IN THE CORONERS COURT
OF VICTORIA
AT KYNETON

Court Reference: 1742/ 2010

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Michael Patrick ORMSBY

Delivered On:	12 November 2014
Delivered At:	KYNETON
Hearing Dates:	2 May 2013 & 3 May 2013
Findings of:	David Bruce Sidney COTTRILL (Coroner)
Representation:	VISTA/ E.W. Tipping Ms. P.R. Riddell (Counsel) Department of Human Services Ms. T. Porritt Assistant to Coroner Leading Senior Constable M. Herman

*Police Coronial Support Unit

*Counsel Assisting the Coroner

I, David Bruce Sidney COTTRILL, Coroner having investigated the death of Michael Patrick ORMSBY

AND having held an inquest in relation to this death on 2 and 3 May 2013

at KYNETON

find that the identity of the deceased was Michael Patrick ORMSBY

*born on 16 June 2000

and the death occurred at 1855 hours 9 May 2010

at Edgecombe Road, Kyneton adjacent to Kyneton Bushland Resort

from:

1 Motor vehicle accident related multi trauma

in the following circumstances:

1. Michael Ormsby was born on 19 June 2000 and at the date of his death was aged 9 years.

2. Michael Ormsby had been referred to Dr. J. Anne S. Smith, Consultant Paediatrician in February 2003. She had seen him on nineteen occasions leading up to November 2009. She describes that when Michael was three years old it was already recognised that he had developed mental and behavioural problems and in particular severe global developmental delay with marked impairment of communication skills (language and non verbal skills). She describes *"he was extremely difficult to control, required constant supervision and at times he behaved in an aggressive and impulsive manner. He had bitten others, he also screamed, apparently without provocation and he became extremely distressed and agitated without an apparent reason"*. Dr. Smith reports that there was little developmental progress and Michael's violent and aggressive behaviour was described as being unpredictable, not amenable to reason and at times required physical restraint by strong adults in order to avoid injury to children and others in the vicinity.

Dr. Smith also reported *"Michael is likely to have very high needs for the remainder of his life. He requires housing in suitably safe accommodation unlikely to be damaged by hitting or kicking. He requires constant supervision in order to avoid self injury and injury to those in his surroundings. He is fully dependant on others for managing his toileting needs, feeding, clothing and bathing. He is unable to communicate effectively and requires trained, patient and compassionate individuals, who are able to anticipate his needs interpret his body language and attempt to interact with him in a manner that is likely to minimise ongoing emotional distress and agitation. He requires ongoing medical review to monitor his response to Risperdal and other psychotropic medications that might be considered in the future"*.

3. A statement prepared by Ms. Judith Murdoch, Regional Services Manager E.W. Tipping Foundation and Vista Community Support Organisation Loddon Mallee provides a later overview of Michael as "*a nine year old boy with a diagnosis of Autism and Intellectual Disability he requires support in all aspects of his life. Michael is non-verbal, doubly incontinent and has behaviours of concern primarily related to communication and sensory issues associated with Autism. Behaviours of concern include biting, scratching, vomiting and regurgitating, escaping from care by climbing and running, removing clothing, playing with faecal matter and removing his harness whilst being transported. Michael has severe Autism Spectrum disorder and will place all matters of unsuitable items in his mouth to address his sensory needs requiring vigilance from those providing care. Michael has a fascination for leaves and tress and will head for trees (especially gum trees) at every opportunity. Several specialist interventions have occurred to assist people to support Michael and reduce the behaviours of concern*".

4. Michael's mother Monica Snaidy suffered from a mental illness and the sole care of Michael remained with his father also known as Michael Ormsby.

In 2009 Michael Ormsby (senior) was diagnosed with a terminal illness. At that time Michael was receiving a range of services from Vista Community Support (school transport and some respite,) in addition to respite from a family day care provider and case management together with behavioural intervention support from Disability Client Services. In October 2009 Michael Ormsby (senior) agreed to a voluntary referral to DHS Child Protection Unit and a plan commenced to make appropriate arrangements to meet Michael's specific support needs when his father was no longer able to.

5. In 2005 Michael was attending the Bendigo Special Development School and had been placed in the care of Lynette Wattie through Cobaw Family Day Care. She was assisted by DHS, Disability Client Services and Child Protection. By March 2009 Michael was being transported daily to and from school by VISTA Community Support organisation (VISTA). These supports include residential options for children at the request of DHS and a continuum of services specialising in the provision of individualised support where service gaps exist and in circumstances where the complexity of a person's situation or presentation may preclude them from other services. On 2 November 2009 at the request of the Department of Human Services Case Manager VISTA commenced the provision of regular weekend respite care from the end of each school day on

Friday until return to school on Monday. In January 2010 DHS Disability Client Services established and maintained a permanent booking at Kyneton Bushland Resort to be utilised for Michael's weekend respite accommodation. The facility was chosen because it enabled easy access to Michael's father and had a variety of activities including facilities appropriate to support Michael's special needs including playground and swimming pool. The respite accommodation at Kyneton Bushland Resort commenced on 30 March 2010. At that time Michael's father had returned to Kyneton from Bendigo Hospital and was under palliative care. His life expectancy was limited.

6. For the following three months Michael stayed at Kyneton Bushland Resort on each weekend and was cared for in the same unit. The unit was described as being well situated for the care providers as it was the greatest distance from the road and accessible to the playground and pool. Michael was supported to visit with his father on numerous occasions, sometimes including multiple trips in a day. He often displayed distress after the visits.

7. From 12 February 2010 Jessica Stuart commenced employment as a casual support worker with VISTA. She was employed primarily for the purpose of supporting Michael and commenced in the school transport program immediately. She was assisted by shadow shifts on three occasions for the transport programme and respite programme with experienced program staff. According to a report provided by Judith Murdoch Regional Services Manager E.W. Tipping Foundation, Jessica (aged 20 years) was identified as an employee with considerable potential and she accepted a Permanent Part Time contract on 4 May 2010. She was enrolled in a VISTA sponsored Certificate 4 in Out of Home Care.

8. According to Jessica, Michael was her first client and she had been advised that he was severely Autistic and was going to be hard work. She stated that she didn't mind because it was what she wanted to do and she had the experience of a family friend who was autistic and she knew what to expect. She describes being with Michael for eighty to ninety hours per fortnight, her duties including picking him up from Kyneton around 8.00 a.m. and driving him to his school in Bendigo. When his school was finished at 3.00 p.m. she would drive Michael and two other boys back to Kyneton. On weekends she shared respite care of Michael at the Bushland Resort with two other carers, looking after him in shifts. She described the duties as including changing his nappy,

showering him, preparing meals and feeding. The carers were responsible for giving Michael his medication and putting him to bed. He was regularly taken to see his father either at home or in the hospital for durations of ten minutes to an hour depending on Michael's behaviour. It was not uncommon for Michael to play up after seeing his father. Activities at the resort included swimming in the pool, walking in the bush and playing with a ball. She described having dealt with Michael for three to four months "*I knew caring for him would be a challenge and I thoroughly enjoyed it, I never had thought to change from Michael, I got to know him and understand him even though he couldn't talk. He had his moods like everybody else does*".

9. On Sunday 9 May 2010 Jessica started her shift with Michael at 3.00 p.m. He was dressed in a navy blue black jump suit. At 4.00 p.m. Michael was taken to visit his father at 32 Palmer Place, Kyneton. The visit lasted until 5.30 p.m. when Jessica drove Michael back to Kyneton Bushland Resort. The trip took approximately ten minutes. Upon arriving at the resort Jessica was suffering from a migraine and decided to drive back to Kyneton for some medication. Michael was placed back into the vehicle into the third row of seats on the passengers (near side) side. She drove back into Kyneton and stopped at a BP Service station to purchase some panadol. She then returned and drove the vehicle (a Toyota Tarago van) back to the resort. She observed that Michael was still strapped into his seat and appeared to be happy playing with a ball. The vehicle was parked outside room 11 near the front door at about 6.45 p.m. As Michael was removed from the vehicle he commenced throwing a tantrum and attempted to bite Jessica and pinched her breast. She had hold of Michael's hand as he bit her right arm and once outside the vehicle he continued to wriggle to break her grip and was screaming. Michael again bit Jessica's right arm on the same spot but a lot harder which forced her to loose her grip. He then ran off into the darkness, there was no street lighting or additional lighting around the resort. Michael ran in a south westerly direction away from the rooms across a grassed area through a small row of gum trees and across another grassed area onto Edgecombe Road. He was not making any noise and Jessica was unable to catch him falling over in the darkness. She was using her mobile phone as a torch and calling out to Michael. He then turned and commenced running north along Edgecombe Road towards a 2005 Holden Barina panel van driven by Gwenda Healy. The vehicle was travelling at approximately 76km/h and from Langley towards Kyneton. Healy first saw Michael running towards her with his hands up in the air in the middle of the south bound lane. Because of the darkness of the night and lack of street lighting she was unable to see Michael until he was reasonably close. She locked up her wheels whilst braking trying to avoid him and her vehicle moved left of lane towards the grass

verge. She was travelling at approximately 54km/h when Michael was struck by the vehicle. Healy's vehicle struck Michael in the area of the driver's side headlight. Healy pulled up and got out to stop the traffic as there where vehicles travelling behind her and others travelling towards her. Ambulance and police were called to the scene and at 1700 hours Gisborne Highway Patrol Unit with Leading Senior Constable Young arrived and took over investigations. Acting Sergeant Barnes also attended to supervise the scene and investigation. Air ambulance arrived shortly thereafter. Michael was found to have died as a result of the collision.

10. An inspection and report of Dr. V. Murdolo, Director of Pathology Bendigo Health established the cause of death as motor vehicle accident related multi trauma.

11. A police investigation of the scene established that in the course of the collision with Healy's vehicle Michael had been thrown onto the bonnet before landing on Edgecombe Road in the middle of both lanes on the marked lines. An inspection of Healy's vehicle revealed that Michael was struck by the vehicle thereby breaking the clear plastic bonnet protector at the driver's side front headlight. He was thrown onto the bonnet leaving a dent in front of the driver's position before cracking the windscreen. There was no noticeable head strike on the windscreen and the severe head trauma observed appeared to have been sustained when he struck the road after being struck by Healy's vehicle. Although there were other vehicles which stopped immediately at the accident scene and could possibly have struck Michael on the roadway there was no clear evidence to suggest that this had occurred. A subsequent investigation by the Major Collision Investigation Unit established Glenda Healy was travelling at about 76km/h when she braked and impacted Michael Ormsby at about 54km/h. It was clear that no blame can be attached to Glenda Healy for her involvement in this tragic accident.

12. Jessica Stuart described in a statement her frantic attempts to catch Michael in the darkness *"Michael was not screaming or making any noises at all. It was dark, I couldn't see or hear him. As I was running I tripped over a hole in the ground. I had my mobile phone in my hand and was trying to use it as a light. I was going to start making calls. I dropped my phone. I got back up and got my phone. I kept running and yelling, "Michael, where are you, you need to come back". There was a line of trees near the road, I was yelling out, "Michael, Michael, where are you." A lady responded to my call. The lady said, "There is a little boy here on the road. He just got ran*

over". I started getting scared and I ran towards the road. I was just coming out the bushes. I tripped over again as I got onto the road and grazed my leg on the gravel. I dropped my phone again and that's when I saw him. He had blood all over his face. A lot of cars and a lot of witnesses were there around him. I started crying. I then spoke to these people as I tried to compose myself. I then asked them if they had rung 000, they said the police and ambulance had been called. I rang my boss, Judith Murdoch. There was no answer. I tried to ring a few times but there was no answer. I tried to ring Shane and his phone was switched off. I tried other people from work. I put my jacket over Michael to try and keep him warm. There were a lot of people at this time, although I was the only one that knew him. Just before the police arrived I rang 000 and asked for the ambulance as it was taking a while, I spoke to the operator and hung up when they arrived. Police and ambulance then arrived".

13. I am satisfied that the death of Michael Ormsby was as a result of a tragic accident and that no blame could be attributed to Jessica Stuart his direct carer at the time or any other of the organisations involved in providing direct care or assistance to Michael. The purpose of the assistance to Michael was to increase his capacity to live life independently, as best as that could be achieved. His diagnosis of autism and intellectual disability dictated a requirement for support in all aspects of his life. His carers were particularly aware of these issues and had adopted appropriate strategies to address potential risks and to ensure his welfare and safety. This is particularly clear from the evidence provided by Michael's long term carer Lynette Wattie. Evidence of support plans, strategies and written instructions provided by her demonstrate a significant and meaningful commitment to Michael's welfare and provided appropriate strategies for his safety and the safety of others. Whilst Michael had always demonstrated a propensity to act violently, to attempt to escape and to run away in any direction and without any consciousness of or regard for surrounding dangers, it is not possible to conclude that there was any lack of care which contributed to his tragic death.

Signature:

Coroner: David Bruce Sidney Cottrill
Date: **21/05/2014**