IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012 / 3727

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Darren Hannah

Delivered On:	7 October 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date:	7 October 2014
Findings of:	Caitlin English, Coroner
Representation:	
Police Coronial Support Unit:	Leading Senior Constable Stuart Hastings

I, Caitlin English , Coroner, having investigated the death of Darren Hannah

AND having held an inquest in relation to this death on 7 October 2014
at Melbourne
find that the identity of the deceased was Darren Carr Hannah
born on 18 June 1971
and the death occurred on 6 September 2012
at 8 Scartree Court, Bundoora
from:

1 (a) UPPER AIRWAY OBSTRUCTION
1 (b) INGESTION OF DIRT IN AN INTELLECTUALLY IMPAIRED MAN

in the following circumstances:

Introduction

1. Darren Hannah was 41 years old when he died. Mr Hannah had an intellectual disability, mild autism and was partially blind. At the time of his death he was residing at Plenty Residential Service, 8 Scartree Court, Bundoora. Plenty Residential Service (PRS) was managed by Disability Accommodation Services, Department of Human Services (DHS).
2. Due to Mr Hannah residing at premises managed by the Department of Human Services, he is a person 'in care' pursuant to s 3 *Coroners Act* 2008. As such, his death is a reportable death to the coroner (s 11 *Coroners Act*). Further, his 'in care' status mandates the coroner to hold an inquest into his death (s 52 (2)(b) *Coroners Act*).

Background

3. Mr Hannah was the first child of Lorraine and Kevin Hannah, born on 18 June 1971. His mother described him as a beautiful baby who had no problems at birth. Mr Hannah had one younger sibling, a brother Craig.
4. As a baby, Mr Hannah reached milestones such as sitting up and crawling and saying 'dad, mum' at the appropriate stages. He developed normally up until about the age of 15 months. His demeanour then began to change considerably and his developmental progress slowed. He began to exhibit symptoms of what was ultimately diagnosed as autism.

5. As he grew older he engaged in self-harm, such as slapping and pinching himself, as well as head banging.

6. His parents sent him to day care for handicapped children. After three years, staff had difficulties coping with his behaviour.

Disability services

7. As a child, Mr Hannah became too strong for his mother to handle and he had periods of both high spirits and self injurious behaviour. At about the age of seven, he was accepted into Janefield Training Centre in Plenty Road, Bundoora. His mother stayed with him during a planned admission for the first four months.

8. He was accepted as a permanent resident at Janefield, which later changed its name to Plenty Residential Services (PRS).

9. His condition continued to deteriorate regardless of attempts by doctors, psychiatrists and staff to control his condition with medications and programs.

10. Mr Hannah was non verbal. His father stated he only ever uttered a couple of words during his lifetime.

11. Mr Hannah continued to be self injurious in that he would hit himself in the face and bang his head. He pinched himself, and he became legally blind after damaging his retinas from banging his head.

12. From the age of two, Mr Hannah was prone to ingesting any substance he found on the ground, such as dirt and dog faeces. He would also eat sticks and stones if they were in the dirt. His father referred to him requiring '*constant attention whenever he was in the backyard or other open area.*'

Mr Hannah's health

13. Mr Hannah was treated by General Practitioner, Dr Usha Venkataraman, who had treated him since 2003. He would see Mr Hannah once or twice a month for regular check ups.

14. He described Mr Hannah:

Mr Hannah suffered from severe intellectual disability and loss of vision in both eyes due to self inflicted injury since young. He had been under the care of Department of Human Services since young due to his severe intellectual disability. He was constantly agitated, whining constantly. He had very limited communication skill. He would strip his clothes,

would do rectal digging. He would try to run in the garden with every opportunity he got to eat the grass and soil. '

15. Dr Venkataraman prescribed medication to control his mood and to reduce his agitation and anxiety. He referred to Mr Hannah's behaviour as requiring constant supervision by staff.

16. At the time of his death, Mr Hannah's medications included diazepam, chloropromazine hydrochloride, clonazepan and lithium. These medications were designed to reduce and stabilise his agitation, and minimise his self harm.

17. Mr Hannah was also under the care of psychiatrist, Dr Rakesh Khanna. Dr Khanna treated Mr Hannah from October 2007. He stated:

    '*Darren had been under the care of other Psychiatrists in the past and had trials of different medications. Dr Usha Venkataraman...was the primary medical contact for him. He was assessed by the Centre of Developmental Disability Health Victoria in October 2004, who had endorsed the treatment plan. He had been under the care of the BIST*[1] *team who had implemented protective helmets, arm braces, shoes laced up to the ankle.*'

18. In respect of Mr Hannah's diagnosis, Dr Khanna stated he '*showed features suggestive of autistic disorder and possible psychosis. He has been treated with many psychotropic medications over the years. Without treatement he posed a significant risk to self and others.'*

19. Dr Khanna tried a few changes to Mr Hannah's medication, which included the introduction of Lithium Carbonate. He last saw Mr Hannah on 30 April 2012 and stated Mr Hannah *'remained difficult to manage but was largely stable in his instability.'* He recommended the same treatment regime under the supervision of Dr Venkataraman.

20. Mr Hannah's behaviour of eating inedible objects was diagnosed as Pica. This was a long-standing behavioural problem for him. Pica is characterised as an appetite for eating non edible substances. For the behaviour to be considered as pica, it must persist for longer than one month and the person must be at an age where eating such objects is developmentally inappropriate.

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[1] Behaviour Intervention Support Team

Living arrangements

21. Mr Hannah resided at a group home at Scartree Court with four other adults which was managed by the DHS.

22. Mr Hannah had a Behaviour Support Plan (BSP) which was reviewed annually and provided staff with strategies to help support him.

23. The house he lived at had 24 hour staff support with three staff rostered on at peak times during the day and an 'active' night, which means a staff member is awake during the night. Two staff were rostered on during the day and one staff member was active at night.

24. Mr Hannah was described as not interacting much with his co-residents. He did not attend a formal day based placement, save for three hours on a Tuesday at ACES Northern Outreach Program. Although he did not communicate verbally he was described as having well developed receptive skills and could communicate through his behaviour to staff who worked with him and knew him well.

25. The residents at Scartree Court each had their own room but shared the toilet, bathroom, lounge and kitchen areas.

26. Staff would help Mr Hannah with tasks such as taking medications, grooming, health care planning, eating and also support his community participation by escorting him to public places. Mr Guanzon, a staff member [2] at Scartree Court stated he would accompany Mr Hannah swimming, an activity he enjoyed.

Events prior to Mr Hannah's death

27. On Tueday 6 September 2012, there were two staff on duty at Scartree Court, Mr Guanzon and Ms Em Tran. Mr Guanzon had worked there for approximately two years and Ms Tran for about three months.

28. That morning two of the residents had gone to a placement so there were three remaining, including Mr Hannah in the house.

29. Mr Guanzon described Mr Hannah's activities as follows:

'Darren was active the whole morning, his usual self, wandering around the house and into the yard...As always, Darren was restless, continually asking for drinks and stripping his clothes off frequently. I observed of the Pica disorder where he was eating dirt in the morning. I

[2] Mr Guanzon was employed by DHS as a Disability Direct Support officer.

redirected Darren from the rear yard to inside the house and away from the soil to clean his mouth with water.'

30. Mr Guanzon returned from taking another resident to the doctors at 12.15pm and Ms Tran left for her lunch at 12.20pm. When she returned at 1.25pm, Mr Guanzon left for his break as well as to attend a pharmacy to pick up medication for another resident. Mr Guanzon recalled Mr Hannah as *'...fine and still pacing in and out of the toilet and patio area when I left.'*

31. There is a protocol when one staff member leaves to tell the other staff member and acknowledge where each of the clients are.

32. Ms Tran states that after the 'hand over' Mr Guanzon went to lunch. She stated that at about 2.20pm, Mr Hannah urinated on the floor and she went to get a mop and bucket to clean it up. She stated: *'When I was mopping I saw Darren walk towards the music room, which is at the other end of the unit. I didn't see him come back through the dining area but I was in the laundry, so he may have done that without me noticing.'*

33. Mr Guanzon stated he returned from lunch at 2.20pm. Whilst tending to some paperwork he noticed how quiet the house was. He asked Ms Tran where Mr Hannah was and she stated possibly the music lounge at the rear of the house. When he could not find Mr Hannah he went to the backyard.

34. Mr Gaunzon stated:

'I found Darren in the patio area of the back yard in a sitting position on the floor leaning against the house wall with his head slumped to one side. I said, 'Darren, come on inside, let's have a drink' but there was no response. I called Em to come outside and have a look. When Darren did not respond to any verbal prompts, I came closer to him and shook his shoulders and noticed his colour was abnormal and he was cold to touch. Darren was not wearing a top at the time as he had taken it off. I alerted Em to press the duress alarm immediately and I went back inside to get a blanket. By instinct, I felt for his pulse in his neck and saw his mouth full of mud. Again I ran inside and took hand gloves and ran to Darren and put him in recovery position and started first aid by putting him on his side and started to clear his airway.

As I was clearing his airway, it was like clay that was coming out in clumps. It had been raining the night before, so the ground was wet and soft...Em was on the phone doing all the communications and I was yelling out to her what I was doing and observing Darren at

the time. A short time later Shamilla, the Deputy Unit Manager came running while ring[ing] 000.

...I was still taking out the mud/clay from Darren's mouth when all this was happening and he wasn't responding at all. The three of us attempted CPR on Darren without success.

The 000 operator told Shamilla [for] us to commence pulmonary compressions until the fire officers arrived but to stop the mouth to mouth. We continued with the compressions until the fire officers arrived and took over.

Ambulance and paramedic officers arrived shortly after.'

35. When Ambulance officers arrived they tried to ventilate Mr Hannah but were unsuccessful due to his airway being blocked. Mr Hannah was unconscious with no palpable carotid pulse.

'The patient's airway was full of mud and dirt and an attempt was made to clean out his airway by use of a laryngoscope and with Magill's forceps. This attempt proved ineffective...'

36. Resuscitation efforts were ceased due to a presenting rhythm of asystole. Mr Hannah was pronounced dead by ambulance officers at 3.20pm.

Post mortem investigation

37. Dr Michael Burke Forensic Pathologist from the Victorian Institute of Forensic Medicine performed a post mortem autopsy on Mr Hannah on 12 September 2012. He formulated the cause of cause. I accept his opinion.

38. The autopsy report states:

'The post mortem examination showed a large amount of dirt within the deceased's oropharynx and airway. This would be expected to lead to obstruction to air flow and a subsequent hypoxic cardiac arrest.'

Further investigation

39. The Coroner referred the circumstances of Mr Hannah's death to the Coroners Prevention Unit,[3] for advice as to the level of care and supervision provided to Mr Hannah around the time of his death.

40. The CPU review noted that the duress alarm activated by staff was a non-specific alarm that alerts management to the need for assistance. It was not until management arrived a few minutes later that emergency services were contacted. As this was a clear medical emergency, it is appropriate that emergency services be contacted as the priority.

41. CPU review identified two factors which appeared to contribute to Mr Hannah's death.

42. Firstly, Mr Hannah had a well known and documented habit of pica and he had easy access to dirt in the back yard of his house. In this instance, Mr Hannah accessed the back yard unbeknownst to staff giving him an opportunity to consume large quantities of dirt, sufficient to choke. Therefore, DHS could have taken steps to either restrict Mr Hannah's access to the back yard, or limited his access to the backyard to times when he was supervised. Alternatively, DHS could have identified and removed hazards in the back yard, such as dirt, to minimise the availability of inedible substances and choking hazards.

43. Secondly, in terms of staffing levels and supervision, Scarstreet Court had two staff rostered on during the day. However during lunch breaks only one staff member was present. On this occasion, Mr Guanzon was on lunch break and Mr Hannah accessed the back yard when Ms Tran was cleaning a hazard off the floor. This gave Mr Hannah the opportunity to remain in the backyard unsupervised and consume large quantities of dirt, sufficient to choke.

44. DHS conducted an internal incident report, completed by Acting Unit Manager Ms Donna Bailey and actioned by Ms Anne-Marie Halewood.

45. The Coroner has been advised that the internal practice review made a number of recommendations that have since been implemented at Scartree Court. They are as follows:

    - A pica awareness strategy regarding the potential consequences of pica behaviour;

[3] The Coroners Prevention Unit is a specialist service for Coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

- The review of behaviour support plans and residential health care plans of all residents with pica behaviour; and
- The review of the PRS duress alarm policy.

46. Mr Hannah's father described staff at Scartree Court as very caring and committed, and despite their efforts, Mr Hannah's behaviour never really improved.

47. It is clear that Mr Hannah had extremely high needs and an array of challenging behaviour. He required constant and vigilant supervision. The information of Mr Hannah's DHS file and his BSP indicates staff developed clear treatment and support plans, with regular reviews.

48. Mr Hannah's mother stated:

'I know Darren should have been supervised 24/7 but you can take your eyes off... I know it was a difficult situation for everyone involved.'

Finding

I find Mr Hannah died from upper airway obstruction in circumstances where he was intellectually disabled and ingested dirt.

In view of the internal practice review conducted by DHS after Mr Hannah's death and new practices implemented since, I am satisfied that sufficient measures have been taken to alert DHS staff to the dangers associated with residents who engage in pica behaviour and to implement strategies to minimise future risk.

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

Mr Kevin Hannah
Mrs Lorraine Hannah
Disability Accommodation Services Manager, Department of Human Services

Signature:

CAITLIN ENGLISH
CORONER
Date: 7 October 2014