IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 3768

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: JAY DION SYKES

Hearing Dates:	18 March 2015
Appearances:	No Appearances
Present:	Mrs Pamela Lawrence Mr Joseph Lawrence Mr Wayne Lawrence
Police Coronial Support Unit:	Leading Senior Constable Stuart Hastings
Findings of:	AUDREY JAMIESON, CORONER
Distributed on:	7 September 2015

[1] This finding draws on the totality of the material, the product of the coronial investigation of Jay Dion Sykes' death. That is, the court records maintained during the coronial investigation, the Coronial brief and the evidence and information obtained at the Inquest. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

I, AUDREY JAMIESON, Coroner having investigated the death of JAY DION SYKES

AND having held an Inquest in relation to this death on 18 March 2015

at Southbank in the State of Victoria

find that the identity of the deceased was JAY DION SYKES

born on 5 December 1994

and the death occurred on 25 August 2013

at the Austin Hospital, Studley Road, Heidelberg 3084

from:

1 (a) ASPIRATION PNEUMONIA IN A SETTING OF ACQUIRED BRAIN INJURY

in the following summary of circumstances:

1. Jay Dion Sykes was admitted to the Austin Hospital on 28 July 2013 with breathing difficulties on a background of recurrent aspiration pneumonia. He died on 25 August 2013. Jay was 18 years of age at the time of his death and had been residing at a Department of Health and Human Services[2] (DHHS) facility in Dredge Street, Reservoir since 10 February 2013.

2. The death of Jay Dion Sykes was "reportable" [3] because immediately before his death, Jay was "a person placed in....care" as it is defined in the *Coroners Act 2008* (Vic) (the Act).[4] Prior to his death, Jay was a person under the control, care or custody of the Secretary to the Department of Health and Human Services (DHHS).

3. On 18 March 2015, an Inquest under section 52(1) of the Act began into the death of Jay Dion Sykes.

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2 Previously known as the Department of Human Services.
3 *Coroners Act 2008* (Vic) s 4(1) and 4(2) (c).
4 *Coroners Act 2008* (Vic) s.3(1).

BACKGROUND CIRCUMSTANCES

4. Jay was born 5 December 1994 to Ms Helene Sykes and Mr Jim Plagiannakos. He was born premature at 31 weeks. As Ms Sykes had used heroin and methadone during her pregnancy, Jay required an extended period of hospitalisation whilst withdrawing from these substances. Child Protection received a report about these circumstances.

5. Jay remained in the Royal Children's Hospital (RCH) until 9 January 1995 when he was released into the care of his mother. On 12 February 1995, Jay was brought into the RCH by Ms Sykes and Mr Plagiannakos and was admitted with head injuries alleged to have occurred by Jay falling out of the couple's double bed. At the time of presentation Jay was fitting and was noted to have what appeared to be abrasions and bruising to his body. Jay was found to have suffered from cerebral hypoxia with resultant irreversible brain damage. His injuries were considered non-accidental.

6. Jay's injuries were the subject of a police investigation. Mr Plagiannakos was subsequently charged with attempted murder, intentionally causing serious injury and recklessly causing serious injury. All charges against Mr Plagiannakos were subsequently dropped.

7. Jay became severely disabled from this head trauma sustained when he was an infant resulting in Cerebral Palsy. He suffered with tetraparesis, aphasia, visual impairment and intellectual disability as well as epilepsy and gastro-oesophageal reflux disease (GORD).

8. Child Protection received a report of Jay's admission to RCH on 12 February 1995. On 15 February 1995, a Protection Application (PA) was issued by Child Protection on the basis of the severity and apparent non-accidental nature of Jay's injuries. He was placed in foster care by way of an Interim Accommodation Order (IAO) after being discharged from hospital aged four months. On 20 October 1995, the PA was found proven and Jay was placed on an Interim Protection Order (IPO) for a period of three months. This was subsequently extended on a number of occasions until 22 April 2010 when Jay was placed on a Long Term Guardianship to Secretary Order until his 18th birthday. Jay remained with and in the care of his foster parents and legal guardians, Pamela and Joseph Lawrence and their children until after his 18th birthday. On 13 December 2012, the Victorian Civil and Administrative Tribunal appointed Mr and Mrs Lawrence as Guardian and Administrators with respect to Jay's medical and legal affairs. The Guardianship to Secretary Order expired in December 2012, shortly after Jay turned 18 years of age. Child Protection closed Jay's case in January 2013. It was planned that Jay would be taken

into care by the Disability Client Services located at Dredge Street Reservoir on or about his 18th birthday however, illness delayed the transition. He commenced residing at Dredge Street on 10 February 2013.

9. Jay was severely disabled. He was non-communicative and required full care to complete all activities of daily living.

10. The Lawrence family continued to manage Jay's financial and legal affairs and visit him weekly[5] at the Dredge Street residence.

SURROUNDING CIRCUMSTANCES

11. When Jay turned 18 years his medical management through the RCH also transitioned. His medications at this time included Nexium 40mg nocte, Motilium 10 TDS, Lamictal 100mg BD, Sabril 500mg mane, 1 gram nocte and Valium 5mg BD.

12. General medical practitioner Dr Matthew Daly, from the Oakhill Clinic in Reservoir, looked after Jay from February 2013 when he moved into the Dredge Street facility. Dr Daly treated Jay for a variety of conditions including chronic constipation, failure to gain weight, a persistent chest infection and a pressure wound on his left elbow. Dr Daly said that Jay's recurrent aspiration related chest infections were associated with his GORD.

13. Jay's medical needs appear to have continued to escalate in the following months. Dr Daly stated that in April 2013, Jay required the inclusion of Ventolin nebulisers into his treatment regime as he was *felt to have increased difficulty with his breathing*. He was also referred to a Speech Pathologist and a Dietician because of his risk of aspiration from poor feeding. Dr Daly was also concerned about Jay's inability to gain weight. In late May 2013, Dr Daly was asked to review Jay because of a 12 day history of constipation. Investigations included an X-ray which showed marked constipation and blood tests which revealed mild anaemia. Jay failed to respond to frequent Microlax enemas and an increase to his regular dose of Movicol. There was also a marked decrease in his appetite and he was choking during feeds which necessitated the use of suctioning by his carers.

14. On 6 June 2013, Jay presented from the Dredge Street facility to the Northern Hospital (NH) Emergency Department (ED) and was diagnosed with aspiration pneumonia. A nasogastric tube was inserted and he was treated with intravenous antibiotics. On 14 June 2013, Jay was

[5] Transcript of Evidence @ p12.

transferred to Northern Health's Broadmeadows Health Service, but had to be returned to the NH the following day due to the dislodgement of his nasogastric tube. Jay was found to have dysphagia and remained at the NH until 2 July 2013 when he was transferred to Northern Health's Bundoora Extended Care Centre (BECC), a sub-acute rehabilitation facility, for further rehabilitative care. Jay remained at BECC until 13 July 2013, during which time he had several Medical Emergency Team Calls (MET Calls) for respiratory distress.

15. Jay was transferred back to the NH on 13 July 2013 for treatment of respiratory distress and desaturation. He returned to BECC on 22 July 2013. Jay's ability to swallow and his caloric intake continued to be monitored due to his state of malnutrition, constipation and the risks associated with his swallowing difficulties. On 28 July 2013 Jay suffered another episode of respiratory distress necessitating his transfer to an acute facility.

16. Jay's foster brother, Wayne Lawrence (Wayne) had been charged with the Guardianship role in the absence of his parents who were travelling overseas at the time. After consultation with his mother, Wayne requested that Jay be transferred to St Vincent's Hospital as Jay was known to the hospital through the St Vincent's Young Adults with Complex Disabilities clinic. According to Wayne, St Vincent's Hospital had taken over Jay's care from the RCH and received a handover from them when Jay became an adult.[6] St Vincent's agreed to accept Jay's transfer however Jay was diverted to the Austin Hospital while in transit. According to Wayne, it was his understanding that the ambulance paramedics charged with transferring Jay made the decision to divert to the nearest hospital because of the seriousness of Jay's condition. The NH was the closest hospital but was apparently on bypass and hence why the diversion to the Austin Hospital.[7]

17. On 28 July 2013 at 4.58pm, Jay was admitted to the Austin Hospital ED along with a letter from BECC and ambulance records listing breathing difficulties and respiratory distress as the principal reasons for transfer. Jay's recent history of multiple transfers between the NH and BECC because of repeated aspiration pneumonia associated with significant impaired swallowing reflex (dysphagia) was also documented. Clinical assessment of Jay in the ED and initial investigations were not indicative of a chest infection, but there was evidence of an unsafe swallowing reflex, consistent with the reported history.

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[6] Transcript of Evidence @ p8.
[7] Transcript of Evidence @ p10.

18. On 29 July 2013, Jay was transferred from the ED to a general medical bed in the hospital under the care of General Medical Unit 5 (MU5). He was "nil-by-mouth" and his regular medications were administered via the naso-gastric tube that was insitu on his admission. He was assessed by a Dietician and Speech Pathologist to determine his ongoing nutritional requirements and how it would be managed. Nursing staff noted Jay to be alert but non-verbal and requiring full nursing care.

19. On 30 July 2013, Jay had a fine bore naso-gastric tube inserted under fluoroscopic guidance in order to facilitate ongoing nutritional feeding. Jay was also assessed by numerous members of the allied health team. On 2 August 2013, Jay underwent a video-fluroscopic swallowing study which confirmed severe dysphagia and displayed a very high risk of aspiration.

20. In the following week the Austin discharge planning staff contacted Jay's residential facility to clarify their capacity to manage Jay given that he now required ongoing naso-gastric tube placement. The residential facility advised the Austin staff that they could not manage a naso-gastric tube.

21. Mr and Mrs Lawrence returned from their overseas trip on 11 August 2013. They immediately attended at the Austin Hospital and attended thereafter as often as they could to assist in caring for Jay and were also able to feed him when hospital staff had been unable to.[8]

22. On 14 August 2013, a family and multi-disciplinary meeting was held to discuss all aspects of Jay's current and ongoing management and needs. Present at the meeting were Mr and Mrs Lawrence, representatives of the medical staff including Professor O'Brien, Head MU5, Dr David Lim, Registrar MU5, Dr Tarinee Ku, Resident MU5, allied health professionals including a Speech Pathologist, a Dietician, a Social Worker and a representative from Respecting Patient Choices. Also present at the meeting were DHHS representatives including Ms Michelle Hanson, Domain Manager and Mr Rodney Dobson, House Supervisor. At the time of the meeting it was known that Jay's naso-gastric tube had been dislodged that morning.

23. Arising from the meeting was an agreed management plan which included:

    a. the naso-gastric tube was not to be reinserted and Jay could eat as tolerated and as recommended by the speech pathologist;

[8] Transcript of Evidence @ p11.

b. if oral feeds were unsuccessful comfort measures (palliation) was to be implemented;

c. only oral (if tolerated) antibiotics to be administered in the case of infection;

d. return to the Dredge Street residential facility with community palliative care support and general practitioner follow-up;

e. direct admission to the Palliative Care Unit (PCU) if Jay clinically declined;

f. address bladder and bowel issues; and

g. Austin Health to provide continuing care.

24. Over the following days, Jay's condition continued to deteriorate. He was unable to tolerate oral feeds and unable to take his anti-epileptic medication necessitating the change to sublingual Clonazepam to prevent seizures. On 21 August 2013, a referral was made to the Palliative Consult Service resulting in Jay being placed on the waiting list for a bed in the PCU.

25. On 24 August 2013 at approximately 3.00pm, Jay was admitted to the PCU. He was receiving oxygen via nasal prongs but was noted to be unresponsive and had an unrecordable blood pressure. Mr and Mrs Lawrence took turns at maintaining a bedside vigil.

26. On 25 August 2013 at 7.00am, Jay died. Mr Lawrence and nursing staff were present at the time. It is reported that he died peacefully.

INVESTIGATION

Identity

27. The identity of Jay Dion Sykes was not in dispute and required no further investigation.[9]

Medical cause of death

28. On 27 August 2013, Associate Professor (AP) and Deputy Director of the Victorian Institute of Forensic Medicine, David Ranson, carried out a medical investigation into the death of Jay. The medical investigation comprised a review of the documentary materials,[10] an external examination of Jay's body and review of a post mortem CT scan. AP Ranson reported that on

[9] See 'Coroners Release Authority and Confirmation of Name' signed by Joseph Lawrence dated 26 August 2013.
[10] The documentary material available to AP Ranson included Jay's medical records, the e-Medical Deposition Form from the Austin Hospital and the Police Report of Death to the Coroner (Form 83).

the basis of the information available to him, a reasonable medical cause of death could be ascribed to aspiration pneumonia in a setting of acquired brain injury.

Police Investigation

29. Senior Constable Tristan Barlow was the nominated Coroner's investigator[11] and prepared the Inquest brief on my behalf.

PURPOSE OF THE CORONIAL INVESTIGATION

30. The Coroners Court of Victoria is an inquisitorial jurisdiction.[12] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[13] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[14]

31. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[15] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[16] These are effectively the vehicles by which the prevention role may be advanced.[17]

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[11] A Coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the Coroner with his/her investigation into a reportable death. The Coroner's investigator takes instructions directly from a Coroner and carries out the role subject to the direction of a Coroner.

[12] Section 89(4) *Coroners Act 2008*.

[13] Section 67(1) of the *Coroners Act 2008*.

[14] This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[15] The 'prevention' role is explicitly articulated in the Preamble and Purposes of the Act.

[16] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[17] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

32. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

33. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

34. Section 52(3A) of the Act provides that a Coroner is not required to hold an Inquest in respect of a deceased who was immediately before death, a person placed in custody or care if the Coroner considers that the death was due to natural causes however, I exercised my discretion pursuant to section 52(1) of the Act to hold an Inquest because Jay's family raised concerns about potential public health and safety issues related to Jay's care that I deemed warranted a public hearing.

STANDARD OF PROOF

35. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[18] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    a. the nature and consequence of the facts to be proved;

    b. the seriousness of an allegations made;

    c. the inherent unlikelihood of the occurrence alleged;

    d. the gravity of the consequences flowing from an adverse finding; and

    e. if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

[18] (1938) 60 CLR 336.

36. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INQUEST

37. An Inquest was held on 18 March 2015. No witnesses had been summoned to appear as the investigation had not identified any issues associated with or surrounding the death of Jay that warranted extending the investigation.

38. A Summary of the circumstances surrounding Jay's death was provided by Counsel Assist, Leading Senior Constable Hastings from the Police Coronial Support Unit.

39. I invited Mrs Pamela and Mr Joseph Lawrence and their son, Wayne to discuss their concerns with me from the bar table. Of significance, Mrs Lawrence articulated her concerns about the lack of information provided to her by the Dredge Street facility about all matters related to Jay's care including his trips to the general practitioner and hospital for constipation, the development of the pressure sore on his elbow, and about their apparent inability to feed Jay evidenced by his weight loss. She had raised the lack of/poor communication with Michelle Hansen, Disability Accommodation Services Manager and several times at Dredge Street,[19] but felt that it never improved. Wayne had similar complaints about the lack of communication and on one occasion, "rude" communication during his dealings with the NH and BECC.[20] Mrs Lawrence said her experience at the Austin Hospital was the same, except for the meeting she and her husband attended on 14 August 2013. She said that despite being at the hospital every day, no doctor spoke to them about Jay's state of health.[21] Mrs Lawrence said that adult hospitals such as the Austin Hospital *don't make disabled people like Jay feel comfortable.*[22]

COMMENTS

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

1. In all the circumstances, I am satisfied that there would be no benefit from conducting a full Inquest into Jay's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Jay's death which resulted from aspiration pneumonia in a setting of acquired brain injury and its associated

[19] Transcript of Evidence @p18.
[20] Transcript of Evidence @ p 19.
[21] *Ibid.*
[22] Transcript of Evidence @ p13.

complex medical conditions. I am also satisfied that the care received by Jay from the DHHS, the Northern Hospital, BECC, the Austin Hospital and other treating practitioners, was reasonable and appropriate in the circumstances. The family's concerns and disappointment about the lack of communication to them about Jay's deteriorating medical condition from his residential care facility, the NH, BECC and including his final days at the Austin Hospital are matters that each facility should reflect upon and attempt to address. Effective communication with a family that contributed so much to Jay's wellbeing should have occurred without hesitation. Save for the multi-disciplinary meeting on 14 August 2013 which is a commendable and effective model, I accept the family's account of this time that they would have personally benefited from more regular and timely communication.

2. Ineffective or the lack of communication to the Lawrence family is not however causal or contributory to Jay's death, so I make no further comment in this regard.

3. Jay lived well beyond his expected years after sustaining a significant disabling head injury. Jay's life was forever changed rendering him dependant on others for all activities of daily living for his short 18 years. The Lawrence family cared for Jay from the age of 4 months through to his adulthood and by all accounts, cared for him as if he was their own. He was a part of their family. The Lawrence family are to be commended for their care, compassion, and I suspect, many sacrifices which I am sure that absent Jay would not have lived to reach adulthood. Their distress at his death only six months after Jay left their home to reside at the DHHS facility was palpable.

FINDING

I accept and adopt the medical cause of death ascribed by Associate Professor David Ranson and I find Jay Dion Sykes died from aspiration pneumonia in a setting of an acquired brain injury by non-accidental means sustained when he was an infant.

AND I further find that there is no relationship between the cause of Jay's death and the fact that he was a "person placed in care".

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

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

- Mrs Pamela Lawrence
- Mr Shane Beaumont, Manager Complex Support and Systemic Improvement, Residential Services & Complex Support, Service Implementation & Support, Department of Health and Human Services
- Secretary to the Department of Health and Human Services
- Ms Annabelle Mann, Legal Counsel, Royal Children's Hospital
- Northern Health
- Ms Pauline Chapman, Austin Health
- Senior Constable Tristan Barlow
- Leading Senior Constable Stuart Hastings, Police Coronial Support Unit

Signature:

AUDREY JAMIESON
CORONER
Date: **7 September 2015**