IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4503

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PETER WHITE, Coroner having investigated the death of EMMERSON ELIZABETH BOYLE without holding an inquest:

find that the identity of the deceased was EMMERSON ELIZABETH BOYLE

born on 19 October 2010

and the death occurred on 2 September 2014

at 13 Wonga Place, Gowanbrae, Victoria

from:

1 (a) DROWNING

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

1. Emmerson Elizabeth Boyle was a three year old girl who lived with her parents and two older brothers in Gowanbrae, Victoria. Emmerson was described as a confident, healthy and happy three year old. She had no known medical conditions and had never attended hospital for any injury.
2. On 2 September 2014, Emmerson died after being found submerged in water in the bath at home. Despite extensive resuscitation attempts by an off duty fireman, a fire crew and paramedics, Emmerson was unable to be revived. Her death was reported to the Coroners Court of Victoria.
3. Forensic Pathologist Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine performed a post mortem medical examination. Dr Glengarry provided me with a report of her findings at autopsy. Examination of the brain showed a mild diffuse swelling, a non specific finding, and a small area of microdysgenis in the left hippocampus. There was a bruise under the scalp but no underlying skull or brain injury. Dr Glengarry speculated that it may have resulted from a fall in the bath or from a fall earlier in the day. In Dr Glengarry's opinion the cause of Emmerson's death was 1(a) drowning. I adopt Dr Glengarry's findings in relation to the medical cause of death.

4. I conducted an investigation into Emmerson's death. As part of my investigation, Detective Senior Constable Leah Bound provided me with a coronial brief of evidence. The brief contains statements from Emmerson's family, neighbours, attending fire brigade officers, paramedics and police. I was also provided with transcript from interviews with Emmerson's brothers and photographs of the scene. I have received Emergency Services Telecommunications Authority (ESTA) records, transcript and the Inspector-General for Emergency Management investigation report into the ESTA calling taking on 2 September 2014. Ambulance Victoria (AV) also provided me with information arising out of its internal investigation. I have relied on the totality of the material before me in setting out this finding.

Circumstances on 2 September 2014

5. On the morning of 2 September 2014, Emmerson's mother Pauline dropped Emmerson off at the family business to be cared for by her father Rohan, while Pauline was at work. At approximately 8.55am, Emmerson was picked up by her grandmother, Elizabeth, and they went shopping for father's day presents. They then returned to Pauline and Rohan's home in Gowanbrae.

6. Elizabeth reported that Emmerson had a runny nose and a cold but was otherwise ok. She spent the morning watching television and listening to stories. Pauline arrived home between 1 and 1.30pm. Pauline brought home a dress that she had ordered on the internet for Emmerson and Emmerson immediately put the dress on. Emmerson started twirling around on the floorboard in the hall and into the lounge room. She lost her balance and fell onto the lounge room floorboards, which were covered with a rug. She hit her face on the floor but bounced back up and continued to twirl around.

7. Emmerson then sat on the couch in the family room sill in her new dress. Emmerson got her leg caught in the dress and fell off the couch hitting her forehead. Emmerson cried for about a minute and Pauline put her back on the couch. Emmerson then fell asleep for an hour.

8. Later that afternoon, Pauline suggested that Emmerson have a bath as she liked to have a bath when she was not feeling well. Pauline ran a bath in the upstairs bathroom and then took Emmerson upstairs. Emmerson climbed into the bath herself and began playing with her toys. Pauline sat on the toilet seat and chatted to Emmerson about what she had done during the day.

9. After about ten minutes, Pauline assisted Emmerson out of the bath and took a towel off the rack in order to dry her. Pauline reported that Emmerson said 'no, not that towel Mum, that's Josh's towel' so Pauline told her to wait there while she went downstairs to get Emmerson's pink towel. Pauline looked for Emmerson's towel in the downstairs lounge room but could not see a pink towel so she took a blue towel and walked back up stairs. As she walked upstairs, she noticed there were wet footprints on the wooden floor and tiles outside the bathroom. Pauline assumed that Emmerson had gone into her bedroom, which is next door to the bathroom so Pauline leaned over to see if she was there. Emmerson was not in the bedroom.

10. Pauline looked in the bathroom and saw bubbles in the bath and then saw Emmerson's hair. She was completely submerged with her face up and her eyes open. Emmerson's lips were blue. Pauline reached in and pulled Emmerson out of the water.

11. Pauline called out to her son Tom, who was playing on the computer, to get their neighbour Sonia and then ran downstairs with Emmerson. She ran to the front door, opened it, and called out to a neighbour, John who was in his driveway, to call an ambulance.

12. John, a Station Officer in the Metropolitan Fire Brigade (MFB) who was off duty, ran inside his house to call 000. John called 000 on his home phone and then left his house to assist Pauline with cardiopulmonary resuscitation (CPR). He reported that he handed his phone to his son to speak to the ambulance. The telephone was subsequently handed to another neighbour Sonia. As the phone was a landline phone, she was unable to relay information from the scene.

13. John entered Pauline's house and observed Pauline in the master bedroom on the ground floor conducting CPR on Emmerson who was on the bed. As part of John's role as Emergency Medical Response with the fire brigade, he is First Aid trained. He took Emmerson off the bed and placed her on the floor. He observed that her airway was not clear as he was unable to force air in by mouth to mouth. He did a series of chest compressions but her airway remained blocked so he picked her up and held up upside down with her back to him and expelled liquid from her lungs. He repeated this action four times.

14. Police were the first to arrive at the scene. They assisted John with the CPR until a MFB crew arrived. Ambulance Victoria paramedics arrived after that. (I will deal with the exact timings of the arrival of these crews below). Emmerson's father Rohan had also arrived home from work and was present during the resuscitation attempts.

15. After a 59 minutes of resuscitation attempts, Emmerson was not responding. The decision was made to cease resuscitation at 18.04 hours. Emmerson was taken by ambulance to the Sunshine Hospital with her parents.

ESTA call taking and Ambulance Victoria response times

16. AV conducted a review into the call taking and dispatch aspects of this case. The review identified a number of issues. AV sent ESTA an inter-departmental memorandum 'Observation Report' outlining its issues about whether ESTA applied the most appropriate coding when dealing with the case, and whether the call taking was in accordance with the required standard. ESTA provided a response advising that all matters raised in the Observation Report were valid.

17. AV provided a summary of the ambulance dispatching to this case. The IGEM also provided me with his report on the ESTA management of the call and dispatch.

18. The initial 000 call was received by ESTA at 16.39.57 on 2 September 2014. It took 59 seconds for an ESTA call taker to answer the first 000 call due to a short term increase in calls. The call disconnected from the network shortly before ESTA answered. This resulted in an ambulance being dispatched at a lower priority to a patient with an 'unknown' problem. This was not the nearest ambulance.

19. When the caller rang back, ESTA took one minute and nine seconds to answer the call. The second call taker identified the patient's complaint as 'drowning/not alert' but was unable to update the event details due to a software error in the Computer Aided Dispatch (CAD) system.

20. An ESTA team leader used a nearby CAD terminal to update the event in the CAD system, in order to assist the call taker who was unable to do so. The team leader recorded some details incorrectly as they were not the person taking the call.

21. The IGEM report noted that 'the delay in answering the first 000 call and the subsequent inaccuracies in the event details lead to a 7 minute delay in ESTA dispatching the nearest available ambulance and Mobile Intensive Care Ambulance crews'.[1]

22. There was also a delay of three minutes in creating an additional event for the MFB to attend under its emergency medical responder role. It took 8 minutes and 32 seconds for ESTA to dispatch the MFB.

23. The MFB crew arrived 17 minutes and 40 seconds after the first 000 call. The first ambulance crew arrived five minutes after that.

24. Ambulance Victoria further noted that once the case was upgraded to a Priority Zero case, the Advanced Life Support ambulance at the Moonee Ponds branch on a Priority Zero meal break was dispatched to the case.[2] Review of the GPS tracking system identified that the Moonee Ponds ambulance did not leave the branch for five minutes after it had been dispatched. This was due to the paramedics having removed the drugs from the ambulance as they had 20 minutes of their shift left and had worked for nearly 12 hours without a break and thought it unlikely that their meal break would be interrupted by a Priority Zero case. Before they could leave the branch they had to retrieve the drugs from the branch safe. I note that the individuals involved have been disciplined over this incident.

25. The IGEM made five recommendations directed at ESTA as a result of its review. I note that ESTA has supported all of the recommendations and undertaken the recommended actions. Having regard to section 7 of the *Coroners Act 2008* (the Act) I do not propose to duplicate the IGEM's investigation or the recommendations made. I am satisfied that the IGEM undertook a thorough investigation and identified all of the causal factors that lead to the delay in dispatching the appropriate ambulance crew and MFB crew.

26. Despite the delay in formal emergency services arriving at the scene, I am satisfied that effective cardiopulmonary resuscitation was commenced on Emmerson as soon as the neighbour John arrived at the scene. Although it would have been ideal for emergency service backup to arrive sooner to assist John and take over resuscitation attempts, I cannot be satisfied that the delay in the dispatch and arrival of the paramedics lessened Emmerson's chances of being resuscitated.

Findings

27. I formally find that the deceased is Emmerson Elizabeth Boyle. I find it most likely that after Emmerson was left alone in the bathroom (out of the bath), for an unknown reason she climbed back in to the bath. Her parents reported that she was capable of climbing into the bath herself. I note the evidence that Emmerson was a confident in the water and had undertaken swimming lessons. How she became submerged in water remains unknown however I am satisfied that the cause of her being submerged was accidental, whether she hit her head getting into the bath or her head cold made her disoriented.

28. I find that Emmerson died on 2 September 2014 after accidentally downing in the bathtub at home.

[1] Page 3 of the IGEM report.

[2] I have been advised by AV that paramedics on Priority Zero meal breaks can only be recalled to respond to Priority Zero cases.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic) I order that this finding be published on the internet.

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

Mr and Mrs Boyle

Mr Colin Grant, Ambulance Victoria

Mr Tony Pearce, Inspector General for Emergency Management

Det Sen Const Leah Bound, Coroner's Investigator

Signature:

PETER WHITE
CORONER
Date: **17 February 2016**