FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Brendan Kevin Triffett

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Brendan Kevin Triffett with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

9 and 10 May 2022 in Hobart with written closing submissions received by 19 October 2022

Representation

Counsel assisting: S Nicholson

Counsel for Kingston Pool and Wellness Centre: S Cash, instructed by P Kolovos

Counsel for Mark Cranage: P Halley, instructed by R Hopkins

Introduction and scope

1. Mr Brendan Triffett, aged 40 years, died suddenly and unexpectedly on 13 March 2018 whilst engaging in supervised hydrotherapy, using a mask and snorkel, at the Kingston Pool. He was limited in his mobility due to an acquired brain injury and was morbidly obese. He had lived in a care home for many years and was supported by various organisations and health professionals.
2. The thorough coronial investigation which followed Mr Triffett's death included a focus upon the medical cause of his death. Although the forensic pathologist at autopsy determined that Mr Triffett had suffered a cardiac arrhythmia, it appeared that drowning may have been the terminal cause. Based upon that possibility, the investigation explored the decision-making and risk assessment by various support organisations and personnel in respect of Mr Triffett engaging in hydrotherapy. In this regard, there was evidence that Mr Triffett's mother and at least one other care provider expressed concerns about risks to Mr Triffett of engaging in hydrotherapy. These included lack of thorough assessment of the program and pool facilities as well as the difficulty of managing Mr Triffett's behaviour. As a result of these concerns, it appears that the

hydrotherapy program did not proceed at that time but, about three months later, Mr Triffett's sessions commenced without his mother's knowledge. Thus, the investigation explored numerous aspects of the decision-making and planning by relevant organisations, the arrangements with and suitability of the Kingston Pool and the decisions and actions of the therapist conducting the sessions.

3. However, the scope of the inquest was narrowed considerably a short time before the inquest hearing when expert evidence from a cardiologist was received in the investigation expressing the unequivocal opinion that Mr Triffett's cardiac arrhythmia occurring in the pool was a fatal event in itself, that it was unrelated to him being in the water and that it was not foreseeable from his medical history. The forensic pathologist and the coronial medical consultant both agreed with the conclusions expressed by the cardiologist. I discuss the cause of death in detail further in this finding.

4. As a result of the consensus of expert opinion, it became unnecessary for me to continue to investigate many aspects of the decision-making surrounding Mr Triffett's hydrotherapy, including the roles of his care providers, because his death was unrelated to him being in the water.

5. The scope of the inquest, as revised, was as follows:

    a) The cause of Mr Triffett's death, including his prospects of survival if a defibrillator and/or additional personnel or facilities were available.

    b) Regarding the Kingston Pool:

        i) Terms of use or discussions regarding use of the facilities by clients such as Mr Triffett (and Mr Mark Cranage in providing hydrotherapy to Mr Triffett); and

        ii) Its capacity for provision of first-aid, rescue and resuscitation; and that actually provided to Mr Triffett.

    c) The hydrotherapy of Mr Triffett undertaken by Mr Mark Cranage, sports therapist, on 13 March 2018 with focus upon:

        i) Mr Cranage's assessment of the suitability of Mr Triffett for hydrotherapy;

        ii) Mr Cranage's assessment of the suitability of the Kingston Pool for Mr Triffett's hydrotherapy;

        iii) Observations made by Mr Cranage of Mr Triffett's condition on the day and whilst he was providing hydrotherapy.

Evidence in the investigation

6. The documentary evidence in the inquest comprised Exhibits C1 to 48. The exhibit list is attached to this finding.
7. It is to be noted that the documentary exhibits are particularly comprehensive due to the matters traversed in the investigation before the scope was narrowed. Many of the exhibits contained matters that remained relevant for the inquest, such as information about Mr Triffett's health and background. Counsel did not object to the tender of the exhibits at inquest, and it was appropriate that they be admitted into evidence.
8. The following witnesses provided oral testimony at inquest:
    a) Mrs Donna Triffitt, mother of Mr Triffett;
    b) Mr Stuart Talbot, owner of the Kingston Pool and Wellness Centre ("the Kingston Pool" or "the pool");
    c) Mr Mark Cranage, Mr Triffett's sports therapist;
    d) Associate Professor Neil Strathmore, cardiologist; and
    e) Dr Donald Ritchey, forensic pathologist.

Mr Triffett's background and health

9. Mr Triffett was born in Ouse, Tasmania, on 28 February 1978. He had never married and had one daughter, Kristen Farley, with whom he had no recent contact. He was in receipt of a disability support pension at the time of his death.
10. Mr Triffett was the eldest child of Kevin Triffett and Donna Triffitt.[1] He grew up in an environment where he regularly experienced violence perpetrated by his father towards his mother and himself. When he was 8 years of age, Mrs Triffitt left her husband and took Mr Triffett with her; however, he later chose to live with his grandmother and uncle.
11. Mr Triffett struggled with school and progressed into employment as a logger and bushman. He began using illicit drugs at this time, starting with cannabis before progressing to "party drugs". Mrs Triffitt described his personality as being "horrible" while using drugs. She said that he became desperate for money to pay for his escalating drug use and she would receive visits from a number of his associates seeking money from her to pay her son's drug debts. On occasions, Mr Triffett threatened her with violence in an effort to obtain money. He also was known to steal

[1] Note the different spellings of this surname.

from his family members. Mr Triffett developed an extensive criminal history, involving a variety of offending, including for violence, drugs and dishonesty.

12. On 13 March 2004, when he was aged 27 years, Mr Triffett was at a friend's house in New Norfolk and ingested a large quantity of illicit drugs including amphetamine, benzodiazepines, morphine, methadone and "ecstasy". Ambulance Tasmania paramedics attended and found him to be unresponsive and convulsing. He was transported to the Royal Hobart Hospital and remained in a coma for some time. He was not expected to live and his life support was eventually turned off. However, Mr Triffett continued to breathe by himself and eventually came out of his coma. He could not eat, talk or walk, though he was able to recognise family members. He remained in hospital until July 2005 and during his hospitalisation, he underwent extensive physiotherapy while being assessed as to the extent of his brain injury. Discharge correspondence from the hospital records stated that, at the time of discharge, he was a quadriplegic, clinically blind and incontinent of urine. He was discharged into a care home.

13. Mr Triffett slowly achieved a partial recovery, regaining speech, vision and some movement. It appears that his recovery to this degree was significantly due to the unwavering dedication and efforts of his mother.

14. In 2006, he commenced to live in a group home (supported independent living) in Mornington operated by Eskleigh Services, where he lived until his death. In addition to supports provided by Eskleigh Services, other service providers were engaged for his remaining needs. From mid-2017, Mr Triffett was accepted as a NDIS participant, with his NDIS plan including funding for both his supported independent living and for day supports. An organisation called Wellways was engaged to provide support coordination to Mr Triffett to help him implement the goals of his NDIS plan.

15. In a statement for the inquest, Mrs Triffitt provided a helpful summary of her son's life and incapacities. She described his inability to walk, although being able to transfer from sitting to standing with the help of a staff member and a mobility aid. Mrs Triffitt said that his behaviour eventually changed for the better after suffering his brain injury. She described her son as turning into a happy person with many plans. She said he enjoyed movies and woodworking. He went back to TAFE and was interested in computers. In her affidavit, Mrs Triffitt said *"He had a huge belly laugh, which was very memorable and loud. I loved the man he'd become without the drugs and alcohol."*

16. Mr Triffett, at times, could not control his impulsive behaviour and would become physically and/or verbally aggressive if his requests were denied. He was also prone to overtly sexualised behaviour towards women, including making offensive comments

and attempting to touch them. He continued to have drug-seeking tendencies regarding his prescription medication, although the opportunities for addiction and abuse were limited. He consumed alcohol and cigarettes heavily and would often ask taxi drivers to stop and buy him alcohol, food or cigarettes whilst en-route to community activities or family visits. His doctors and carers allowed him a supply of alcohol and continued to monitor his allocation. He was a very heavy smoker, smoking about 40 cigarettes per day. Considerable efforts were made by his doctor, and by himself, to reduce his smoking. In 2016 it seems that he had some success with nicotine patches but subsequently resumed smoking. In the months before his death, he again expressed the desire to stop smoking.

17. Mr Triffett was classed as morbidly obese and weighed approximately 140 kilograms. He also suffered chronic back pain, epilepsy, liver disease, sleep apnoea, hepatitis C, and emphysema. He was fitted with a colostomy bag. He suffered pressure sores due to being wheelchair-bound.

18. Mr Triffett was under the regular care of his general practitioner. Mr Triffett's medical records dated 26 February 2018 noted a very high cholesterol level and a dangerously high amount of fat on his liver. He was advised to stop consuming alcohol and to reduce his food intake.

19. It is apparent from his medical records that the management of Mr Triffett's chronic back pain medication was a focus of his treatment. He had no medical history involving cardiac symptoms, despite clear risk factors. An ECG was performed in October 2016 with unremarkable results. At the time of his death he was prescribed antidepressant, antiepileptic and anti-inflammatory medication. He was generally happy and optimistic and did not have suicidal tendencies. Before his death, he was able to communicate effectively and make decisions for himself. The evidence indicates that, in the period before his death he had a very positive mindset. He had formed the goal of being able to walk again and was also looking forward to family events.

Mr Triffett's swimming lessons

20. Of all of the various therapies available to Mr Triffett to assist his physical condition, it is clear from the evidence that, for some years, he consistently maintained a passion for hydrotherapy and swimming. Medical records and other documentation in the investigation also refer to Mr Triffett participating in hydrotherapy at St Giles pool in 2014. NDIS documents dated May 2017 described Mr Triffett's first goal as to go swimming. Mr Triffett loved to swim but was unable to do so independently due to

incapacities. He could use his right arm and leg in a manner similar to a dog paddle, with assistance from staff. He required a staff member to support him at all times in the water.

21. In September 2017 Mr Triffett's support worker from Wellways had a discussion with him regarding his request for swimming. Mr Triffett signed documentation to allow Wellways to speak to sports therapist, Mr Mark Cranage, and the Kingston Pool to further his aim.

22. Mr Cranage held appropriate qualifications to work with Mr Triffett. He held an associate degree in exercise and sport science, Certificate 4 in Disability, Certificate 4 in Allied Health Assistance, and first aid and disability aquatics qualifications.

23. Relevantly, Mr Cranage had been taking hydrotherapy sessions using the Kingston Pool for six years before Mr Triffett's death with clients aged between 18 months and 80 years with neurological or physiological impairments.

24. On 27 September 2017, Mr Triffett met with Mr Cranage and toured the pool. Mr Triffett was, again, extremely enthusiastic about the meeting and about the prospect of commencing swimming. He requested two hydrotherapy sessions a week, with an aim of achieving his goal of walking again. However, Mr Triffett's first hydrotherapy session was postponed as a result of further discussions regarding safety concerns expressed by Mrs Triffitt and a carer from Eskleigh.

25. I note that Mr Triffett's regular general practitioner, Dr Yee Ng, was aware of Mr Triffett commencing hydrotherapy. Dr Ng's notes indicate that Mr Triffett told him on 26 February 2018 that he had started his hydrotherapy sessions and these were helping with his back issues.

26. The inquest did not, in its narrowed scope, focus in depth upon the details of the decision-making and risk assessment regarding Mr Triffett participating in hydrotherapy sessions. As detailed further on, Mr Cranage was fully familiar with the pool itself, its equipment and the rescue personnel available. However, it is the case that Mr Cranage was not fully familiar with all of Mr Triffett's medical conditions and history. For example, he gave evidence that he was not aware that Mr Triffett suffered epilepsy or lung issues. He was aware of the fact of his past brain injury, physical limitations, and his smoking. It was apparent from Mr Cranage's evidence that he relied significantly upon indications from Wellways and Eskleigh, and was of the erroneous belief that they had conducted a risk assessment (independent of him) in respect of Mr Triffett's swimming sessions at the Kingston Pool.

27. It would appear that the service providers, however, relied upon Mr Cranage to undertake his own assessment and to seek relevant medical information. In hindsight, the information exchange and discussions concerning risk (particularly regarding Mr Triffett's medical conditions) between Mr Cranage and Mr Triffett's support personnel might have been more fulsome and better documented. Such discussions could have culminated in Mr Cranage, as the therapist providing the service, preparing a documented risk assessment prior to Mr Triffett's hydrotherapy sessions. Nevertheless, I am satisfied that any lack of information and comprehensive risk assessment did not contribute to his death and that it was an appropriate decision for Mr Cranage to provide Mr Triffett with hydrotherapy at the Kingston Pool.

28. On 20 February 2018, Mr Triffett undertook his first hydrotherapy session with Mr Cranage. As described below, the process commenced by Mr Triffett being transferred into the pool hoist and lowered to Mr Cranage in the pool. Mr Cranage placed a pool noodle under his back for buoyancy and supported Mr Triffett with his arms during swimming. The process involved Mr Cranage taking Mr Triffett to the deep end of the pool (1.7 metres), taking him swimming from side to side and monitoring him at regular intervals. Eskleigh notes record that during this one hour session, he was laughing and smiling.

29. On 27 February 2018, during the second successful session, Mr Triffett was said to have exercised vigorously in the pool and felt that the exercise was helping his back.

30. On the 6 March 2018, during his third session with Mr Cranage, Mr Triffett was noted to have worked very hard in swimming from side to side.

31. For his fourth session on 8 March 2018, Mr Triffett was provided with a facemask and snorkel at his request. Eskleigh approved the purchase. Mr Cranage explained in evidence that Mr Triffett loved the feeling of being face down in the water and wanted to spend his time in this position. He told Mr Cranage he had used a facemask and snorkel previously. In evidence, Mr Cranage provided the following evidence when questioned by counsel assisting:

"Did you, was it necessary for you to conduct any assessment of him using the snorkel in terms of as part of his swimming lessons?..... What had happened, when we, prior to obtaining the snorkel and masks, we'd asked the support staff about it and everyone thought it was a great idea because of, what it was going to be used for and Brendan was excited and – then we had the snorkel and mask and we wanted to make sure that it fit first of all and it was comfortable with the mouth piece and Brendan being Brendan then he grabbed it, he stuck on it, put the mouth piece and he was happy to go, and I'd asked him had he used a

snorkel before and a mask and he said he had, so what I did just to make sure was to see how he was with the snorkel and the mask, and with him, I could get Brendan vertical, I could have him in a vertical position and I could move towards the deep end, I could still stand in the deep end, and I could lower him and his head would go in, well that was it, once he had his face in the water he was happy, he was breathing, he was doing everything, he got his, I [indistinct word(s)] his head up and that was my first wallop and then, and then it was a case of then going through with him what we would then do and that would then if he had the snorkel and mask on is that I would rotate him – um and he couldn't he wasn't allowed to go down he had to stay on the surface of the pool water."

32. Before Mr Triffett commenced using the snorkel, Mr Cranage tested it on himself. When fitting it to Mr Triffett, he checked the seal of the mask around his face and positioning of the mouthpiece. Mr Cranage advised Mr Triffett to raise his arm above water if he experienced any difficulty. This was also the signal to be used if he had an issue or difficulty when using the snorkel. Mr Cranage monitored Mr Triffett by keeping his arms on either side of him at all times and rotated him onto his back regularly to check his wellbeing and safety.
33. Before his death, Mr Triffett did not experience any difficulty nor signal or advise Mr Cranage of any issues in his hydrotherapy, with or without the snorkel. It is apparent that the swimming sessions were the highlight of his life at that time, and provided him with enormous satisfaction and a sense of freedom.

Circumstances of death

34. At 8.45am on the morning of 13 March 2018, Mr Triffett was woken by his carer, Mr Justin Ridgeway. Mr Ridgeway described Mr Triffett as being "fine" that morning, and observed that Mr Triffett engaged his normal morning routine of having breakfast, smoking and drinking coffee in a travel mug. Mr Ridgeway and Mr Triffett then caught a taxi to the Kingston Pool for his swimming session.
35. The description of the events leading to and after Mr Triffett's death is primarily informed by the pool's CCTV footage. The pool operates a number of cameras at the premises, which recorded the movements of Mr Triffett, Mr Cranage and pool staff. At the commencement of the coronial investigation, The CCTV system was taken by forensics officers and the footage was downloaded. The footage gives a good overall view of Mr Triffett's movements at the pool, his movements within the water, the incident itself and the attempts by staff to try and resuscitate Mr Triffett.

36. The internal clock within the CCTV system was slow by approximately 30 minutes. In recounting the events as follows, I have adjusted the time depicted on the footage to reflect, as accurately as possible, the actual time of the events.
37. At 9.56am Mr Triffett (in his wheelchair) and Mr Ridgeway entered the pool facility. With Mr Ridgeway's assistance, Mr Triffett stood up from his wheelchair using a walking frame and moved to the pool's hydraulic lift chair, which was lowered into the water. Mr Triffett was wearing board shorts and a singlet. Mr Triffett was also assisted in this process by Ryan Talbot, a pool employee. Mr Ridgeway remained on the pool deck throughout the session.
38. At 10.07am Mr Cranage moved Mr Triffett from the lift chair and Mr Triffett entered the water, supported by Mr Cranage. Mr Cranage moved Mr Triffett to the deep end of the pool, and put on Mr Triffett's swimming mask and snorkel for him.
39. At 10.08am Mr Triffett and Mr Cranage began swimming – involving Mr Cranage supporting Mr Triffett in swimming from side to side in the pool, face down in the water and breathing through his snorkel. Over the following six minutes, Mr Triffett made regular checks of Mr Triffett, rolling him over and checking the snorkel and his well-being.
40. At 10.14.18am Mr Cranage made his last check of Mr Triffett, checking the fitting of his mask. Mr Triffett was, at that time, alive and making swimming movements. The movements involved Mr Triffett moving his right arm and leg in a swimming motion whilst being supported by Mr Cranage.
41. At 10.14.40am, 22 seconds following the last check, Mr Triffett made his last visible movement.
42. At 10.15.15, 35 seconds later, Mr Cranage rolled Mr Triffett over to face upwards and found him not breathing, blue and unresponsive. The snorkel's mouthpiece was still in his mouth at that time. Mr Cranage then called to Mr Ridgeway, telling him that something was wrong and to call for an ambulance. Mr Triffett then commenced expired air resuscitation (EAR or mouth breaths) on Mr Triffett and moved him to the side of the swimming pool.
43. At 10.16am Caitlin Burns, a swimming instructor working at the pool (who was actually employed by Mr Cranage in his business), was alerted to the situation. She jumped into the pool and commenced cardiopulmonary resuscitation (CPR) on Mr Triffett. Another male who was in the pool at the time then assisted Mr Cranage and Ms Burns with moving Mr Triffett to shallower water, where he was placed onto a submerged platform to assist with CPR and EAR.

44. At 10.20am Mr Triffett was removed from the pool and onto the pool deck. Resuscitation attempts continued with Mr Triffett remaining unresponsive.
45. At 10.30am the first ambulance paramedics arrived and commenced resuscitation procedures, including defibrillation. Two minutes later, the first police officers arrived. At about the same time, additional paramedics arrived at the scene.
46. At 10.59am the resuscitation attempts upon Mr Triffett were discontinued by the paramedics, who determined that he was deceased.

Comments

The cause of Mr Triffett's death

47. The issues that arose predominantly in the investigation were whether drowning contributed to Mr Triffett's death; and, in a similar vein, whether he would have had a chance of survival had he not been in water.
48. For the following reasons, which were amplified by expert evidence just prior to and during inquest, I find that Mr Triffett died solely as a result of natural causes, being a cardiac arrhythmia.
49. I further find that the event could not have been foreseen and it occurred independently of his swimming activity or immersion in water.
50. It is appropriate, given the significance of this issue in the investigation, to set out the expert evidence and explain my reasoning.
51. A post-mortem examination was undertaken by Dr Donald Ritchey, a very experienced forensic pathologist, on 14 March 2018. Dr Ritchey also prepared a detailed post-mortem report supported by a sworn affidavit.
52. Dr Ritchey observed at autopsy that Mr Triffett was morbidly obese, weighing 140.2 kilograms with a body mass index of 42. He observed widespread healed brain injury consistent with Mr Triffett's history of acquired brain injury following a past drug overdose. Dr Ritchey observed advanced natural disease of the heart and its blood vessels, being atherosclerotic and hypertensive cardiovascular disease. He noted that Mr Triffett's lungs were markedly congested and oedematous and there was early centriacinar emphysema and florid active respiratory bronchiolitis - both lung diseases caused by smoking.
53. In his report, Dr Ritchey opined that there were several possibilities regarding the *mechanism* of death, although the underlying cause of death was hypoxic brain injury sustained after a remote drug overdose.
54. Dr Ritchey stated in concluding his report;

"One possible mechanism of death is drowning – likely complicating a seizure or cardiac event. Water in the mouth and marked pulmonary oedema support the possibility of drowning, however the report that the snorkel was within his mouth suggests a significant aspiration event causing drowning is less likely. Pulmonary oedema is a non-specific finding at autopsy.

Individuals with epilepsy are also at increased risk of death due to seizure or drowning. Although a seizure is possible there was no tongue biting and the urinary bladder was full and a condom type catheter on the penis contained no urine. Most individuals with a seizure become incontinent of urine.

These findings are interpreted by me to suggest that Mr Triffett has likely suffered a fatal cardiac arrhythmia that occurred whilst swimming. Whilst many fatal cardiac arrhythmias are natural in manner it is my opinion that the severe hypoxic brain injury from a remote drug overdose is the underlying cause. That is, was it not for the brain injury, this particular sequence of events would not have occurred."

55. Ultimately, Dr Ritchey in his report gave the cause of death as follows;

"I (a) Cardiac arrhythmia whilst swimming;

I (b) Acquired hypoxic brain injury;

I (c) Remote drug overdose;

II Epilepsy, atherosclerotic and hypertensive cardiovascular disease, emphysema with florid respiratory bronchiolitis, morbid obesity (BMI 42)."

56. In Dr Ritchey's opinion, the particular sequence of events that led to Mr Triffett's death would not have occurred but for his acquired brain injury. By this, Dr Ritchey may have intended to convey that Mr Triffett would not have suffered a cardiac arrhythmia but for the acquired brain injury. He may have also have meant that Mr Triffett would not have been in the situation of undertaking hydrotherapy but for his brain injury. Applying the usual principles of legal causation and considering the medical evidence, the acquired brain injury should properly be characterised as a background condition and too remote to be considered causative of death in this set of circumstances.

57. Whilst adopting Dr Ritchey's conclusion that Mr Triffett suffered a cardiac arrhythmia whilst swimming, there remained open in this investigation the question of whether drowning formed any part of the mechanism of death. Whilst that question was a live

issue, various matters surrounding Mr Triffett's hydrotherapy were investigated at some length.

58. Shortly before inquest, I received a report from an experienced cardiologist, Associate Professor Neil Strathmore (AP Strathmore), which was prepared at the request of the legal representatives for Mr Mark Cranage. At that time, AP Strathmore had the benefit of comprehensive evidence from the lengthy investigation.

59. AP Strathmore agreed with the conclusions of Dr Ritchey regarding the proximate cause of Mr Triffett's death. He stated in his report:

"Mr Triffett had several reasons for arrhythmia. In particular, he had significant cardiovascular disease with left ventricular hypertrophy and atheroma, even though there was no acute myocardial infarct. These conditions could predispose to ventricular arrhythmia or to asystole. In addition, he was on drugs which could also predispose to an arrhythmia such as amitriptyline.

The history of the event with loss of consciousness and cyanosis is typical of a sudden cardiac death due to an arrhythmia."

60. Importantly, AP Strathmore went on to provide his opinion that he did not consider that there was any particular connection to Mr Triffett's arrhythmia and his presence in the swimming pool but rather this fact was coincidental.

61. In response to AP Strathmore's report, Dr Ritchey provided a brief affidavit in which he agreed that the fact that Mr Triffett was in a swimming pool at the time of his death was unlikely to have been a contributory factor.

62. At inquest, I was greatly assisted by the evidence of both Dr Ritchey and AP Strathmore. Dr Ritchey helpfully detailed the manner in which Mr Triffett's cardiovascular disease precipitated his arrhythmia and sudden cardiac death. Dr Ritchey also gave evidence of several other factors that militated against drowning having occurred as the terminal event - these included the absence of significant fluid within the stomach, absence of heavy and congested lungs and Mr Triffett's sudden unresponsiveness with inability to resuscitate. Although AP Strathmore was not as highly qualified on these specific points, he also considered that the event was too sudden for drowning, with none of the expected signs or symptoms.

63. AP Strathmore provided knowledgeable evidence regarding the propensity of abnormal heart rhythms, including fatal cardiac arrhythmias, to emanate from diseased hearts such as that of Mr Triffett. Consistent with this evidence, Dr Anthony Bell, coronial medical consultant, provided a report in the investigation in which he stated that 5 to 15% of total mortality in industrialised nations is due to sudden cardiac arrest.

64. AP Strathmore gave evidence that Mr Triffett was, unfortunately, in the category of people whose first presentation of heart disease is sudden cardiac death. He acknowledged Mr Triffett's risk factors (obesity, high cholesterol and smoking) but said that his sudden cardiac death could not have been foreseen at that time, stating that he did not consider that there was anything in Mr Triffett's history that would have pointed in that direction.

65. Importantly, none of the medical experts who provided evidence were of the view that Mr Triffett should not have been engaged in hydrotherapy at the time of his death. AP Strathmore said that it is not exercise by itself that causes abnormal rhythm but an underlying cardiac condition. Dr Bell provided an opinion to the same effect and commented that Mr Triffett appeared to enjoy swimming, stating *"in a difficult life, enjoyment is important".*

66. I fully accept the evidence of Dr Ritchey, AP Strathmore and Dr Bell. Most sadly, this is a case of unexpected death from natural causes unable to be foreseen at that particular time, with presence in the water being an incidental factor.

The efficacy of CPR and prospects of survival if a defibrillator had been available

67. An automated external defibrillator (AED) was not present at the Kingston Pool at the time of Mr Triffett's cardiac arrest. The evidence indicates that the ready availability of an AED was the only thing, in the circumstances of Mr Triffett's sudden cardiac arrest, that *may* have provided some chance of his resuscitation.

68. In his evidence, AP Strathmore dealt with the low chances of Mr Triffett being able to be resuscitated, even utilising the best CPR, being defibrillated and having a "shockable rhythm". He commented that, in fact, there was a good chance that Mr Triffett had proceeded from his cardiac arrest directly into asystole (cessation of electrical and mechanical activity of the heart). In this case, there was no, or almost no, possibility of successful resuscitation because of the lack of shockable rhythm.

69. AP Strathmore said that even if a shockable rhythm existed and resuscitation involving defibrillation occurred in the most optimal circumstances, there would be less than a 10% chance of survival, and an even lower chance of him being able to function as previously due to his pre-existing brain injury. AP Strathmore made particular reference to the poor chances of resuscitation in someone with such comorbidities as Mr Triffett. I note also that successful defibrillation of Mr Triffett would be hampered by the difficulty in extracting him from the pool quickly and ensuring that his body was dry.

70. Dr Bell's evidence contained in his report was in accordance with the evidence of AP Strathmore. I will set out his helpful passage of reasoning regarding defibrillation and the circumstances in which it can assist. He stated;

"The only effective approach for the treatment of ventricular fibrillation and pulseless ventricular tachycardia is defibrillation, with earlier efforts yielding better outcomes. The success of defibrillation and patient survival depends upon the duration of the arrhythmia, type of arrhythmia and the promptness of defibrillation. When VF has been present for seconds to a few minutes and the fibrillatory waves are coarse, the success rate for terminating VF with defibrillation is high. As VF continues, the fibrillatory waves become finer and more difficult to terminate the arrhythmia. When VF continues for more than four minutes, especially if not accompanied by excellent CPR, irreversible damage to the central nervous system and other organs begins, which can reduce survival even if defibrillation is successful. The use of automated external defibrillators (AEDs) by early responders is another approach to more rapid resuscitation. In most but not all studies, AEDs have been found to improve survival after out-of-hospital cardiac arrest. One example of the efficacy of AEDs when used by bystanders prior to the arrival of emergency responders comes from a study of 49,555 out-of-hospital cardiac arrests at nine USA regional centers from 2011 to 2015, of which 4115 (8.3%) were observed in public by bystanders. Among the observed public arrests, 60% had an initially shockable rhythm, and 19% were shocked with an AED. Patients shocked by bystanders using the AED were significantly more likely to survive to hospital discharge (67 versus 43%) and to have favorable neurologic function at discharge (57 versus 33%)

In this case the time scale to defibrillation was too long for survival which is regarded as walk out of hospital outcome.

The presence of an AED had the possibility to reduce the time scale to return of spontaneous circulation (ROSC). This would have required a changed approach to the management. The initial plan would have been immediate extraction, dry chest, and defibrillate. If there was any delay obtaining and charging the AED then chest compressions should be started and continued until the AED is ready to fire and chest compressions started immediate after the shock then the situation can be reassessed. The staff would require training and refresher training combined with teamwork training. Consideration of the actions, immediate extraction as above need to be pre-planned. If these factors were all in place the patient's chance of survival would be improved."

71. Dr Bell went on to state;

"Overall the current outcome despite the efforts of emergency personnel, resuscitation from out-of-hospital SCA (sudden cardiac arrest) is successful in only one-third of patients, and only about 10% of all patients are ultimately discharged from the hospital, many of whom are neurologically impaired, as shown in the Australian study cited above.

In this case if all systems worked perfectly the outcome would be in the usual range if not worse due to the event occurring in water imposing difficulties and unavoidable extra delays. A second and unrelated issue is that in patients with an acquired brain injury the neurological outcome is worse, noting that the acquired brain injury is unrelated to SCA."

72. The expert evidence traversed issues associated with the difficult circumstances in which CPR had to be administered to Mr Triffett by those at the pool, in water, without a firm surface, and with no prior experience. Upon the evidence, Mr Triffett's sudden cardiac arrest in the pool was the first such event to occur in the period of 16 years since Mr Talbot commenced ownership of the Kingston Pool.
73. AP Strathmore also pointed out in evidence that the need for CPR in hospital can similarly occur and situations arise where the patient has collapsed in a difficult location and the nearby staff members are not adequately prepared or trained. He gave evidence about the many variable factors influencing decision-making for any one incident where CPR is required.
74. The expert evidence particularly emphasised the likely futility of CPR, however it was administered, due to Mr Triffett's significant obesity and lack of shockable rhythm. The best view on the evidence is that Mr Triffett was in asystole and deceased very quickly. Even if he still had a heart rhythm of fine ventricular fibrillation, I am satisfied that CPR could not have made a difference to his outcome.
75. Nevertheless, it is clear that the CPR response by all those involved was rapid, intense and cooperative. Those persons engaged in assisting Mr Triffett are to be commended.
76. Mr Talbot gave evidence that shortly after the death of Mr Triffett an AED was installed at the Kingston Pool and remains permanently at the venue. The pool staff are refreshed regularly in its use as part of their lifesaving training.

Mr Cranage's assessment of the suitability of Mr Triffett for hydrotherapy

77. Mr Cranage was a credible witness in all respects. He appeared to be a caring person, a competent therapist and was genuinely affected by Mr Triffett's death.
78. I accept his evidence that he was told about Mr Triffett's brain injury and limited mobility caused by a drug overdose in the past. He was told by the support services

that there were no other matters which would make him unsuitable for swimming sessions. Mr Cranage knew that Mr Triffett was a smoker and was clearly aware that he was obese. However it would have been optimal if he had been fully informed of Mr Triffett's full medical picture and if there had been a documented assessment made by him on that basis. Such an assessment could have included a plan for extrication from the pool in an emergency. Mr Cranage was the person ultimately responsible for Mr Triffett in the water. However, I emphasise that Mr Triffett was suitable for hydrotherapy and therefore the lack of adequate communication or information made no difference to the outcome.

79. Mr Cranage was also careful to fit Mr Triffett with the snorkelling mask before his first session and planned how to appropriately monitor his safety. The video evidence of Mr Triffett's use of the snorkel is evidence of the fact he was able to engage in the activity competently.

80. Mr Cranage was able to properly handle Mr Triffett during his swimming sessions and there were procedures in place for him to safely enter and exit the pool. Mr Cranage described Mr Triffett as being his normal self on 13 March 2018 – loud, cheeky and desperate to snorkel. Mr Triffett did not like the fact that Mr Cranage had agreed to roll him over to check his safety at intervals and he would slap out at Mr Cranage roughly when he did so.

81. Mrs Triffitt was particularly concerned about her son's use of the snorkel. Dr Bell stated in a supplementary report;

"The snorkel, which allows swimmers to keep their face down in the water while breathing, is widely used by divers, spear fishermen and monofin swimmers. A snorkel adds an additional dead space of 160-170 ml of gas (the volume of air that is inhaled that does not take part in the gas exchange, because it either remains in the conducting airways or reaches alveoli that are not perfused or poorly perfused. It means that not all the air in each breath is available for the exchange of oxygen and carbon dioxide) and causes an increase in the concentration of carbon dioxide (CO2) in the inspired gas due to expired air trapped in the snorkel which is then re-inspired. With a snorkel there is significant increase in all ventilation variables except the respiratory rate. The increase in total ventilation results from an increase in tidal volume (volume of each breath) rather than increasing respiratory rate. Thus the work of breathing is increased when breathing through a snorkel.

The work of breathing increase will incur a greater oxygen requirement and require an increase in cardiac output making the heart work harder, as will the swimming effort.

These changes are extremely unlikely to result in the cardiac arrest. A cardiac mechanism is required."

82. In summary, I find upon the evidence that Mr Cranage correctly assessed Mr Triffett to be suitable for hydrotherapy, including with a mask and snorkel. I also find that he devised an appropriate program with adequate safety measures.

The suitability of the Kingston Pool for Mr Triffett's swimming sessions

83. The evidence indicated that the Kingston Pool had sufficient facilities for rescue and resuscitation. The pool was registered with NDIS as a suitable venue. It is clearly apparent from the evidence of Mr Talbot and Mr Cranage that Mr Triffett's swimming sessions were booked with a view to ensuring that sufficient trained personnel at the pool were present at the time. There were about 8 persons trained in first-aid and life-saving present on the day, and who were involved in Mr Triffett's removal and attempted resuscitation. The hydraulic hoist was in working order and the pool deck was kept clear. Pool noodles were readily available for flotation. The moveable underwater platforms creating very shallow water (about 30 centimetres deep) assisted with safety. A spinal board was at hand for extraction of persons from the pool. Apart from an AED, I cannot identify any additional equipment or personnel that could have enhanced Mr Triffett's chances of surviving his cardiac arrest.

Terms of use of Kingston Pool

84. Mr Cranage did not sign any documented terms of use in respect of Mr Triffett's sessions at the pool. He was not required to do so by Mr Talbot. Mr Cranage was a qualified and experienced sports therapist, with knowledge of the pool, its facilities and Mr Triffett's requirements. No issues arise on this point that are connected with Mr Triffett's death.

Findings required by s28(1) of the *Coroners Act 1995*

a) The identity of the deceased is Brendan Kevin Triffett;

b) Mr Triffett died in the circumstances described in this finding;

c) Mr Triffett died of natural causes, being cardiac arrhythmia caused by heart disease; and

d) Mr Triffett died on 13 March 2018 at Kingston in Tasmania.

Recommendations

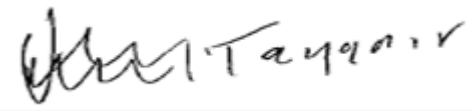
In the circumstances of Mr Triffett's death, I do not consider that it is appropriate to make recommendations.

Acknowledgements

Mrs Triffitt participated in the inquest process with dignity. In making these findings, I have taken into account her evidence and articulate submissions. Her enduring dedication to her son's welfare greatly enhanced the quality of his life. I convey my sincere condolences to Mrs Triffitt and to Mr Triffett's loved ones.

I am grateful for the assistance of counsel assisting, Mr Nicholson, and the other counsel appearing at this inquest. I am also appreciative of the work of the Coroner's Associates and the investigation undertaken by Senior Constable Richard Keegan.

Dated: 7 December 2022 at Hobart in the State of Tasmania



Olivia McTaggart
Coroner