30pm and observed Mr Myhill apparently sleeping.

9. Ms Schwab states that at 11.19pm she was woken by another resident who informed her that Mr Myhill had fallen in the bathroom. Ms Schwab attended the bathroom where she found Mr Myhill lying on the floor. He was conscious and requested that she get a chair to help him up.

10. Ms Schwab states that whilst assisting Mr Myhill to stand she saw his face turning blue and that he appeared to be experiencing respiratory distress. Ms Schwab ran to the kitchen and contacted emergency services before returning to the bathroom to attend to Mr Myhill.

11. Upon Ms Schwab's return Mr Myhill had stopped breathing. Ms Schwab commenced cardiopulmonary resuscitation until the arrival of Ambulance Victoria paramedics.

12. Mr Myhill was unable to be revived and was declared deceased at the scene.

REPORT TO THE CORONER

13. The matter was appropriately reported to the Coroner. Having regard to the circumstances, and having conferred with a forensic pathologist, I directed an autopsy and routine toxicological testing. An autopsy was performed by Dr Melanie Archer, Forensic Pathologist, at the Victorian Institute of Forensic Medicine.

14. Dr Archer advised that the immediate cause of Mr Myhill's death was:

    I (a) Neck injuries sustained in a fall

15. Dr Archer confirmed that the cause of Mr Myhill's death was a fracture of the neck (at the level of the 5th cervical vertebra), occurring after a fall. This type of fracture is commonly known as a 'carrot stick' or a 'chalk stick fracture'. Dr Archer advised that Mr Myhill had partial fusion of the vertebrae (spinal bones) of his neck, known as 'ankylosis'. This is a well-known risk of this type of fracture, and can occur with relatively minor trauma, including falls. Dr Archer advised that the fused spinal column loses its flexibility and can act as a lever, especially in backwards motion of the head.

16. Dr Archer opined that the ankylosis of Mr Myhill's neck was noted in an antemortem radiology report included in Mr Myhill's medical history. Dr Archer commented that ankylosing spondylitis, the condition classically associated with carrot stick fractures, was a possible cause.

17. Dr Archer did not observe any spinal cord damage underlying the fracture. However, she advised that the presence of an extradural spinal cord haematoma is likely to have induced spinal cord compression and may therefore have been the mechanism of Mr Myhill's respiratory compromise. Additional complications of carrot stick fractures include the potential for airways compression due to retropharyngeal haemorrhage, bleeding into the soft tissues behind the 'windpipe').

18. Toxicological analysis of post-mortem specimens detected the antiepileptic drugs lamotrigine, levetiracetam, and valproic acid. There was also detection of a metabolite of clonazepam, a hypnotic sedative drug, paracetamol, an analgesic, and doxylamine, an antihistamine, all within levels of therapeutic use.

FURTHER INVESTIGATION

19. I directed a Coronial Brief of Evidence be prepared. Subsequently, a brief was submitted by First Constable Steven Carrigg on 8 January 2020. The brief comprised of statements from Mr Myhill's General Practitioner Dr Chee Sheng Wong, Mr Myhill's cousin Wayne Ramsay, Ms Schwab, Ms Kylie Wilson, House Supervisor at 4 Alexander Avenue, as well as a statement from First Constable Carrigg, in addition to photographs taken at the scene.

20. For the purposes of my coronial investigation Mr Myhill "was a person placed in custody or care" within the definition of the *Coroners Act 2008* and the death was not due to natural causes. Therefore, I was required to hold an inquest in relation to Mr Myhill's death.

21. Having regard to the circumstances of the matter, I was advised that the Disability Services Commissioner **(the Commissioner)** were investigating the disability services provided to Mr Myhill by the department. In order to avoid unnecessary duplication of inquiries and

investigations as outlined in section 7 of the *Coroners Act 2008* from January 2020 I left my investigation in abeyance until the completion of the Commissioner's concurrent investigation.

22. In October 2020 the Court was provided with a copy of the Commissioner's investigation report dated 8 October 2020 outlining the Commissioner's findings and the Commissioner's intention to issue a Notice to Take Action plan **(NTTA)** to the department.

23. The Commissioner made a number of findings in the report against the department, including that "*DHHS group home staff failed to implement appropriate risk management strategies to mitigate Mr Myhill's falls risk when he got out of bed at night*".

24. The Commissioner's report outlined that:

    …from mid-February to mid-March 2019, Mr Myhill's seizures appeared to increase and he could not sleep, frequently got up from his bed, appeared confused and was thought to be in pain.

    For example, Mr Myhill was out of bed ten times on the night of 28 February 2019 and nine times on the night of 1 March 2019 and appeared uncomfortable while in bed. Wakefulness throughout the night continued until mid-March 2019.

25. The Commissioner considered that due to "*Mr Myhill's changed behaviour at night during this time, he should have had additional supports in place.*" The Commissioner further noted in the report that, "*Consideration should have been given to implementing risk management strategies such as increased staff support at night and/or an alarm/sensor mat that could have alerted staff to when Mr Myhill was awake and out of bed so assistance could be provided*."

26. In January 2021, at my request, my then coroner's solicitor wrote to the department, advising that it was my tentative view to adopt the conclusions reached by the Commissioner that the department's group home staff failed to implement appropriate risk management strategies to mitigate Mr Myhill's falls risk when he got out of bed at night. My coroner's solicitor also advised that it was my intention to finalise the coronial investigation by way of a summary inquest and enquired whether the department sought to challenge or resist the conclusions reached by the Commissioner in relation to this issue.

27. In February 2021, I received a response penned by Ms Carley Northcott, Director, National Disability Insurance Scheme (NDIS) Service Delivery, Community Services Operation Division. Ms Northcott advised that the department was not seeking to challenge or resist the conclusions reached by the Commissioner.

28. In her response, Ms Northcott outlined that,

> *the department has been aware of the importance of falls prevention in disability group homes and in response to a recommendation from the Commissioner, the department developed and distributed falls prevention advise to disability services in February 2020. This was by partnering with Monash University.*
>
> *The practice guidelines and resources were designed to reduce falls risks in residential group homes and have been implemented by the transfer providers (including Possability).*

29. Ms Northcott provided me with a copy of the falls prevention resources and advised that the department is in the process of publishing the resources on its website.

30. Ms Northcott further outlined that the department had accepted the Commissioner's findings and NTTA of the draft and final investigation report. She advised that the department was working closely with Possibility to implement the Commissioner's NTTA, which included a specialist's review of resident's care and health management and staff training.

31. I recognise the changes implemented by the department to minimise falls risks in disability group houses and the department's continued work with the new service providers, including Possability in response to the Commissioner's NTTA.

32. I am satisfied, having considered all of the evidence before me, that no further investigation is required.

Finding

33. I find that Wayne Myhill died between 23 and 24 March 2019 at 4 Alexandra Avenue, Ararat, Victoria as the result of neck injuries sustained in a fall.

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

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

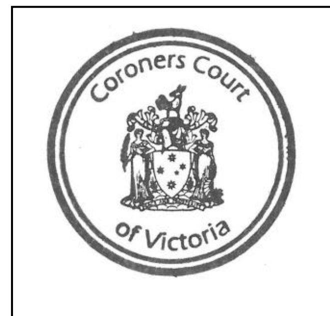
    Mr Kevin Ramsay, Senior Next of Kin;

    Disability Services Commissioner;

    Ms Carley Northcott, Department of Families, Fairness and Housing; and

    First Constable Steven Carrigg, Coroner's Investigator, Victoria Police.

Signature:



PHILLIP BYRNE
CORONER

Date: 03 February 2022