

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3270/08

Inquest into the Death of RICKARD DAVID THOMAS

Delivered On:	17th August 2011
Delivered At:	Melbourne
Hearing Dates:	21, 22 February 2011
Findings of:	CORONER K. M. W. PARKINSON
Place of death:	St Vincent's Hospital, Melbourne
PCSU:	Sergeant Tracey Weir
Appearances:	Mr J Constable for the family of David (Rickard) Thomas Mr H Burchill for Fitness First Australia Pty Ltd

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Court reference: 3270/08

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: THOMAS
First name: RICKARD DAVID
Address: 83 Lawson Avenue, Frankston, Victoria 3199

AND having held an inquest in relation to this death on 17th August, 2011
at Melbourne

find that the identity of the deceased was RICKARD DAVID THOMAS
and death occurred on 5th October, 2007

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from

1a. HYPOXIA AS A RESULT OF CARDIAC ARREST (VENTRICULAR
FIBRILATION) FROM UNKNOWN CAUSE

In the following circumstances:

1. An inquest was conducted into the death of Mr David (Rickard) Thomas at St Vincent's Hospital Melbourne on 5 October 2007. The following witnesses gave evidence in the proceedings: Ms Emmylou MacCarthy, Fitness First Australia Pty Ltd employee and attending staff member at incident; Mr Peter Elliott, General Counsel Fitness First Australia Pty Ltd; Dr Antony Tobin, Intensive Care Specialist, St Vincent's Hospital, Melbourne; Mr James Bellett, Paramedic Ambulance Victoria; Mr Geoff Taurins, MICA paramedic Ambulance Victoria.

2. The death of David (Rickard) Thomas was brought to the attention of the State Coroner by letter from the family dated 8 July 2008. David collapsed at the Fitness First fitness centre on 3 October 2007 whilst undertaking a workout and subsequently died at St Vincent's Hospital on 5 October 2007. The cause of death was registered as Hypoxic Brain Injury.

3. No report was made to the Coroner at the time of death, despite the death being an unexpected death and reportable pursuant to s.3 and s.13 of the *Coroners Act 1985* (the act in operation at the time of the death)

4. The capacity of the Coroner to investigate the death, in particular with the assistance of a forensic pathologist undertaking a post mortem examination, has been constrained. No post mortem examination was performed and therefore there is no ability to further inquire into the underlying cause of the cardiac event, which likely resulted in the hypoxic brain injury.

5. The issues raised by the family in their correspondence included their concerns as to the circumstances surrounding the collapse and the nature of the initial response to the collapse and the immediate first aid provided. The family were concerned to understand whether the death was preventable in the context of more effective immediate response, having regard to staffing resources, training and the facilities available to staff in responding to the emergency. David's father, Mr Peter Thomas, a MICA paramedic of many years experience was particularly concerned as to the level of first aid training held by staff and their capacity to institute effective CPR. This he said was relevant not only to David's death but also to possible prevention of future deaths.

6. The family does not dispute the registered cause of death, that is, Hypoxic Brain Injury and have expressed the not unreasonable view, having regard to the available medical evidence, that David's death likely falls into the category of cases where young people have some cardiac arrhythmia and die suddenly without any other warning or any other evidence of illness.

7. As a result of the length of time that had passed before the death was reported and the limitations upon the nature of any investigation which might be usefully undertaken, I determined that the holding of an inquest was the most appropriate manner to investigate matters relating to the death and in particular the issue of contribution or prevention.

8. I now turn to set out the background to this matter and my conclusions on the evidence in the proceedings.

9. David was born on 9 March 1978 and was 29 years old at the time of his death. He was a fit and healthy young man. He was not being treated with any medication. There is no evidence before the court that he used illicit drugs of any kind.

10. On 3 October 2007, David attended at the Fitness First Health Club at Collins Street, Melbourne. Records show that he was a regular attendee since joining the club in January 2007.

11. The club is located on the first and second levels of the building, occupying the entire level of the first floor where the majority of the workout and exercise rooms are located. Access to the centre is by way of lifts or stairway from Collins Street. The reception and seating areas are located at the West end of the building on the first floor and have a partial view through to the training areas. The free weights area where David was working is located at the East end of the floor. The reception area has a fixed line telephone, with a number of fixed line telephones located in offices around the perimeter of the centre. The first aid facilities are located at the reception area.

12. On the evening of 3 October 2007, there was one staff member present, Ms Emmylou MacCarthy. Ms MacCarthy was not a qualified fitness trainer and was employed as a receptionist.

13. At approximately 9.28pm that evening, a member of the club advised Ms MacCarthy that David had collapsed in the free weights area. Ms MacCarthy called '000' and advised of the collapse and then attended upon David. Her evidence was that it appeared he was having some type of seizure although she was not certain. She established he was not breathing and that he had a faint pulse. Ms MacCarthy formed the view that David had suffered an epileptic seizure and this was the initial advice provided to emergency operators.

14. Ms MacCarthy left David to return to the reception area to update emergency services. At about this time emergency services upgraded his status from collapse to cardiac arrest for the purposes of prioritising the ambulance attendance. Ms MacCarthy was asked whether there was a defibrillator on the premises and was instructed to obtain the defibrillator and advised to commence using the device. She does not recall being advised to commence CPR. The operator also advised her to obtain a mobile phone so that instructions could continue as she proceeded.

15. Her evidence was that she had some difficulty in continuing uninterrupted communication with the '000' operator as a result of there being no phone available at the location of David's collapse. Because no portable phone was available and operating on the premise, it was necessary for her to return to the reception phone on two occasions to convey information to the operator.

16. Paramedics were dispatched to the scene at 21.31 and arrived at 21.38. They initially had difficulty accessing the location with their equipment, as the lift was not operating. One of the paramedics went ahead via the stairway. On arrival at the patient at 21.40, he identified David to be in cardiac arrest (ventricular fibrillation). He was told that CPR had not been commenced. Ms MacCarthy was at that time setting up the AED device.

17. Paramedics commenced resuscitation with the assistance of Ms MacCarthy and continued resuscitation until they received some cardiac output.

18. The evidence is that there was a period of at least 12 minutes before the ambulance arrived and resuscitation efforts commenced. This meant that David had been oxygen deprived for that period.

19. David was transported to St Vincent's Hospital where he was admitted to the Intensive Care Unit. It became apparent that he had sustained a non-survivable brain injury. He was treated by Dr Antony Tobin, senior intensive care specialist, who stated:

"He received standard support care for an out of hospital cardiac arrest including cooling to 33 degrees for 24 hours for cerebral protection. A CT of the brain was reported as normal and a trans-thoracic echocardiogram showed a normal size left ventricle with severe global dysfunction consistent with cardiomyopathy, myocarditis or post resuscitation stunning. A urine drug screen was positive for benzodiazepines, which may have reflected post arrest sedation. After re-warming, when his sedation was weaned, generalised myoclonic jerking of the body was noted to be present suggesting severe hypoxic brain injury."

20. Dr Tobin stated that this indicated a grave prognosis and that after discussion between clinicians and his family, medical intervention was ceased and David died on 5 October 2007.

21. Dr Tobin's evidence was that the CT scan was performed to determine in the context of the collapse, whether there had been an intra-cerebral bleed, which might explain the collapse and that this was excluded as there was no evidence of a bleed. The echo-cardiogram identified that the left ventricle was working very poorly, however it was difficult to state whether this was as a result of a longstanding underlying heart disease such as cardiomyopathy or as a result of the prolonged resuscitation with multiple electric shock, which would also cause the same appearance.

22. Dr Tobin was asked about the initial assessment that David was suffering a seizure. His evidence was that it is not uncommon for a person in cardiac arrest to suffer what may appear to be an epileptic seizure, but which to a trained eye is in fact a hypoxic seizure, indicative of cardiac arrest and warranting immediate resuscitation efforts. His evidence was that minutes are significant in the context of the potential for hypoxic brain injury.

23. Dr Tobin gave evidence was that whilst early defibrillation is the best treatment, "people can be sustained and survive for long periods of good CPR if it is started early and of good quality". T118.

Issue of resuscitation efforts and first aid training of staff.

24. Mr Peter Elliott, General Counsel, Fitness First Australia Pty Ltd, gave evidence that there are no mandatory requirements as to first aid qualifications of staff working at fitness centres, although the industry body recommends that a current Certificate 1 First Aid qualification is appropriate. Mr Elliott stated (Exhibit 1) was that it was the policy of Fitness First that "not less than one staff member present in the club at any time hold first aid qualifications".

25. Ms MacCarthy's evidence was that she had trained as a beauty therapist and that during the course of this training she had undertaken a first aid qualification. This was in year 2000 and she had not attended any refresher training since that time. Her evidence was that she was never asked whether she was first aid trained by her employer and that it was not a criteria for her employment. Her evidence was also that she was not familiar with the industry code of conduct in relation to recommended level of first aid training and nor had she been provided with any first aid training whilst employed with the company.

26. Mr Elliott's evidence was that there is no industry standard or regulation that an automated external defibrillator device (AED) be located at the premises, but that an AED is located at each of their facilities. Whilst in his statement he reported that regular training was undertaken of staff in the use of such devices he was unable to identify any such training having occurred and Ms MacCarthy's evidence was that she had not been trained in the use of an AED. Whilst the device is designed to be operated by an untrained person, all witnesses agreed that it would be helpful for staff in a facility such as a fitness centre, to be familiar with and trained in the use of the device.

Issue of staffing levels at the gymnasium on the evening.

27. Mr Elliott stated that there is no regulatory requirement for more than one staff member to be present in the club and that there is no minimum staffing level or even industry recommendation as to this matter irrespective of how many persons may be using the facility at any one time. He stated that the Fitness First centres are usually staffed by two or more staff members whether they are permanent or casual employees or session by session fitness trainers.

28. It was apparent from Mr Elliott's evidence that he was unfamiliar with the particular operating procedures within the Collins Street Fitness First gymnasium at that time. He was unable to assist the court as to the nature of first aid training, if any, which may have been required of, or provided to staff at the gym in 2007, or as to the staffing or rostering arrangement usually in place at the particular gymnasium.

29. His evidence was that there were usually more than one employee at the premises, however he had no capacity to identify the actual staffing numbers at any one time as those

records were not kept by the head office and were generally kept by the local fitness centre and were apparently no longer available. He accepted that the only staff member on duty that evening was Ms MacCarthy.

Issue of access to telephone points and AED device.

30. Mr Elliott's evidence was that there is fixed phone access in the fitness centre, however he was unaware of any portable phone facility. He acknowledged that in a case such as the present where there was only one staff member on duty, this would require the staff member to leave the patient to communicate with emergency services.

31. Ms MacCarthy gave evidence that there was a portable phone at the premises however it did not work. In the event she borrowed a mobile phone from a facility member. Her evidence was that she would have been assisted by the availability of a portable phone.

32. The AED device was appropriately and conveniently located with the first aid equipment and Ms MacCarthy was aware of that location.

Conclusion and Finding

33. I am satisfied that the emergency response by Ambulance Victoria paramedics was appropriate as was the medical care and management provided at St Vincent's Hospital.

34. The evidence in this case establishes that there were inadequate arrangements in place in the fitness centre to provide for appropriate response to emergency medical event such as that experienced by David.

35. The fact that there was one staff member available, that emergency phone access was limited and that the staff member was not currently accredited to Level 1 First Aid training standard, meant that despite the best efforts of Ms MacCarthy, the immediate emergency response was constrained.

36. However, whilst there is evidence that early intervention by the administration of CPR and defibrillation is more likely to obtain a favourable outcome in circumstances of collapse, I am unable to conclude on the evidence before me that David would have survived had there been earlier commencement of resuscitation efforts, that is before the ambulance arrived. In those circumstances I am not satisfied that the factors set out in paragraph 35 above contributed to the death.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. There is an apparent lack of regulation or supervision of the standards of operator practice in this industry. There is no regulation of minimum first aid training required of staff where they are supervising the operation of a fitness facility. The industry code of conduct is a voluntary code with no apparent supervision of its implementation by individual fitness centre operators.

2. Mr Elliott gave evidence as to the regulatory background of the fitness industry as it relates to health and safety including first aid training and staffing requirements.

3. His evidence was that the industry has a national body, Fitness Australia Inc. for the purpose of self regulation and promoting the industry. This body, by its predecessor, Fitness Victoria, had developed a code of conduct for the safe operation of fitness facilities. Those standards included minimum first aid qualifications for staff and ongoing training. The document published in April 2007 (Exhibit 2) states at paragraph 42:

"A supplier must ensure that during all hours of opening there is a Registered First Aider (Level 1) on the fitness centre premises."

4. Mr Elliott provided a document to the court with his original statement (Exhibit 3), setting out the components of a Level 1 First Aid course. Whilst he acknowledged in evidence that it did not represent a course provided by Fitness First to its employees, his evidence was that this was the standard or level of training expected of a Level 1 qualified First Aider. That course outline identifies that the certificate is valid for three years and that annual refresher of cardiopulmonary resuscitation skills is recommended, the latter being consistent with Australian Resuscitation Council guidelines.

5. Whilst he gave evidence that since David's death, a private training operator had been engaged to provide ongoing first aid training to staff, he was unable to provide any material to identify that such training had been delivered. His evidence was that the program was largely confined to permanent staff and that it was delivered on an "as needs basis". (T13-14).

6. He agreed that minimum standards set out in the code of conduct were appropriate for implementation, he was unable to confirm that such standards are in place in his facilities or more generally in the industry.

7. The evidence is that people with a range of age, health status and fitness levels utilise fitness centres. Whilst attendees make declarations as to their health and capacity to undertake exercise, this does not negate an obligation upon an operator to ensure that in an emergency, first aid trained staff with current qualifications, are available and have the resources to support them in their response.


RECOMMENDATIONS:

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

1. That the Minister for Health and the Minister for Sport and Recreation consider enacting regulations mandating the presence of an employee with minimum current Level 1 First Aid qualification, including automated external defibrillator device enhancement, at all times during the operating hours of fitness centres in Victoria.
2. I direct that a copy of these findings be provided to the interested parties and to:

The Honourable David Davis MLC, Minister for Health;
The Honourable Hugh Delahunty MP, Minister for Sport and Recreation;
The Secretary, Department of Health;
The Secretary, Department of Sport and Recreation;
The Chief Executive Officer, Fitness Australia Inc.
St Vincent's Hospital Clinical, Rick Management Department;
Each of the witnesses in these proceedings.

Signature:



Kim M. W. Parkinson
Coroner



17th August, 2011