IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012 / 2435

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Daniel Tyson Pelka

Delivered On:	2 October 2013
Delivered At:	Coroners Court, Melbourne
Hearing Dates:	18 September 2013
Findings of:	Peter White
Representation:	Ms Rhiannon Pelka for the Pelka family Mr Michael Regos of DLA Piper for Connecting Skills Australia
Police Coronial Support Unit	Senior Constable Ross Trevaton

I, Peter White, Coroner having investigated the death of Daniel Tyson Pelka

AND having held an inquest in relation to this death on 18 September 2013
at Melbourne Coroners Court
find that the identity of the deceased was Daniel Tyson Pelka
born on 10 February 1993
and the death occurred on 25 June 2012
at Frankston hospital Emergency Department, Frankston, Victoria
from:

1 (a) aspiration of latex glove
1 (b) intellectual disability

in the following circumstances:

1. Daniel Pelka (herein referred to as Daniel) was the much loved 19 year old son of Werner Pelka and Tracy Kenyon and brother of Rhiannon Pelka. Daniel suffered from severe mental and physical development delay since birth. He lived with his father and during the day had attended Kankama Association Incorporated[1] (Kankama) in Mornington since January 2012. Kankama has since been amalgamated with Connecting Skills Australia.

2. Daniel's severe intellectual and physical impairment caused him to be short in stature, unable to speak and require full time care. It also rendered him prone to placing objects in his mouth. Daniel's Client Support Needs Level at Kankama was assessed as level 5 which indicated that a high level of support was required.[2]

3. On 25 June 2012, Daniel was in the activity room known as the Vegas Room. In the afternoon, Daniel was in the Vegas Room with about nine other clients and staff members Lauren Andrew and Christian Fennell. Another staff member, Susan Coyle was working out of the centre on a community program. Mr Fennell did a clean up of the Vegas room at about 1.45pm and recorded in his statement that there was nothing on the ground.

4. Notes prepared after the incident by Ms Andrew and Mr Fennell[3] indicate that at about 2.10pm, Ms Andrew and Mr Fennell started to change clients in the bathroom connected to

[1] Kankama Association Incorporated is a day care centre for adults with disabilities.

[2] The Department of Human Services (DHS) support level needs range from level 1 to level 5.5. Level 5.5 is the highest level of support. If a client requires one on one support, an application must be made to DHS for separate funding.

[3] See page 42 to 44 of the inquest brief

the Vegas room. They left the sliding bathroom door open in order to keep an eye on the other clients, in particular one patient who had a fall that afternoon. At about 2.20pm, Mr Fennell had to shuffle Daniel who was sitting in the middle of the room out of the way in order to get other patients past and into the bathroom. Ms Coyle returned to Kankama at approximately 2.40pm with a client who needed to use the bathroom. The bathroom was occupied so she went outside the Vegas room to wait.

5. At about 2.45pm, Daniel was seen lying on the floor of the activity room, which on the evidence was his normal behaviour when he was tired. Ms Andrew went to check on Daniel and found him lying on the ground on his stomach in front of the kitchenette, blue in the face. Ms Andrew has called for Mr Fennell and Ms Coyle to help and informed Lee Ann Rake, the manager of Kankama. Ms Coyle commenced CPR and checked Daniel's airways but found no obstruction.

6. Staff members Jade Meadows and Rebecca McKay attended the Top room and assisted Ms Coyle in performing CPR. Ms Coyle was having difficulty performing CPR as the air did not seem to be flowing into Daniel's lungs. Daniel was placed on his side and Ms Coyle applied a few strong blows to his back to attempt to dislodge anything stuck in his airway. Ms Coyle then found a white latex glove in his mouth that had been stuck in his airway. They continued CPR.

7. An ambulance and a MICA unit attended and took over Daniel's treatment. He was taken to the Frankston Hospital Emergency Department however staff at the hospital were unable to resuscitate him.

COMMENTS

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

8. At the inquest I heard evidence from Ms Coyle, Disability Support Worker and Ms Lee Ann Rake, Client Services Manager at Kankama. Both witnesses outlined changes that have been made at Kanama since Daniel's death. I also heard from Ms Mary Murphy of Connecting Skills Australia.

Staff ratios

9. As at 25 June 2012, Ms Rake has undergone an assessment of staff ratio needs and concluded that more staff were needed to properly care for their clients, in particular when high needs clients required two staff members to change them. Ms Rake had brought this issue to the attention of management.

10. I am satisfied that people within the Kankama organisation recognised that staff shortage was an issue at the time of Daniel's death.

Knowledge of Daniel's condition

11. Although Ms Rake gave evidence that communication between staff relating to client's needs was not optimal, I am satisfied that staff at Kankama were aware of Daniel's condition and his propensity to place things in his mouth.[4] The initial assessment of Daniel for his suitability to attend Kankama was performed by Tania Bernado, and notes the issues Daniel had with placing things in his mouth.[5] Mr Fennell states that he was aware of this in cleaning up the room.[6]

12. I am also satisfied that Daniel's condition meant he needed almost full time supervision as his propensity to place things in his mouth placed him at risk of choking.

13. The gloves were located in the bathroom adjoining the Vegas room and in the kitchenette in a high cupboard. Once used the gloves were placed in to bins in the bathroom.[7] The bins were not secure.[8] Mr Fennell and Ms Andrew's notes from the day suggest that the cleaner came to the Vegas room at about 2.20pm.[9] Ms Andrew told him that they were not ready for him to empty the bins yet as they had not finished changing all of the clients. Ms Andrews then observed the cleaner empty a bin in the Vegas room that was approximately two to three meters away from where Daniel was found.[10]

14. I am satisfied that at the time, there was insufficient risk management in relation to securing objects that could potentially be a choking hazard. I am satisfied that in those circumstances,

---

[4] Exhibit 2, Statement of Lee Ann Rake, p19 of inquest brief

[5] Tania Bernardo's notes of assessment, p 47 of inquest brief

[6] Statement of Christian Raymond Fennell, p11 of inquest brief

[7] Ibid.

[8] Ibid.

[9] See page 42 to 44 of the inquest brief

[10] Ibid

Daniel was able to access a latex glove that he ultimately swallowed and caused his death. I find that insufficient care was taken to ensure the glove was not available for Daniel to put in his mouth.

Actions taken after Daniel's death

15. At the inquest I heard evidence about changes that have taken place since Daniel's death. These changes include:

    a. Placing the latex gloves in locked cupboards and proving staff with a 'bumbag' containing a few gloves for their needs.

    b. All staff are now required to have level 2 first aid training.

    c. Secure bins for the disposal of gloves and other potential choking hazards.

    d. Increase in the staff to client ratio, depending on the clients' needs.

    e. The facility is now cleaned outside of business hours to ensure that clients do not have access to cleaning products and chemicals.

16. I am satisfied that Kankama (and later Connecting Skills Australia) recognised the shortcomings in the facility that existed as at 25 June 2012 and have taken steps to rectify these issues.

17. I note that the facility does not have a defibrillator machine due to the cost involved. Ms Coyle in her evidence suggested that this would be a useful addition to the safety measures in place at the facility.

18. I also note that the staff at Kankama were very fond of Daniel and describe him as being a sweetie and were obviously distressed by the loss of Daniel.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

19. **Recommendation 1**: That Connecting Skills Australia undertake an independent risk analysis of the premises by a qualified risk assessor in order to seek to identify hazards to clients at the facility and in particular programs.

20. **Recommendation 2**: That Connecting Skills Australia revisit the option of placing a defibrillator machine at the facility.

21. **Recommendation 3**: That Connecting Skills Australia revisit the option of applying for one on one funding from the Department of Human Services for clients with similar to those exhibited by Daniel.

I direct that a copy of this finding be provided to the following:
Mr Werner Pelka and Ms Tracy Kenyon, senior next of kin
Connecting Skills Australia
Detective Senior Constable W H Simpson, investigating member

Signature:

Peter White
Date: **2 October 2013**