FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 3425/10

In the Coroners Court of Victoria at Melbourne

I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: BRYAN
First name: KYLE
Address: 16 Tamworth Court, Cranbourne, Victoria 3977

without holding an inquest:

find that the identity of the deceased was KYLE JAMES BRYAN
and death occurred on or about 3rd September, 2010

at 16 Tamworth Court, Cranbourne, Victoria 3977

from
1a. COMPRESSION OF THE NECK CONSEQUENT UPON HANGING
2. CEREBRAL PALSY, EPILEPSY

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and Kyle Bryan was not immediately before he died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Kyle Bryan was aged 11 years at the time of his death. He lived at 16 Tamworth Court, Cranbourne.

2. A coronial brief has fully addressed the tragic circumstances of Kyle's death.

Incident Summary

3. 11 Year-old Kyle Bryan lived with his paternal grandmother in Cranbourne, Victoria. Kyle had cerebral palsy and epilepsy. He could not walk or talk and was fed via a feeding tube. Kyle slept in a special purpose bed with foldable sides that were designed to prevent him from falling out. His grandmother acted as his full-time carer.

4. At approximately 06.45am on the 3rd September, 2010, Kyle was found deceased in his bedroom by his grandmother. The neck collar of his long sleeve windcheater pyjama top had become hooked on a protruding metal bar at the lower end of his bed. The rest of his body was resting on the floor. This caused pressure to be applied to his neck.

Coroners Prevention Unit

5. I sought assistance from the Coroners Prevention Unit (CPU[1] to determine whether previous deaths in Victoria or interstate had occurred in similar circumstances to that of Kyle's death.

6. The CPU identified several relevant coronial investigations between 2000-2010 where a person's clothing became caught on a piece of furniture and they were unable to extricate themselves due to a physical limitation or disability, causing death. The search did not identify any previous deaths that occurred in the same circumstances as Kyle's.

7. Former State Coroner Graeme Johnstone investigated the death of an elderly woman who died when her nightgown became caught on a bedroom door handle after she had fallen at a nursing home. In his 2004 finding, Coroner Johnstone noted that while her death was rare and unusual, knowledge of the principles of safe design could eliminate the potential for injury. He related this principle to the successful measures taken in custodial settings to eliminate possible hanging points.

8. Kyle's death may well have been prevented if 'safe design' principles were applied and potential hanging points eliminated in the bed design. Any government or non-government organisations involved in the supply or subsidy of equipment to individuals with a disability should also ensure that 'safe design' principles are adhered to. However in saying this, I acknowledge that this mechanism of strangulation is certainly rare and was likely unforeseeable.

RECOMMENDATIONS:
Pursuant to section 72(2) of the **Coroners Act 2008** and in light of the above comments and in the hope of preventing another tragic death in the future, I make the following recommendation:

1. I recommend that "Hendicare" review the design of their special-purpose beds, giving proper consideration for safety and the elimination of any potential hanging points.

I direct that a copy of this finding be distributed to the following parties, in the hope that Kyle's death may lead to a broader awareness of the potential risk of hanging involving special-purpose beds:

[1] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner in formulating preventing recommendations and comments, and monitors and evaluates their effectiveness once published.

- Jane Galvin, Royal Children's Hospital - TOCAN Group (the Transportation of Children and Youth with Additional Needs Partnership)[2]
- Caroline Mulcahy, Chief Executive Officer - Carers Victoria
- Arthur Rogers, Executive Director - Disability Services Division, Department of Human Services

Post Mortem Medical Examination

9. On the 6th September, 2010, Dr Noel Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination only on Kyle James Bryan. Dr Woodford found the cause of death to be hanging with contributing factors Cerebral Palsy and Epilepsy.

10. Dr Woodford noted the police form 83 circumstances. He noted Kyles's grandmother commenced resuscitation, and an ambulance called, however, Kyle was unable to be revived.

Finding

I find the cause of death of Kyle Bryan to be hanging with contributing factors Cerebral Palsy and Epilepsy.

Signature:

John Olle
Coroner
Date: 9th August 2011

[2] The TOCAN partnership includes: The Royal Children's Hospital Safety Centre, Autism Victoria, Vic Roads, the Association for Children with a Disability, Australian Child Restraint Resource Initiative, the School of Occupational Therapy, Latrobe University, Britax Childcare, and representatives from The Royal Children's Hospital Occupational Therapy Department, the Victorian Paediatric Rehabilitation Service, Neuro Rehabilitation Research, Critical Care and Neurosciences.