# Proposed improper use of the Vineland 3 test

The Vineland 3 test has been designed, tested and validated for use with people with Autism and/or Intellectual Disability **ONLY**.

The NDIA is proposing to misuse this test by applying it to ALL people with a disability, disregarding the fact that it has ***never*** been validated for use with people who only have a physical disability.

This test requires that someone else (a partner, carer, support worker, etc) has to answer questions about the person with disability while that person is out of the room. These questions include:

- Can the person understand at least 10 words?
- Can the person properly respond to a question containing the word 'what'?
- Can the person write their own name without spelling errors?
- Does the person return to their parent/carer when approached by a stranger on the street?

As an adult with a Bachelor of Industrial Engineering and Computing with First Class Honours, who works in software development on planning/rostering/optimisation/disruption management software for major world airlines including Malaysian Airlines and Etihad, having to have this *drivel* answered by someone else *about* me because I have an acquired ***physical*** disability is both degrading and insulting, as well as being an abuse/misuse of the Vineland 3 test.

Further, the Vineland 3 test miscategorises many physical symptoms from conditions that cause physical disabilities as "maladaptive behaviours". It took me 23 years to get a proper diagnosis from the health system due to assumptions that the physical symptoms I was experiencing were psychological or laziness (i.e. behaviours), and part of the reason I *now* have a physical disability is due to not having had appropriate treatment for that condition for those 23 years.

I do NOT want to find myself having to fight the NDIA over a Vineland-based misdiagnosis of physical symptoms as "behaviours" that have to be "fixed" when the symptoms involved were never behaviours in the first place. One example is that "trouble going to sleep" is categorized as a "maladaptive behaviour" - but anyone who suffers chronic pain (which commonly accompanies physical disabilities) will frequently have trouble going to sleep as a result of the pain that they are experiencing. For those people, it's absolutely **not** a "behaviour" - it's a direct consequence of physical symptoms.

In extreme cases, the miscategorization of physical symptoms as "behaviours" has resulted in people's deaths. Attached is the Inquest report for "Lena Divola" who died in care in December 2007 because the symptoms of a brain bleed after having hit her head on concrete a couple of days prior were dismissed as simply being a "manipulative behaviour to be resisted". She was left lying paralysed in her own vomit for at least 30 hours before medical help was sought, without food, without medication and with little water while everyone "encouraged" her to get up on her own.

I ***strongly*** object to being subjected to tests that are ***completely untested, unvalidated, and inappropriate for use with my disability***, especially when they miscategorize my physical symptoms and require someone else to speak on my behalf.

I challenge the NDIA CEO Martin Hoffman to actually *read* the list of questions in the Vineland, and think seriously about how he would feel were someone to demand that his partner or close relation answer those questions about himself. Would it feel appropriate for those questions to be asked about himself? If not - why are they being inflicted on people regardless of age, education level, disability type, etc, despite those questions not being appropriate for anyone who did not have either Autism and/or an Intellectual Disability?

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the **Coroners Act 2008***

**Court reference:** 28/08

**Inquest into the Death of LENA DIVOLA**

| | |
|---|---|
| Delivered On: | 20th May, 2011 |
| Delivered At: | Level 11, 222 Exhibition Street, Melbourne 3000 |
| Hearing Dates: | 9th and 24th August, 2010 at<br>Melbourne Magistrates Court, William Street,<br>Melbourne |
| Findings of: | PETER WHITE |
| Representation: | Mr Paul Halley for Dr Langdon<br>Ms Fiona Ellis for Australia Community Support Organisation and employees<br>Mr Anthony Burns for Mr John Divola<br>Ms Patricia riddell for Mr Simon Wardale |
| Place of death: | The Alfred Hospital, Commercial Road, Melbourne 3004 |
| Police Coronial Support Unit (PCSU): | Leading Senior Constable Greig McFarlane |

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the **Coroners Act 2008***

**Court reference:** 28/08

In the Coroners Court of Victoria at Melbourne
I, PETER WHITE, Coroner

having investigated the death of:

**Details of deceased:**

Surname: DIVOLA
First name: LENA
Address: Armadale House, 10 Myamyn Street, Armadale 3143

AND having held an inquest in relation to this death between 9th and 24th August, 2010
at Melbourne Magistrates Court, William Street, Melbourne
find that the identity of the deceased was LENA DIVOLA
and death occurred on 31st December, 2007

at The Alfred Hospital, Commercial Road, Melbourne 3000

in the following circumstances:

**Background**

1. Lena Divola was a 59-year-old woman who suffered from a dual disability in that she was intellectually disabled and suffered from a concurrent psychiatric condition of schizophrenia. She also suffered from depression, hypertension, ischaemic heart disease, hypercholesterolemia and arthritis.

2. It is also relevant that she was an obese woman and required the assistance of a four-wheeled walking frame, to walk any distance. She had first been admitted to a psychiatric hospital in 1965 at aged 17 and had many subsequent admissions.

3. At the time of her death, Lena was taking a considerable number of medications on a daily basis, which included the anti-coagulant medication Warfarin.

4. Over the previous five years she had been resident at the Department of Human Services owned, Armadale House, which I note here was run by the Australian Community Support Organisation (ACSO). There were four other co-residents. ACSO staff attended on these residents 24 hours a day.

5. Lena was the much-loved sister of John Divola and was supported by Mr Divola and his family who consistently went to considerable lengths to include her in important family occasions.

6. I further note that her behaviour had regularly involved her in making unnecessary requests for medical attention and on one occasion, in the making of a false claim of sexual assault against a member of staff.[1]

7. The consensus of Armadale House staff was that it was difficult to determine when her behaviour was genuine and this was further complicated by the fact that some staff who knew her well believed that she was capable of adapting her response to what she thought staff knew and expected of her.

8. I also note however that Tracy Allen offered the opinion that her instances of difficult behaviour over the last few years had become relatively rare.[2]

9. Dr Rob Shields, Lena's consultant psychiatrist, described her behaviour as at the highest spectrum of challenging behaviour and I note here that Lena's family did not challenge this view. When asked why he so rated Lena's behaviour he said it was not only the type of challenging behaviours she exhibited, but their frequency and persistence.[3] She could quickly deteriorate after a period of stable behaviour.[4]

10. The result of these and other behaviours was that staff saw her as being manipulative and attention seeking. The sexual assault allegation was viewed with particular concern and following her recanting of this particular allegation, a new policy was put in place by Tracy Allen to meet such behaviour.[5]

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1 This claim of sexual assault against a staff member was later withdrawn by Lena with an accompanying apology.
2 Tracey Allen was the Dual Disability Program Coordinator responsible for Lena until November 2007, when she was replaced in that role, by Mr Simon Wardale.
As to her opinion about the frequency of Lena's difficult behaviour, see exhibit 16 at page 1. See also transcript page 478 at line 4, and Transcript from page 558 where Ms Allen later agreed with Counsel for Dr Langdon that Lena's case manager believed that her instances of challenging behaviour had continued. See also her Case Note entries between the 1/7/2007 and the 14/12/2007, which suggest that she complained almost daily of physical ailment and the continuing use of Lena's 'reactive strategy' to distract her from that behaviour.
3 See transcript page 333.
4 See transcript page 321. See also the Patient Management Plan prepared for Lena by Psychiatrist Dr Yap at exhibit 2d.
5 See exhibit 2b, which was later amended by document exhibit 16b, dated the 1st of October 2007.

11. It is significant that the amended strategy[6] was based on a direction to deal with Lena only in front of CCTV cameras, for staff not to enter her room and, when she was in her room, to only to deal with her from the hallway.[7]

12. Having reviewed all of the evidence together with Counsels submissions, I am satisfied that a number of incidents which occurred in the two weeks prior to her death are also relevant to her cause of death and, accordingly, I now set out the largely uncontradicted evidence concerning those matters.

**Circumstances surrounding death**

13. It is common ground that on the 15th of December 2007 an Armadale House co-resident assaulted Lena.

14. As a result, Lena saw the GP retained by ACSO, Dr James Langdon, at his rooms on the 17th and later underwent a CT scan. Lena saw Dr Langdon again on the afternoon of the 24th of December and he reported that 'the earlier scan had not indicated other than a normal condition'.

15. In the late afternoon of the 24th, following their visit to Dr Langdon's surgery, Disability Support Worker Michelle Lesek,[8] took Lena for a coffee and cake reward at Giorgio's café, which is situated near the House at the corner of High Street and Glenferrie Road.

16. As they returned from their excursion, Ms Lesek received a call from senior colleague Mr Simon Wardale,[9] who informed her that a healthcare professional was waiting at the House to conduct a check on Lena's warfarin levels.

17. It was a very hot day. Ms Lesek observed that the walk back to the House was proving to be a bit of a struggle for Lena and asked if she would like to sit on her walking frame and be pushed along, which invitation Lena accepted.[10]

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6 This amended strategy is discussed below under the heading Comment.
7 See Exhibit 16b and Transcript at page 122 (Ms Lesek), P 673 (Mr Simmonds)
8 Michelle Lesek holds a degree in Psychology and was employed at Armadale House as a Disability Support Worker. At the time under review, she also held a Certificate in First Aid. (Transcript page 1210, but not a Certificate 4 in disability support. (Transcript page 137).
9 Mr Wardale was Lena's Disability program Co-ordinator, (having taken over from Tracy Allen in mid November 2007, i.e. about 5 weeks before the incidents under investigation).
He was also the on call duty supervisor at Armadale House over Christmas, 2007. It is relevant that as On Call supervisor he was also responsible for 5 other ACSO houses in the area. Mr Wardale had a lengthy experience dealing with people with intellectual disabilities and held a B Sc Honours degree. I note that he now holds a senior position within the Department of Human Services.
10 The walking frame in question is one, which is in common use in Victoria. It is designed to be used both as a walker and when stationary, as a seat. It was common ground that it was not designed or intended for use in the manner employed by Ms Lesek. I further note that Ms Lesek testified that she had never been trained in the proper use of the walking frame.

18. Ms Lesek then began to push Lena who sat so that her back faced the direction in which they were moving. Whilst being pushed in this manner, the frame struck a rough section of pavement causing its momentum to slow abruptly. This caused Lena to topple backwards resulting in a heavy fall and the striking of the back of her head on the pavement.

19. Almost immediately, Lena was assisted to her feet by two male passers-by. According to Ms Lesek's case note,

> *"Lena didn't appear to lose consciousness."*[11]

20. Ms Lesek found a lump on the back left portion of Lena's head.[12]

21. In further testimony, she gave various estimates as to its diameter size ranging between one-half of a centimetre to one and one half centimetres.[13]

22. Lena was taken back to Armadale House where she complained of a headache and back pain. These matters were communicated to Mr Wardale who spoke directly to Dr Langdon to press for the appointment. At around 4.30 pm she was taken again to see Dr Langdon.[14] (At this time, Ms Lesek was aware of the potential dangers of a head injury for persons using warfarin).[15]

23. On examination Dr Langdon noted in her medical diary that she (Lena), reported falling and hitting her.....

> *"back and head - no rib (fracture), a lump on head, observe for 4 hours if change in mental state - Hospital A&E."*[16]

24. Ms Lesek's opinion was that this medical care record note was undertaken to inform co-workers (including herself), of the medication health care needs of different residents, although she would not usually look for it in that diary.[17]

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11 See case notes page 1 Exhibit 20a. Also, see however, transcript page 169 where Ms Lesek testified that she was unable to remember if Lena lost consciousness, and was also unable to remember what she told Dr Langdon about that matter.

12 See transcript page 124

13 See transcript page 125 and 147.

14 I am satisfied that Dr Langdon initially indicated resistance to the idea that he should return to his clinic on what was Christmas eve, to see Lena for a second time that day. I am also satisfied that following the intervention of Simon Wardale, Dr Langdon better understood the reasons for the consultation and did in fact return and examine her as requested by Mr Wardale.

15 See transcript page 127.

16 See exhibit 4b. I further note that Dr Langdon did not consider that a CT scan was called for at this time, (a decision later supported in evidence by Mr Kevin Siu, a specialist neurosurgeon who was called by Lena's family to address the question of cause of death. See transcript page 537 and later at page 585, where Mr Siu further supported Dr Langdon's advice, even though Lena was using anti-coagulant medication. Mr Sui's further testimony was however that there was a need for greater caution when dealing with a patient who was unreliable in relaying symptoms. See transcript at page 538.)

17 See transcript at page 165.The evidence generally suggested that the clinical notes made by House staff, were

25. Ms Lesek recorded the fact of the fall and the visit to Dr Langdon's clinic in Lena's clinical case notes.[18] Unfortunately, that note failed to detail Dr Langdon's recommendation concerning referral to a hospital A&E, which advice he had recorded in the medical diary.

26. I further note that Ms Lesek described the visit and Dr Langdon's recommendation, in significantly different terms in her statement where she stated,

> *"He told me to monitor it over the next few days to see how it goes."*[19]

27. Ms Lesek gave evidence that on her return to the House she told staff about her recollection of Dr Langdon's instructions, (i.e. 'to monitor over the next few days').[20]

28. Dr Langdon's evidence as to this conversation was to the effect that,

> *"I gave the instructions that she should be observed for four hours afterwards and if there was any deterioration she should be taken to an emergency department."*[21]

29. Against Ms Lesek's version of these events I note that Mr Wardale's evidence was that he was not present at the house when Lena and Ms Lesek returned and did not make any inquiries about Dr Langdon's advice.

30. Mr Wardale further testified that he would have expected such information to be passed between staff members.

31. I note here that Mr Wardale did not subsequently seek information about that matter himself and that there was no policy in place to ensure that such communication between shift staff occurred.[22]

32. It is also relevant that the evidence of Mr Taylor suggests that Ms Lesek told him about the fact of the fall (but not the content of Dr Langdon's direction) before her departure from the House and that Lena also told him about this matter.[23]

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more likely to be referred to than the medical diary, when staff sought information about a particular medical history. This matter is further discussed under the heading Comment below.

18 See page 1 of exhibit20b

19 See exhibit 4 at page 2, which evidence was repeated at Transcript page 129.

20 See transcript page 174 where she comments, 'that it could have been Simon Wardale', who she recalled was in the building following her return from the clinic.

21 See transcript page 197.

22 See transcript at page 944-945.

23 See transcript at page 838.

33. Further colleague, Ms de Wilt,[24] testified that she was aware that Lena had had a fall but was not aware of any instructions given by Dr Langdon. She was also unsure if she had read the clinical notes prepared by Ms Lesek, which refers to 'hitting her head on the pavement'.

34. On the morning of the 25th Lena complained of not feeling well and of pain due to the fall the previous day. She was picked up by a family member at around 11.30am and spent Christmas with family members at her brother, John Divola's, home in Frankston. She complained to family members of continuing headache. As was her habit, she returned unaccompanied to the House by taxi in the evening, arriving between 5.30pm and 6.00pm. [25]

35. At around 5.00am on the following morning, Boxing Day, Lena was found on the floor of her bedroom having vomited on the floor and over her nightdress. The overnight on-duty staff member, Peter Simmonds,[26] was alerted to this by House co-resident, Sylvie Himmelfarb. According to Ms de Wilt, Lena was later observed to be communicative, refusing food and medication, but taking limited fluids.[27]

36. Mr Simmonds initially entered her room and attempted to help Lena up but this was unsuccessful.

> *"Lena made no attempt to get herself up and help me and therefore this proved unsuccessful."*[28]

37. He then phoned the on call supervisor, Simon Wardale, who advised not to help her to get up.[29] Lena continued to request assistance to get up and Mr Wardale advised Mr Simmonds that she should be encouraged to help herself. Mr Simmonds continued from this point to speak to her from the door. Mr Simmonds spoke to Mr Wardale, about calling an ambulance, but he was against this.[30]

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[24] Ms de Wilt was at the time employed at Armadale House as a welfare worker (now as an outreach worker). She held a Disability Certificate IV and had undertaken first aid training. She had worked with Lena over a period of two years but still had considerable difficulty telling the difference between instances of display of Lena's medical as distinct from her behavioural problems. See transcript page 755. She was not aware of the dangers associated with the use of warfarin. Transcript page 757.

[25] See transcript pages 756 -7.

[26] Mr Simmonds testified that at the time of Lena's fall he was a residential welfare worker employed at Armadale House by ACSO. He did not hold a Certificate 4 in Disabilities but was now working towards that qualification. He had also completed standard ACSO training and first aid level 2, and that he had commenced at Armadale House some 3 weeks before Christmas 2007, after 3months at Francis House. He further testified that the night shift on Dec 25/26 was the first occasion he had worked overnight and been left solely in charge. He could not recall if he had previously read any material concerning Lena, although he had been given an opportunity to do so.
He came from a background of having worked as a civilian within the Defence Force for over 10 years. See transcript from page 668.

[27] See Ms de Wilt statement at exhibit 21at page 3.

[28] See statement at exhibit 20.

[29] See exhibit 20.

[30] See transcript at page 674.

38. Mr Simmonds remained on duty until 8.30am on the morning of the 26th and briefed day shift staff Anneke de Wilt about Lena's situation.

39. Over the course of the shift, Ms de Wilt and fellow staffer, Andrew Taylor, kept checking on Lena every 20 minutes or so. During this period, Lena continued to seek physical assistance, and they continued to refuse to help her to get up. Further phone calls were made and Mr Wardale continued to advise that they not intervene.

40. His view was that, Lena's behaviour,

> *"was common behaviour for Lena."*[31]

41. Ms de Wilt, who believed Lena's behaviour was simply a demonstration of her behavioural condition, endeavoured to demonstrate to Lena how she should lift herself up.

42. She was unable to recall details of her conversation with Lena and fellow staff about Lena's fall but agreed that she had had such conversation(s).[32]

43. She also stated that she offered Lena food, drink and an ambulance at one point, which offers were declined.[33]

44. Mr Simmonds returned to commence the night shift at 4.45pm and was surprised to find Lena in exactly the same position still on the floor of her room.[34] He was advised by Mr Taylor and Ms de Wilt that they had,

> *"kept on call, Simon informed and followed all of Lena's reactive strategies for this kind of situation."* [35]

45. He was also advised that Lena had refused cordial, food and medication.

46. At about 9.00pm Mr Simmonds noticed that Lena had fallen asleep, while still on the floor. He checked on her at 11.30 pm and found her in the same position, upon which he closed the door and turned off the light.

47. By this stage, I note here that Lena had been on the floor for a period of approximately 18 hours. During this period, she had remained sitting in her own vomit and had no food, little water

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31 See Mr Wardale's statement and transcript from page 947.
32 See transcript page 759
33 See transcript page 758.
34 A review of the clinical notes over the previous 5 years of her stay at the House revealed no evidence of her refusing to get up over a prolonged period of time.
35 See exhibit 20 at page2.

and no medication, including her psychiatric medication, and that she had not been able to use toilet facilities. [36]

48. The next morning Mr Simmonds woke at 7.00am and went to see Lena who was still asleep. Meike Donald, the day shift carer, arrived at 8.30am and rang Mr Wardale who advised her to contact the CAT team, which she did,[37] without result.

49. Later at 10.00am Ms Donald observed Lena still on the floor with her legs twitching. An ambulance was called to attend. Her Glasgow Coma Scale was measured at 15/15.[38] A decision was made to send her to hospital, however, a second ambulance was required because of her weight. Approximately 3 hours later both ambulance crews were in attendance and her GCS scale was then assessed as 12/15.

**Evidence on cause of death**

50. Following her arrival at The Alfred Hospital, Lena was diagnosed with an altered conscious state (GCS 11) and hyperglycemia (BSL 21), and generalised weakness and vomiting. A CT of the head showed a large intracerebral haemorrhage. There was evidence of left frontal and parietal haemorrhage. She developed seizures during the admission and then a chest infection. Lena Divola subsequently deteriorated quickly and after discussions with family members she was provided with palliative care and died on the 31st of December.[39]

51. Three expert witnesses were called to testify as to the cause of death.

52. Finally the essential difference between their evidence concerned whether the cerebral bleed was traumatic or non-traumatic in nature.

**Mr Kevin Siu[40]**

53. According to Mr Siu, a retired neurosurgeon engaged by Lena's brother John Divola, the intracerebral bleed was a result of the massive subdural haematomas caused by trauma. The bleeds in the frontal and parietal lobe were explained as being a product of *"intermediate coup contusion"*.

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[36] Evidence from a number of witnesses established that Lena was typically a very clean person who took pride in her appearance, and in keeping her room in a tidy condition.
[37] See exhibit 20 at page3. A second incident of vomiting had occurred and she was also found to have defecated overnight.
[38] See discussion at footnote 64 concerning the questionable accuracy of this finding.
[39] See Exhibit 7, the inspection and examination (non-autopsy report), prepared by Senior Forensic Pathologist, Dr Noel Woodford.
[40] Mr Kenneth Siu AM was the head of neurosurgery at the Alfred Hospital for some 13 years, to 2000. He is a widely recognized expert in his field, with some 33 years experience in diagnosis and corrective surgery, in that specialty. His reports were admitted as exhibit 17 and 17a.

54. Mr Siu testified that following even a trivial injury to the head, it is possible to have bleeding into the subdural space without bruising to the scalp. His opinion, in the absence of any other reasonable possibility[41] was that the fall caused a contra coup injury or intermediate coup contusion, which bled into the subdural space into three separate and distinct areas in the left frontal and temporal lobes.

55. In further explaining his view as to how this injury occurred, Mr Siu stated,

> *"Perhaps I can try and explain how - what I see it. The brain is contained in the skull. The brain is anchored to the skull by a number of structures. They are anchored by, actually by the subarachnoid membrane. The veins in the blood returns to the heart via venous sinuses in the skull so the veins from the brain have to go through this subdural space and if you imagine putting a lop - a blob of jelly in a tin, anchored by strands, and you give that tin a big shake, you will tear those veins. Those veins will then bleed into the subdural space. Because the brain, as I mentioned, is divided into several compartments the inferomedial aspect of the temporal lobe where the haematoma is maximal, that's inside - cerebral haematoma - is also abutting against the falx so that has - and the usual condition is the brain is contused against the skull which is a hard structure. It can possible be bruise against the dividing membrane - very tough membrane and that cause the haemorrhage.*
>
> *Yes, go ahead, Mr Burns?*
>
> *Mr Burns: Doctor, if this was a death caused as a result of a spontaneous intracerebral bleed, in how many occasions in your 33 years of neurological practice would you have seen it demonstrate the way it has on the CT scans?*
> *--- I've never seen a case in which a patient had a spontaneous haemorrhage then to have subdural at three different locations. That's - that is - when one is convinced that there's no trauma preceding the illness."* [42]

56. When further questioned on Dr O'Donnell's opinion, Mr Sui stated,

> *"Q. Can you confidently state that there has been no aneurism in Lena's brain?*
>
> *A. A CT scan - this is a CT angiogram is about 90 percent accurate to uh, see an aneurism. When an aneurysm is smaller than five millimetres it still may be missed on the CT but in this particular case. With such a massive haematoma in the brain itself, one*

[41] Mr Siu further stated his view that the subdural haemorrhage was not caused by an interacerebral bleed, (Dr O'Donnell's view), given the pattern of bleeding into distinct separate areas of the frontal lobe.
[42] See transcript at pages 514-515.

*would expect had there been an aneurysm, it would be probably bigger than five millimetres and therefore would be showing on the CT angiogram.*

*The absence of the aneurysm on the CT angiogram is reasonable evidence that there is no aneurysm there.*

*Q. In fact you deal with that as the third last paragraph in your second statement. I will read that to you. "The presence of an intracranial aneurysm or malformation has been reasonably excluded by the second CT scan?" Yes....*

*A. Correct."*[43]

57. Mr Siu further supported his contra coup explanation for the cause of death as against the dual pathology of a traumatic event coupled with a spontaneous but unrelated bleed in the intracerebral area.

*"If she had a fall, falling backwards hitting her head she would suffer a tearing of veins, the veins being the veins in the brain to the venous sinuses of the skull. Those veins are torn giving rise to subdural haematoma and that explains the various locations, the use of the warfarin explains why it was slowly accumulating but I took note of the fact that there is also intracerebral - there is blood in the brain itself, and that was emphasized also by Dr Woodford, he postulated there may be a spontaneous cause and to fit that in I have to invoke two pathological process. The patient had a fall; the patient at the same time had a spontaneous haemorrhage from a number of pathology. To try and fit in (these) two scenarios into one clinical picture, I find it difficult. Because with the first proposition she fell backwards which giving a subdural, I went to the textbooks and identified this relatively uncommon entity, intermediate contra coup injury, which explains why there is significant intracerebral haematoma."*[44]

58. Mr Siu's further opinion was that the delay involved in providing treatment to Ms Divola had contributed to death.[45]

[43] See transcript page 509-510.
[44] See transcript at 511-512 and the text Neurosurgery edited by Wilkins and Rengachary Vol 2 at page 1535 at Exhibit 17b.
[45] See exhibit 17 at page 3 and transcript at page 533. I note here that Mr Siu's response assumes that a CT of the brain would have been undertaken had Lena been taken to an A&E on the 26/12.

**Dr Noel Woodford**[46]

59. Dr Woodford, who consulted with Dr O'Donnell about the source of the bleed, stated in his initial Inspection Report that the intra cerebral bleed was caused by a non-traumatic spontaneous event arising in the medial temporal lobe and spreading to the subdural spaces. This opinion, for reasons beyond Dr Woodford's control, was provided without the history of trauma referred to above and following his consideration of same, he was unable to confirm his earlier advice that Lena's death was related to a spontaneous event.[47]

60. Dr Woodford was later recalled to testify concerning reports received from Dr Siu.[48] Dr Woodford referred to and supported his earlier view that the matter of interpreting scans and the

> *"observed symptomatology,"*

was outside his area of expertise.[49]

**Dr Chris O'Donnell**[50]

61. Against the evidence offered by Mr Siu, Dr O'Donnell's opinion was that the bleed was consistent with a non-traumatic event starting within the tissues of the temporal lobe of the brain and then rupturing out into the subdural space. According to Dr O'Donnell (who had worked with Mr Siu at The Alfred), this is a well recognized pattern of bleeding and speaks to the severity of the bleed.

62. According to Dr O'Donnell, it would be very unusual for the bleeding to start on the surface of the brain and to leak into the subdural space.

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46 Dr Noel Woodford is a senior, highly skilled and experienced pathologist and Head of Forensic Pathology, and recently served a term as the Acting Director at The Victorian Institute of Forensic Medicine (VIFM).

47 Dr Woodford was not aware of the history of Lena's fall and the blow to her head when he gave his opinion set out in Exhibit 7, as this matter was not referred to in the original Form 83 report of Death prepared by Victoria Police. His additional evidence in answer to a question put by Counsel for the Divola family, was that, 'if a haemorrhage results from blunt force head trauma it can take several days to manifest itself but usually that's in the setting of most of the blood being in the subdural space, so an acute subdural haemorrhage and these things can evolve, sometimes they can stop and then re-bleed. A complicating factor here is that Ms Divola was on Warfarin and that can increase the propensity to bleed.' See transcript at page 239.
Dr Woodford further testified that radiology was not his speciality and that he had earlier sought the views of radiologist Dr O'Donnell, when the case was first referred to him.
In the circumstances of the full history put to him by Counsel for the Divola family and in the absence of an autopsy (and advice from a neuropathologist-transcript page 246), he was unable to say whether the cause of death was trauma related or stroke related, (transcript Page 241). His later testimony was that it was unlikely that a fall caused the haemorrhage, (transcript page 246), and he could not say if the bleed, (whatever its origin), may have been amenable to surgical repair, (transcript at page 245).

48 See Exhibits 17 and 17a.

49 See transcript at page 503.

50 Dr Chris O'Donnell is a highly skilled and experienced forensic radiologist and consultant at VIFM.

> *"Its much more likely that bleeding starts in the brain and leaks out. The subdural space is a very large space and bleeding can continue on throughout that surface and rarely would it bleed then back into the brain."* [51]

63. Dr O'Donnell agreed that the location of the bleed can occur with the so-called intermediate coup theory contended by Mr Siu.

64. His further testimony was that the old blood he identified in the Alfred CT scan found in the frontal lobe was between 24-72 hours old, with most of the blood being younger than that, which I note is consistent with the possibility that it commenced on the 24th of December, 2007.[52]

**Findings**

65. Having reviewed all of the evidence and Counsel's submissions I am satisfied that Dr O'Donnell, Dr Woodford and Mr Siu[53] are qualified to assess the cause of death and have '*specialised knowledge*' in their respective fields.[54] I also find that the investigation of the matter has been hindered by the absence of an autopsy and brain pathology examination.[55]

66. Having said that, I am satisfied that Mr Siu's specific experience in patient review and clinical examination and surgical repair, is more likely to have given him a greater insight into the pathology of a complex intracerebral haemorrhage, and as to how this particular event occurred.

67. Further, all opinions were fully tested. In all the circumstances and having particular regard to the evidence given by each expert and the process underpinning the explanations offered, I am satisfied that the opinion provided by Mr Siu is correct and I accept that view.

68. Turning now to the care provided to Lena whilst at Armadale House, I am further satisfied that in total she remained indisposed on the bedroom floor at Armadale House for a total period of not less than 30 hours.[56]

69. This period commenced at some time prior to the discovery of Lena sitting on the floor of her room on the early morning of December 26th and continued until the following morning,

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51 See transcript 1068-69.
52 See transcript at page 575 and 1102..
53 Mr Siu's analysis of the roles played by the clinician (not himself in this case), the pathologist and radiologist are at transcript page 534.
54 See *Cadbury Schweppes Pty Ltd v Darrell Lea Chocolate Shops Pty Ltd,* [206] FCA363.
55 Discussion as to the uncertain manner the request for an opinion came to be referred to VIFM, is set out at transcript page 247.
56 I note that in her opening address Counsel for ACSO conceded on behalf of her client that, ACSO had failed Lena by not organising a medical review of her on the 26th of December, 2007. See Exhibit 1.

December 27th,[57] when staff member Meike Donald again called Mr Wardale in his home. As a result, an ambulance was called arriving at around 10.00am. Thereafter, a second ambulance was called to assist, which finally led to her removal from the floor (and departure from the House) at 1.15pm.

70. From the evidence of Mr Siu I am satisfied that the blunt force injury sustained when she fell on the afternoon of the 24th precipitated a contra coup injury and resulted in a slow intracerebral haemorrhage with bleeding in the brain and into separate parts of the frontal lobe. It follows that I find that Lena Divola died at The Alfred Hospital, Melbourne, on the 31st of December 2007,

From 1 (a) Subdural haemorrhage
(b) Blunt force trauma to head sustained in a backwards fall from the seat of a walker.

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

1. I find that the method employed by Ms Lesek to transport Lena on her walker during the journey back to Armadale House on the afternoon of December 24th, was perilous. While I am satisfied that Ms Lesek's decision to push Lena in this manner was made with Lena's comfort in mind it is also the case that Lena's accidental fall and the injury sustained, occurred because of this error.

2. I further find that by 11.00pm on the night of the 26th of December, Lena had been on the floor for some 18 hours and had, during that time, regularly requested assistance from staff to get to her feet.

3. It is also true that during this period there was little or no reference by staff either to the medical treatment diary note written by Dr Langdon or to the limited clinical note made by Ms Lesek. As a result the general level of staff, awareness concerning both the fact of Lena's injury (arising from her fall), and the separate issue of Dr Langdon's advice was poor.[58]

[57] The evidence of both John Divola and his daughter, Natalie Fairlie, established that in previous incidents of poor or difficult behaviour they had been called in to assist to persuade Lena to co-operate with House staff.
[58] Following my review of the evidence and Counsel's submissions, I find that I am satisfied that Ms Lesek, Mr Wardale, Mr Simmonds, Ms de Wilt, Mr Taylor (and Dr Langdon) all had some awareness of the fact of Lena's head injury sustained on the afternoon of December 24th. I further find that I cannot be satisfied that staff on duty between the night of the 25th and the calling of an ambulance in the late morning of the 27th had read her clinical notes or the treatment diary, or were otherwise aware of Dr Langdon's advice that the head injury should continue to be monitored.

4. I also note that the documented evidence, supported by staff as to their recollections, establishes that Lena's previous attention seeking behaviour (which itself was difficult to discern), had invariably been resolved in a relatively short time. Ms de Wilt did not consider Lena's length of stay on the floor to be unusual,

> "*if she was unsettled or unwell.*"[59]

5. This view was passed on to Mr Wardale with little or no consideration given by anyone, to the possibility of a connection between her condition and presentation and her earlier fall and resulting injury - this, in some part, is due to the failure of Ms Lesek's clinical notes to correctly detail Dr Langdon's instructions.[60]

6. Mr Wardale also believed, from advice received over the telephone and from his own knowledge of Lena, that this was still merely attention seeking behaviour and did not act upon Lena's requests.

7. I also note however, that Mr Simmonds was very inexperienced having only worked at the House for two weeks at the time under examination and had relied upon others, including Mr Wardale, for advice that Lena was capable of getting herself up.

8. Further staff were not trained or qualified to analyse the underlying features driving Lena's behaviour.

9. Thus, the situation was allowed to drift through the 26th with no one called in to examine Lena and with staff, for the most part, continuing to follow the 'no entry' directive issued two months earlier by Tracy Allen.

10. It was in these circumstances that I find that it was in fact assumed by staff that Lena's behaviour (although increasingly atypical), remained behavioural and attention seeking.[61]

11. It is easy to be wise in hindsight and I note Mr Wardale's reliance on the experience of Ms de Wilt and Mr Taylor. It is also the case that Lena's deteriorating presentation was incremental with the evidence of the impact of her isolation and the need to remove her from those conditions, increasing at a relatively slow rate.

12. Irrespective of these considerations, I further hold that it was simply not acceptable for Lena to have been left in that situation over such an extended period.

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59 See transcript at page 756.
60 See exhibit 20 b at page 1.
61 Staff uniformly expressed the view that it was difficult to know if any particular behaviour was medically based or otherwise.

13. It is also the case that there were a number of factors which, by mid morning on Boxing Day, should have caused disquiet for carers and Mr Wardale alike. Apart from the length of her sitting on the floor (say a minimum of 5 hours by then), these included the history of difficulty staff had in discerning whether her presentation was medical or behavioural and her immediate history that included a head injury with anti-coagulant use, and the absence of clear information about Dr Langdon's review of that injury. Also relevant was Lena's history as an unreliable patient when relaying symptoms.

14. From all of the evidence, I am satisfied that by this point (mid morning on the 26th), Lena's situation was such that no staff could reasonably have had any confidence in their view as to what was causing her behaviour. In such circumstances, Mr Wardale should have taken decisive action with family members called in and an urgent call made to an on duty GP.

15. If it was then the case that Lena continued to remain on the floor by conscious choice, or instead that a change in her medical or conscious state had then been detected, or that a GP so advised, - a call to ambulance officers and referral to an A&E, should have followed immediately.[62]

16. Instead, Lena was left to her own devices variously sitting and lying on the floor for a further 24 hours, with Mr Wardale's suggested approach in place and with staff continuing to follow what I consider was the flawed strategy earlier drafted by Tracy Allen, both of which considerations led staff to a failure to intervene and to the general neglect of her presentation. [63]

17. On the evidence of Mr Siu, that presentation included a changing appearance over the days following her fall. This included the vomiting x 2, and the incontinence incident(s) and may have

[62] The call made to Dr Langdon which was not made until the 27th was in my view made not less than 24 hours after it should have been made. Further this call appears to have lacked any real sense of urgency. See transcript page 198. See also Exhibit 1, a concession made by ACSO to the effect that the care provided by Armadale House staff to Lena on the 26th of December 2007, fell below an appropriate level.

[63] ACSO submitted that even if Dr Langdon's advice that she be kept under observation for four hours, (as set out in her treatment diary), had been provided to staff through the clinical notes, that no change would have resulted. While I accept that this follows from the fact that there is no clear evidence that duty staff read the clinical notes (or the medical diary), it remains the case that collectively staff erred by failing to refer to that material.
Further, given the fact of the head injury and that Mr Wardale had organized the second visit to Dr Langdon, the decision not to intervene and call Dr Langdon, or to otherwise address her presentation, was sub-optimal and this was especially so in the circumstances of her known use of warfarin medication.
Staffers were troubled by Lena's situation and were looking for answers and a resolution.
I consider it highly likely that had staff informed themselves of the medical advice (24/12), to keep her under observation for either 4 hours etc (or longer), that it is highly likely that by the morning of 26th, that all involved would have been much more pro-active in dealing with Lena, than was the case.
I further consider that the amended strategy Exhibit 16b was flawed in that it was too broad in its application and made without sufficient regard to the variety of possibilities, which may have occurred. It is also the case that the amended strategy appears to have been introduced without regard to Section 60(2) of the *Disability Act,* which authorises room entry in certain specified situations.

included other symptoms of a slow bleed and deteriorating conscious state, which I observe could easily have been overlooked from where staff stood at the doorway.[64]

18. Further, that same adherence to strategy and the failure to call in professional assistance, led to Lena being left sitting and lying in her own vomit without food or medication over this time, which during the last hours included leaving Lena sitting in her own bodily waste.

19. I can conceive of no circumstances in which such a consequence might have been acceptable.

20. As set out above, it is also relevant that little or no consideration was given to the possibility of a connection between her fall on the afternoon of the 24th and her behaviour following her return from her brother's home. Mr Wardale is not responsible for being unaware of that matter and I acknowledge that Ms Lesek's failure to document in the clinical notes what she was told by Dr Langdon may have indirectly contributed to his general lack of awareness.

21. I am satisfied, however, that in all of the circumstances Mr Wardale fell into error by failing to remain alert to the possibility of a serious head injury and more generally by failing to collect information about Dr Langdon's opinion, and to act decisively as the situation continued into the 26th.[65]

22. Counsel for the Divola family has argued that the evidence supports a finding that the failure of Mr Wardale to get Lena to hospital at an earlier time contributed to her death. It is contended that Dr O'Donnell's finding that some of the blood seen on the CT scan taken on the 27th December was likely to be 2-3 days old, supports the proposition that it started on the 24th of December.

23. I accept that the evidence, as a whole, establishes a causal link between the injury and the commencement of the bleed. I also accept Mr Siu's evidence concerning the mechanism of death and his proposition that delay is associated with the acceleration of death.[66]

24. However, the evidence before me does not establish whether an A&E review on the morning of the 26th would necessarily have included a brain CT scan.

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64 I accept Dr Siu's evidence concerning the probable progress of her deterioration and to the extent that that finding is inconsistent with the GCS results recorded by ambulance staff, I find that I accept his evidence above that set out in the MAS record. See exhibit 17 and discussion at transcript page 527-532. Mr Simmonds' observations, when he arrived at the House on the morning of the 27th, do not change that view.

65 In so finding I am satisfied that staff had previously been pro-active in referring Lena to Dr Langdon, in situations of uncertainty.

66 See transcript page 532-533

25. Given that the evidence is silent on the matter, I do not consider that it is appropriate for me to speculate as to what may have occurred had medical assistance been obtained on the 26th, and it follows that I find that the evidence falls short of establishing a causal link between the delay in referral and Lena's death.

26. In other words, I return an open finding on that issue.

27. I am however satisfied that, despite the genuine concern of Simon Wardale for Lena and her plight, the delay in response reduced her chances of receiving a timely and successful treatment.

RECOMMENDATIONS:
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. In my view, this investigation has highlighted the difficulty which can arise when decision-making responsibility in disability care is entrusted to persons who are themselves physically remote from the scene of the activity under consideration.

2. However, my investigation into just this one case does not support a finding that such a management model is ill conceived. In the circumstances, I recommend that the Secretary of the Department of Human Services review the management arrangements at Armadale House with a view to ensuring that an appropriate level of discretion in management of a particular resident's health issues, is vested in the hands of the senior assistant care provider, on duty at the House at any one time.

3. It is also the case that the reporting of the circumstances in which this injury was sustained and of Dr Langdon's advice concerning the ongoing monitoring of her condition, was unsatisfactory. To protect residents in future I further recommend that all medical instructions provided to staff by medical personnel be incorporated into a resident's file in such a manner that care providers are easily able to inform themselves of all relevant clinical issues at handover.

4. To be certain that all such potentially valuable medical information is not ignored or otherwise overlooked, incoming staff should be required to acknowledge, either on hard copy or on-line, the receipt of such information in respect of each resident.

**Conclusion**

Finally, I would like to take this opportunity to thank Counsel together with the Coroners assistant and their instructors, and the Office of the Public Advocate, as well as those witnesses who testified during the inquest, for their assistance in the conduct of this matter.

Signature:


Peter White
Coroner
Date: 20th May 2011

DISTRIBUTION:
The family of Lena Divola
The Secretary Department of Human Services, in the State of Victoria
The Chief Psychiatrist, in the State of Victoria
The Australian Community Support Organization (ACSO)
Mr Simon Wardale
Ms Michelle Lesek.
Mr Peter Simmonds
Ms Anneke De Wilt
Mr Andrew Taylor
Dr James Langdon
Dr Noel Woodford
Dr Chris O'Donnell
Mr Kevin Siu
Melbourne Metropolitan Ambulance Service.
The Office of the Public Advocate, in the State of Victoria.