QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

CITATION:	INQUEST INTO THE DEATH OF MICHAEL JOSEPH JOY
COURT:	CORONERS COURT.
FILE No:	MACKAY COR 00000839/07(8)
DELIVERED ON:	24 April 2009.
DELIVERED AT:	MACKAY
HEARING DATES:	15 – 17 April 2009
Findings of:	ROSS RISSON, CORONER
CATCHWORDS:	DEATH IN CARE.
REPRESENTATION:	
ASSISTING:	Mr. S.J. HAMLYN-HARRIS.
FOR MACKAY & DISTRICT EDUCATION CENTRE:	Mr. W.G. COOPER, Solicitor of Bill Cooper & Associates.
FOR DISABILITY SERVICES QUEENSLAND:	Mr. C.J. CLARK, Barrister, instructed by the State Crown Law Office.

These are my findings into the cause and circumstances surrounding the death of Michael Joseph JOY.

Mr. Joy's death was reported to me as Coroner at Mackay on the 25th February 2007. It was reported as a death due to natural causes those causes being unknown[1] and as a death in care[2]. As I considered the death to be a reportable death I was required to undertake an investigation.[3]

The inquiries for the purposes of my investigation were undertaken firstly by Constable Jodie L Brennan, who provided the initial report in form 1 and subsequently by Detective Senior Constable Michelle Goodman nee Allen. Her report dated the 15th July 2007 contained a number of statements from people who were involved in some manner and other attachments such as a report, dated the 1st March 2007 prepared by Mr. Peter Rice who was at the relevant time the Chief Executive Officer of the Mackay and District Education Centre (MADEC) and a Critical Incident report, dated the 26th February 2007, prepared by Ms. Charmaine Arnold who at the relevant time was a Program Resource Officer with Disability Services Queensland, Mackay.

The medical cause of death was established by an autopsy undertaken by Dr. Peter FitzPatrick, Pathologist of Mackay on the 28th February 2007.

As I decided that Mr. Joy's death was a death in care, in circumstances that raised issues about his care I was required to hold an Inquest[4].

A pre inquest conference was held on the 11th December 2008 and I heard evidence over three days from the 15th April 2009. Given leave to appear at the Inquest were MADEC who was represented Mr. Bill Cooper solicitor and Disability Services Queensland who were represented by Mr. C. Clark of counsel.

Where an Inquest is held section 45 of the Coroners Act 2003 requires the following findings to be made if possible: -

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[1] *Coroners Act 2003* section 8(3)(e)
[2] *Coroners Act 2003* section 8(3) (f).
[3] *Coroners Act 2003* section 11(2).
[4] *Coroners Act 2003*, section 27(1) (a) (ii).

- who the deceased is; and
- how the person died; and
- when the person died; and
- where the person died; and
- what caused the person to die.

How the person died means by what means or in what circumstances the person died and what caused the person to die refers to the medical cause of death.

In making my findings I must not include in them a statement that a person is or may be guilty of an offence or civilly liable for something.[5] I also may, if I think appropriate, comment upon anything that related to

- public health or safety; or
- the administration of justice; or
- ways to prevent deaths from happening in similar circumstances in the future.[6]

Again I cannot include in any comment I might make, any statement that a person is or may be guilty of an offence or civilly liable for something.[7]

I am not conducting a trial and no party has a right to appear at an Inquest and the purpose of an Inquest is "to seek out and record as many facts concerning the death as the public interest requires."[8]

In making my findings I only have to be satisfied on the balance of probabilities although "the seriousness of the allegation, the inherent unlikelihood of an occurrence of a particular description or the gravity of the consequences flowing from a particular finding" [9]are matters which I must take into account in deciding if a matter has been proved on the balance of probabilities.

Michael Joseph Joy was 43 years of age at the time of his death having been born on the 1st March 1963. He was at that time residing at Unit 7, 26 Martin Street, North Mackay. This unit, which was provided by the Department of Housing, was one that was designed especially to accommodate persons who require the use of a wheelchair for mobility.

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[5] *Coroners Act 2003,* section 45(5).
[6] *Coroners Act 2003,* section 46(1).
[7] *Coroners Act 2003,* section 46(3).
[8] *R v South London Coroner; ex parte Thompson* (1982) 126 SJ 625 per Lane CJ.
[9] Brigginshaw v Brigginshaw (1938) 60 C.L.R. 336

Mr. Joy suffered from Wilson's disease which is an inherited disorder in which too much copper accumulates in the body. He had a brother and sister who had also suffered from the disease and he contracted this at about the age of eleven years. Wilson's disease is a gradually debilitating disease which had deprived Mr. Joy of the use of his legs, requiring the use of a wheelchair, and which was causing his upper body capabilities to deteriorate. Mr. Joy's speech was also affected to the extent that Colin Bruce Joy his designated carer needed to be speaking to his older brother face to face to be able to understand him. As a result Mr. Joy could not communicate using the telephone.

Whilst Mr. Joy's condition severely restricted his ability to care for himself it did not confine him to his unit. Although he was very limited as to what he could do he attended at the Endeavour Foundation regularly and had received his 25 year service award from that organisation. He also attended regularly at the Mt. Pleasant tavern where he was looked after by the patrons whose financial contribution had enabled the purchase of the wheelchair that he was using.

Mr. Joy had moved into the unit at Martin Street in September 2006 and at this stage he was being provided with care by several community organizations including OZCARE which provided personal care Monday to Friday, Pres-care which provided 1.5 hours of domestic assistance each week and three hours each fortnight for assistance with banking, shopping and similar activities and MADEC.

OZCARE was providing hygiene services at the request of Mr. Joy's doctor and this consisted of a morning service which included showering, shaving and general body hygiene. MADEC was providing a Night Attendant Care Service (NAC) which, because of the services involved, was also referred to as a "tuck in" service. This simply involved a short visit, perhaps of about 10 minutes, where a check was made to see if he was in bed, had taken his medication, that the lights were out and the unit secure.

This "tuck in" service had been in place since the 9th January 2006 and, whilst there were a substantial number of visits made when Mr. Joy was not home this did not create any problems. It was simply a matter of those workers calling back if they had time later in their shift.

During October and November 2006 Mr. Joy had a number of falls. As a result of his problem of falling, Mr. Joy spent sometime in the Mackay Base Hospital being discharged from there on 15th November 2006.

Because of his condition he had a "VITAL" call device. This is a small device which could be worn round a person's neck like a necklace. When it was activated by being pushed it initiated a telephone call to a central location where the user of the device could be identified and, if they then could not be contacted by telephone, the Ambulance Service could be called to attend at their location.

Because of his problem with falls and also the fact that he was burning himself frequently when preparing an evening meal or a hot drink Mr. Joy was faced with the prospect of being placed inappropriately in a Nursing Home. Mr. Joy's condition clearly required greater assistance than what he was receiving and, after a period of emergency funding, Mr. Colin Joy obtained from Disability Services Queensland a recurrent funding package of $52,373 through the Adult Lifestyle Support Program. This occurred in December 2006 and during that month and January 2007 there were discussions between Mr. Michael Joy, Mr. Colin Joy, Ms. Jo Richardson Supports Facilitator of Disability Services Queensland and service providers as to provision of a care package based on the amount of funding available.

Ultimately it was agreed that MADEC would provide 34 hours of care per week and that such care would consist of two hours of a morning and two hours of **an** afternoon seven days a week making a total of 28 hours per week with the remaining six hours of care per week being used for community contact such as going to the movies. Obviously with only 34 hours of care being provided during the week there remained a large period of time when Mr. Joy if not cared for by family or friends would be left to care for himself

The NAC or "tuck in" service was separate and would continue as it had been provided. That service was rostered separately. By the time that the day time service started on the 29th January 2007 the NAC service had been in place since January 2006.

When the day time service commenced there was a general idea of the hours of care that were to be provided although no care plan had been drawn up. Also there had not been enough time for any regular pattern to develop. Whilst MADEC had to adapt to the needs of

their clients a regular pattern as to the provision of care did contribute to the smoother running of the service.

As part of the provision of its day time care service MADEC office staff prepared a weekly roster matching clients with carers at agreed hours for the provision of care. At the time of that Mr. Joy went on this roster for the week commencing the 29th January 2007 – the time of the commencement of the day time service to him – there were problems with their preparation. The problems were that they were not produced in a timely fashion for the carers and that clients were missed. It seems that with the more long term client with a regular pattern of care, the carers would point out when a client had been missed off the roster.

It is clear that Mr. Joy was missed off the roster for the 16th February 2007 in the week commencing the 12th February 2007 and on that date both the morning and afternoon services were not provided. Whilst he was on the roster for Sunday the 18th February 2007 he did not receive the afternoon service as the carer failed to attend. Mr. Joy was again missed off the roster on the 24th February 2007 which is of course the day of his death.

Whilst there is a dispute as to whether or not the roster for the week commencing the 19th February 2007 was the first one she had prepared, it is clear that Ms. Shelley George in her role as Disability Coordinator prepared this roster. It is not clear from the evidence whether this roster was checked by Ms. Karen Langtree who was Disability Manager and Ms. George's supervisor. Ms. George was clearly dissatisfied with the training she received and the system in place for the preparation of the weekly rosters.

On the night of the 24th February 2007, Ms. Careen Therese COOK and Janetha Sophia JANSEN VAN VUUREN were rostered to provide the "tuck in" service for Mr. Joy. They arrived at his unit at 26 Martin Street, North Mackay at about 8.40 p.m. and Ms. Jansen Van Vuuren attended at the unit whilst Ms. Cook waited in the car. As the front door was unlocked Ms. Jansen Van Vuuren entered the unit and on getting no response when she called out to Mr. Joy she looked through the unit and found him lying on his side in the foetal position on the bathroom floor. His pants were down and his wheel chair was just in front of where he was lying.

Ms. Jansen Van Vuuren thinking at this stage that Mr. Joy had simply fallen went out to the car to get Ms. Cook to come and help. Ms. Langtree was contacted and when it was shortly

realized that there was something terribly wrong with Mr. Joy the ambulance was contacted. Whilst some faint signs of life might have been detected Mr. Joy could not be revived.

The evidence does not disclose where Mr. Joy's "Vital" call was at this time or what happened to it except that at some stage it was returned to the organization that provided.

Dr. FitzPatrick who conducted an autopsy on Mr. Joy on the 28th February 2007 determined the cause of death as intra abdominal haemorrhage due to traumatic rupture of splenic blood vessels due to fall. He listed as other significant conditions contributing to the death but not related to the condition directly leading to the death as probable portal hypertension and Wilson's disease. Dr. FitzPatrick could not say with certainty if a fall caused the rupture or the rupture caused a fall. He considered that, in light of Mr. Joy's history of falls it was more likely he fell causing the rupture.

Dr. Fitzpatrick could not give any indication of when this rupture may have occurred although he considered that Mr. Joy would have lost consciousness within a matter of minutes after the rupture.

Mr. Joy was missed off the roster because of human error. The system in place at that time in February 2007 in relation to the preparation and checking of rosters was not such as far as possible to ensure that such an error was detected. The fact that Mr. Joy was a relatively new client as far as the daytime service provided by MADEC was concerned should not, as it appears to have been, a factor in whether or not that error was detected.

The evidence suggests that whilst it took some time for there to be improvements in the system for the checking of rosters it was improved. The system now in place at MADEC is computer based with the software flagging any client who may have been missed. Such a system of course depends upon the information as to clients and agreed services being correctly imputed at the start.

Because the services that MADEC was obliged to provide to Mr. Joy for his care were of limited duration each day Mr. Joy's care would at other times have to be provided by others or he would have to take care of himself. Apart from concluding that most likely Mr. Joy fell during daylight hours it is not possible to determine even an approximate time when that may have happened. Therefore, it is not possible to conclude that Mr. Joy being left off the

day time care service roster for the 24th February 2007 contributed to his death in the sense that if the contracted care had been provided he may have received medical assistance sooner and thus may have been saved.

It of course would only be natural that Mr. Joy's family and friends might harbour a nagging doubt that if agreed services had been provided Mr. Joy might not have died.

The evidence does not raise any concerns as to the involvement of Disability Services Queensland in the provision of services by MADEC to Mr. Joy either before or after his death. The department only became aware of problems about the provision of the agreed services to Mr. Joy after his death.

With the introduction of the Disability Services Act 2006, the Minister has power to promulgate disability service standards, which would include administrative procedures of the service providers, which have legislative force and can be enforced by an external certification body known as Quality Assurance.

The findings that I am required to make, if possible, by section 45 of the *Coroners Act 2003* are:

The deceased is Michael Joseph JOY; and

Mr. Joy died in the bathroom of his unit when he fell as he apparently attempted to get out of his wheelchair; and

Mr. Joy died on the 24th February 2007;

Mr. Joy died in his unit at 7/26 Martin Street, North Mackay in the State of Queensland; and.

The cause of his death was intra abdominal haemorrhage due to traumatic rupture of splenic blood vessels due to a fall.

Nothing has been raised in the evidence upon which I can appropriately comment pursuant to section 46 of the Act related to:

- public health or safety; or
- the administration of justice; or
- ways to prevent deaths from happening in similar circumstances in the future.

The Inquest is now closed.