MAGISTRATES COURT TASMANIA

# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Olivia McTaggart, Coroner, having investigated the death of Michael Phillip Hyde-Wyatt

**Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that**

a) The identity of the deceased is Michael Phillip Hyde-Wyatt;

b) Mr Hyde-Wyatt died of natural causes in the circumstances set out in this finding;

c) Mr Hyde-Wyatt's cause of death was pulmonary aspiration of gastric contents (post seizure) due to chronic communicating hydrocephalus and encephalomalacia; and

d) Mr Hyde-Wyatt died on 11 February 2021 at Kingston, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr Hyde-Wyatt's death. The evidence includes:

- Tasmania Police Report of Death for the Coroner;
- Life extinct and identification affidavits;
- Opinion of the State Forensic pathologist regarding cause of death;
- Report from the Coronial medical consultant, Dr Anthony Bell;
- Further expert opinion from Dr Anthony Bell and the State Forensic pathologist;
- Ambulance Tasmania attendance records;
- Tasmanian Health Service and Claremont Village Medical Centre records for Mr Hyde-Wyatt;
- Nexus Inc. records for Mr Hyde-Wyatt and investigations into his death;
- Guardianship and Administration Board Order for Mr Hyde-Wyatt;
- NDIS Plan for Mr Hyde-Wyatt;
- Affidavit of Mark Jessop, Chief Executive Officer of Nexus Inc.; and

- Statement of Julie Magrath, support worker who cared for Mr Hyde-Wyatt at the time of his death.

**Background**

Michael Phillip Hyde-Wyatt was born 25 September 1959 in Zanzibar, Tanzania to Rosemary and Brian Hyde-Wyatt. He was aged 61 years at its death. He has two sisters, Katheryn Hickey and Eileen Langford. In 1966, the family immigrated to Tasmania for Mr Hyde Wyatt's father to take up a position as an agronomist in Launceston, a position he held until his retirement.

Mr Hyde-Wyatt had a happy childhood although, as a very young child he was diagnosed with hydrocephalus (abnormal accumulation of cerebral spinal fluid within the brain) and sustained an acquired brain injury. Unfortunately, he suffered the effects, symptoms and incapacity associated with this condition for the remainder of his life. These included severe visual impairment, distorted head shape, facial palsy, poor coordination and intellectual disability.

Although he was academically competent, successfully completing year 12 at school, he never found full-time employment, which caused him much grief and disappointment. In his younger life, he played table tennis and badminton and held a drivers licence. He spent most of his life living in Launceston with his parents and was a dedicated volunteer with various organisations, including a local radio station, a library and the SES. He was continuously under the treatment of his regular general practitioners and specialists and was prescribed various medications for his medical issues. As time went by, his health deteriorated and medical records indicate that his further diagnoses included schizophrenia, Parkinson's disease, severe dilated cardiomyopathy, kidney disease, hypertension, psoriasis, gastro-oesophageal reflux disease and gout. As a consequence of his conditions, Mr Hyde-Wyatt had a history of falls, poor mobility, confusion and cardiac events.

In 2015, Mr Hyde-Wyatt's father passed away and his mother moved into a nursing home in Sandy Bay for her ongoing care. Subsequently, a Guardianship Order was made in respect of Mr Hyde-Wyatt for financial administration purposes. In her affidavit, Ms Langford described her brother suffering a mental breakdown at about the time of his father's death, with sudden violent outbursts and temper tantrums, likely caused by a loss of certainty relating to his future. Mr Hyde-Wyatt became increasingly irrational, violent and unable to manage his health issues. It was no longer viable for him to stay with family members and the decision was made for him to reside at a care facility.

From 2015 until his death, Mr Hyde-Wyatt lived in several residential care facilities operated by Nexus Inc. He lived in a Nexus Inc. care facility in Austin's Ferry for approximately three years, where he made good friends with some of his carers. However, his problematic behaviour caused short-term transfers to other facilities, before commencing residence in January 2021 at the Nexus Inc. Channel Highway facility (Channel House).

**Circumstances of death**

At about 1.30am on 11 February 2021, Mr Hyde-Wyatt was asleep in his room at Channel House when the support worker on night duty, Ms Julie Magrath, heard a sound and went to check on him. When Ms Magrath entered his room, she noticed that he was tossing and turning around in his bed and flailing his arms. Ms Magrath believed that Mr Hyde-Wyatt was having a seizure and she immediately began timing the seizure, which lasted for approximately three minutes. Ms Magrath noticed that Mr Hyde-Wyatt's lips were blue but he was breathing and she believed that he was coming out of his seizure. Ms Magrath was the only support worker on duty and she was covering the five residents of the facility. She was well qualified as a support worker, having a Certificate 3 and Certificate 4 in disability care with numerous additional certificates. Her required training with Nexus Inc. was current.

Ms Magrath, in her statement for the coronial investigation, said that she heard Mr Hyde-Wyatt snoring at 1.45am, 15 minutes after his episode. She said that she then checked him at 2.00am and heard him snoring again. She said that she further checked on him at 3.00am and 4.00am by peeking her head through his door and, on these occasions, she said that he "appeared as though he was sleeping". At around 5.00am, she went to check on Mr Hyde-Wyatt again as she was surprised that he had not woken to go to the toilet. When she entered his room and turned on the lights, she noticed that there was blood around his nose and on the pillow and Mr Hyde-Wyatt was unresponsive. At this point, Ms Magrath made the decision to call the on-call senior staff member, Troy Briggs, for guidance. She was advised to call an ambulance and did so. She commenced CPR upon Mr Hyde-Wyatt, as instructed by the ambulance operator, until the arriving paramedics took over resuscitation efforts. Unfortunately, Mr Hyde-Wyatt was pronounced deceased at the scene.

I am satisfied that there were no suspicious circumstances indicating deliberate involvement of any person in the death of Mr Hyde-Wyatt. The State Forensic pathologist reported that Mr Hyde-Wyatt died as a result of pulmonary aspiration of his gastric contents following a seizure. The aspiration event was confirmed upon review of post-mortem CT scan images.

**Ms Magrath's actions**

In the week before his death, Ms Magrath noticed some unusual mental absences and confusion in Mr Hyde-Wyatt. She thought he was having "mini-seizures". She made enquiries with other staff, who were not aware of Mr Hyde-Wyatt having a history of seizures. At this point, Ms Magrath should have checked Mr Hyde-Wyatt's medical history using the Client Information Management System (CIMS). In this regard, Nexus Inc. required all staff to log onto CIMS at the beginning of every shift to check and review information about their client. Further, there was a requirement that staff members familiarised themselves with the client and their requirements. If Ms Magrath had checked the system or had properly familiarised herself with Mr Hyde-Wyatt's situation, it would have been evident that Mr Hyde-Wyatt had no history of seizures and that he had a heart condition which caused a significant medical risk. If she had been equipped with this information at the time of his medical episode on 11 February 2021, the circumstances and Nexus Inc. policies dictated that an ambulance should have been called immediately to attend. Ms Magrath also had the option of raising an 'alert' which would have brought to the attention of other staff that Mr Hyde-Wyatt was experiencing seizure-like symptoms.

Ms McGrath's actions in timing the seizure and monitoring Mr Hyde-Wyatt would have been appropriate action had Mr Hyde-Wyatt had a documented history of seizures and an established seizure management plan. Neither of those things existed. Ms Magrath should have called an ambulance at the earliest opportunity. Part of her role was to accurately manage and respond to emergency situations as they arose. Nevertheless, if Ms Magrath was unsure about whether to call an ambulance when Mr Hyde-Wyatt experienced his seizure she could have telephoned the on-call senior staff member for advice.

Regardless of the cause of the event, it was unusual and potentially concerning. Ms Magrath should have called for the attendance of an ambulance.

**The effect of the failure of Ms Magrath to call an ambulance**

I have received additional expert medical evidence from Dr Anthony Bell, coronial medical consultant, and Dr Andrew Reid, State Forensic Pathologist, regarding the nature of the event that led to Mr Hyde-Wyatt's death and the likely time of his death. Both experts were of the opinion that the recovery of Mr Hyde-Wyatt to normal status after the seizure event as described by Ms Magrath, was a plausible hypothesis. Both indicated that Mr Hyde-Wyatt may well have suffered a subsequent aspiration event during the night that was responsible for his death. They were unable to identify from the medical evidence when death was likely to have occurred. They considered it plausible that a fatal aspiration event may have occurred after 4.00am, subsequent to the last check by Ms Magrath. I note from the

ambulance report that when paramedics attended at 5.43am, Mr Hyde-Wyatt was still warm. However, this in itself does not determine time of death. I fully accept the opinions of both experts.

There are some inconsistencies between the various accounts given by Ms Magrath regarding the timing of her checks before Mr Hyde-Wyatt's death. However, I cannot reject her account. It may well be that Mr Hyde-Wyatt did recover from the event at 1.30am but subsequently died unexpectedly at a later time.

I add that, even if Ms Magrath did call an ambulance after the event at 1.30am, it is speculative to determine whether or not the attending paramedics would have recommended that he be transported to hospital.

**Comments and Recommendations**

Ms Magrath's breach of basic protocols, and thus failing in her duty to Mr Hyde-Wyatt, may have deprived Mr Hyde-Wyatt of a chance to be hospitalised, monitored and treated. However, I cannot make any higher finding than this given the degree of speculation required to do so.

Ms Magrath's employment with Nexus Inc. ceased after Mr Hyde-Wyatt's death.

I acknowledge that in response to Mr Hyde-Wyatt's death, Nexus Inc. have undertaken an investigation and several areas of process improvement have been identified. However, this is not a situation where I consider that Nexus Inc. was responsible for any deficits in training, protocols or procedures that might be connected with Ms Magrath's actions or Mr Hyde-Wyatt's death.

I make no recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Hyde-Wyatt.

**Dated:** 22 May 2023 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**

**Coroner**