CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Cameron De Vries
Hearing dates:	10-14 February 2025
Date of findings:	28 February 2025
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Rebecca Hosking, Deputy State Coroner
Catchwords:	CORONIAL LAW – s 24(1)(e) *Coroners Act 2009 (NSW)*, disability support services, the need for risk identification and assessment, the interaction between the views of the guardian and carers for persons with a disability, risks identified with drowning, risks identified with seizure activity.
File number:	2019/272828
Representation	Counsel Assisting the Inquest: Emma Sullivan of Counsel, instructed by Kathleen McKinlay, NSW Department of Communities and Justice Legal The De Vries family: Lesley Whalan SC and Antonia Quinlivan of Counsel, instructed by Niall Connolly Interaction Disability Services (IDS): Tim Hackett of Counsel, instructed by Shaun Bailey
Non-publication orders	A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW). A copy of this order is available from the Registry upon request.

Findings	**Identity:** The person who has died is Cameron De Vries **Place of death:** 24 Church Street, South Windsor NSW 2756 **Date of death:** 31 August 2019 **Cause of death:** Drowning precipitated by a seizure **Manner of death:** Drowning in a bathtub in supported accommodation, unsupervised
Recommendation/s	1. To Interaction Disability Services Pty Ltd (**IDS**): a. That, as part of its existing audit processes, IDS conduct an audit of progress note documentation for participants of the 24 Church Street, South Windsor group home (Church Street) to ensure that support workers are recording accurate and timely notes. b. That IDS conduct a review of the behavioural support documentation for its participants to ensure that: i. The behavioural support documentation itself provides clear guidance to staff as to risks and strategies to manage behaviours of concerns (including in the format of a single summary document) ii. The language employed in documentation in connection with supervision requirements for participants in more precise than terms such as “spot checks” and “periodically” (so as to require further explanation, including as to the timing, frequency and nature of such checks). 2. That IDS continue to develop an updated form of ‘Client Personal Profile’ document to ensure it: a. Includes an “All About Me” support plan based on the participant’s and stakeholders’ input b. Sets out the participant’s support needs and response strategies in a summary format c. Accurately references other critical support documents that provide instructions to staff (for example, a behaviour support plan or risk assessment).

	3. That IDS review the medication administration practices within its supported accommodation to ensure that: a. Medication charts are appropriately completed for participants; and b. Only support workers who administer medication sign the medication chart. 4. That IDS engage a neurologist to review current epilepsy and seizure management policies and procedures. 5. That IDS review its present 'Family Involvement and Maintenance of Relationships policy' with a view to including a section that provides guidance on conflict between family members and/or guardians and support workers as to concerns about the participant's health, including clear guidelines for escalation to IDS management.

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Introduction

1 Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to various aspects of the death.

2 These are the findings of an inquest into the circumstances of the death of Cameron De Vries on 31 August 2019, then aged 20 years. This inquest is held, amongst other reasons, pursuant to the jurisdiction conveyed by s 24(1)(e) of the Act in circumstances where at the time of his death, Cameron was residing in a disability support group home at 24 Church Street, South Windsor (**Church Street**) operated by Interaction Disability Services (**IDS**).

3 Cameron was the much loved son of David and Adelaida De Vries who attended the inquest and the brother of Richard.

4 In his early years, Adelaida was Cameron's primary carer and tenacious advocate. She spent many hours holding Cameron on his hammock to keep him calm.

5 David said of Cameron that he warmed your heart. He was cheeky and determined. He had his own way of communicating; he would take David's finger and lead him to where he wanted to go. Most often with David this was to his hammock as it was David's job to swing him.

6 It was apparent in the course of his inquest that Cameron was also very much loved by his carers. In particular, DSW 3. DSW 3 worked with Cameron for about 11 years, moving workplaces to continue to support Cameron. In his words, DSW 3 loved Cameron like a son. Given Cameron's love for water, DSW 3 called Cameron his "water boy." Cameron was also a loved friend to his housemates.

7 On 31 August 2019, Cameron was found by his carer unresponsive in the bath. He was not able to be revived and he was declared deceased by attending ambulance officers at 9.22am. He was identified by David.

The role of the coroner

8 Pursuant to s 81 of the Act, a coroner holding an inquest concerning the suspected death of a person must make findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

9 In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

The issues examined at the inquest

10 An inquest into the circumstances of Cameron's death was held between 10 and 14 February 2025.

11 The issues examined at the inquest follow.

(a) The cause of Cameron's death, including whether there was a precipitating event (such as a seizure) that led to his drowning, and whether the nature of that event can be ascertained.

(b) Whether the level of ranitidine detected in Cameron's blood in post-mortem toxicology may have resulted in side effects that contributed to his drowning.

(c) In relation to IDS:

(i) whether the risk management and safety plans in place for Cameron's care were adequate and appropriate for his condition(s) - including whether epilepsy or seizure management plans should have been developed and

implemented after Cameron's hospitalisation in March 2019.

(ii) whether existing risk management and safety plans were sufficiently disclosed and effectively communicated to the IDS staff responsible for Cameron's care.

(iii) whether IDS staff received adequate and appropriate guidance from management on the level of supervision Cameron required while bathing.

(iv) whether IDS maintained accurate records - including records of Cameron's recent seizure activity.

(d) Whether it is necessary or desirable to make recommendations in relation to any matter connected with Cameron's death.

The evidence

12 Tendered to the court was a 5 volume brief of evidence compiled by the Officer in Charge of the coronial investigation, Senior Constable Timothy Cox and supplemented by the Assisting team.

13 At the inquest the court received oral evidence from:

(a) Cameron's father, David De Vries

(b) Dr Istvan Szentmariay, Forensic Pathologist

(c) Michelle Dodd, Strategy and Management Consultant

(d) Jane Burn, Registered Nurse

(e) Professor Cook, Neurologist and Epileptologist

(f) DSW 3 - Disability Support Worker, IDS

(g) DSW 4 - Disability Support Worker, IDS

(h) DSW 1 – Disability Support Worker, IDS

(i) DSW 2 – Disability Support Worker, IDS

(j) DSW 5, House Manager, IDS

(k) Kimberley Herivel – Psychologist and Cameron's Behaviour Support Practitioner, IDS

(l) Brett Thompson – CEO, IDS

Findings

14 I find that it was Cameron De Vries that died on 31 August 2019 at 24 Church Street, South Windsor.

15 I find on the balance of probabilities that Cameron died as a consequence of drowning precipitated by a seizure.

16 I am unable to make a finding as to whether the level of ranitidine detected in Cameron's blood post mortem had any impact on his death.

17 I find that the risk management and safety plans in place for Cameron's care were inadequate and inappropriate for the conditions for which he had a known diagnosis. In particular, they were confusing, inconsistent and lacked appropriate detail to provide adequate and useful guidance for those caring for Cameron.

18 In relation to IDS:

(a) I find that while IDS did not review the risk management and safety plans in place for Cameron's care following his seizure on 11 March 2019, this was not inappropriate in the context where

Cameron was discharged from the emergency department against clinical advice; the fact of the seizure was not a confirmed diagnosis (it was recorded as ?seizure) and the discharge summary recommended neurological review 'if having more seizures.'

(b) I find that the risk management and safety plans were not sufficiently disclosed and effectively communicated to the IDS staff responsible for Cameron's care in that while they were available, they were presented in a confusing and inconsistent manner, and they lacked sufficient detail to enable IDS staff to have a clear and coherent understanding of their obligations to Cameron.

(c) I find that the guidance given to IDS staff about the level of supervision Cameron required when bathing was vague and inadequate.

(d) I find that IDS records were inadequate and inaccurate. Particular examples include the ad hoc and inaccurate entry of daily progress notes and the failure of the worker administering medication to also sign for it.

Background

19 I am grateful for submissions by counsel assisting from which I have drawn directly at times in relation to non-contentious issues.

20 Cameron was born on 27 November 1998, to Adelaida and David De Vries. He was the younger brother to Richard.

Diagnosis and medications

21 Cameron was diagnosed aged 18 months with global development delay (**GDD**). Diagnosis of severe autism spectrum disorder (**ASD**) and moderate to severe intellectual disability followed at age 3.5 years.

22 Cameron had a history of vomiting – at times severe enough to require hospitalisation.

23 At the time of his death, Cameron was taking:

(a) Pariet (20mg) – for saliva production

(b) Ferrograd (for iron deficiency)

(c) Ostelin – (for Vitamin D)

(d) Ranitidine (300mg) (for reflux).

24 Cameron was not independent in self care including toileting, dressing and eating. Cameron loved the water. His parents installed a pool because of his love of water. Bathing was a significant part of his routine. Even if he had a shower for the purposes of washing it would usually be followed by a bath.

Provision of care

25 Cameron initially attended a special needs school in Hornsby before attending Tallowood School at Kellyville. After 18 months, he was enrolled in an intensive home school learning program for children with ASD. However, after 18 months he returned to Tallowood School.

26 Cameron's care needs were extensive. In 2009 aged around 10 he entered full time care. He was cared for by several providers until he settled with IDS as a resident at Church Street in 2014[1].

The documentation of Cameron's care

27 As will be discussed in further detail below, one of the difficulties in assessing the parameters in place for Cameron's care is that it was documented in multiple and at times inconsistent ways. The documentation includes:

(a) undated IDS documents detailing his daily routines

(b) Behaviour Assessment Report (**BAR**)

(c) Incident Prevention and Response Plan (**IPRP**)

(d) Restricted Practices Plan (**RPP**)

(e) Behaviour Support Plan (**BSP**)

(f) Client Risk Profile (**CRP**)

(g) electronic progress notes were also recorded by carers.

28 Cameron's IDS morning routine document noted:

> If Cameron is awake from 5.30am can commence personal care. Cameron likes to have a bath and will stay in there for a long period of time. Cameron needs physical support with washing his body; where possible get Cameron to wash part of his body himself.
>
> After bath support Cameron to get changed into presentable clothing before breakfast… After breakfast support Cameron to brush his hair and teeth. Cameron's morning medication is at 7am…

[1] IDS is a not for profit organisation registered with the National Disability Insurance Scheme (**NDIS**). It operates several disability support group homes in NSW.

29 Cameron's IDS afternoon routine document noted:

> Once Cameron finishes his afternoon tea he will then get into the bath to complete his personal hygiene routine…Cameron can spend a long time in there and can be heard singing and splashing around, Cameron can be left unsupervised with **spot checks** [emphasis added].

30 Cameron's BAR was completed by Herivel on 30 November 2017. Herivel assessed Cameron for his adaptive functioning on the ABAS-3 scale, covering ten skill domains including communication, community use, functional academics, home living, health and safety, leisure, self-care, self-direction, social skills, and work. He was assessed to be at the extreme low range of ability.

31 According to the BAR, Cameron exhibited three documented behaviours of concern: namely, self-injury (slapping and hitting his face constantly when unhappy), biting staff members when they attempted to stop him hitting himself and bouts of crying. The BAR identified antecedents to these behaviours and provided consequences to manage them.

32 Cameron's daily routine as outlined in the BAR was similar to that described in his IDS daily routine documents.

33 Herivel last reviewed Cameron's IPRP on 19 September 2018. The IPRP addressed the behaviour of "aggressive behaviour towards self", identified as "slapping, smacking or punching himself in the head/face area". The IPRP authorised physical restraint of Cameron's arms for a period of no longer than 5 minutes and gave instructions on how this was to be performed.

34 The IPRP encouraged sensory play activities including water play as a "key prevention strategy" on a regular basis every day, as this helped Cameron to regulate his emotions/moods.

35 The IPRP was signed by Herivel, Lisa Osborne (Principal Psychologist, Behaviour and Allied Health Services Manager), DSW 5 and Rachel Carey (IDS

Cluster Manager). It also referred to a signed consent form (dated 8 October 2018) from Cameron's parents.

36 On 15 October 2018, Herivel signed a Restricted Practices Plan (**RPP**) for Cameron. Amongst other things, the RPP provided information regarding the environment restraint of "restricted access to water" for Cameron. Relevantly, the RPP included:

(a) references to access to tap restrictions, and

(b) allowing for lengthy periods of water play within Cameron's routine noting that Cameron should be allowed to spend "a good length of time (at least 20 mins) in the bath as part of his regular routine…this currently occurs twice daily. **Supervise Cameron closely**…" [emphasis added].

37 In relation to Cameron accessing taps in the bath – we know from the evidence that modifications had been made such that the tap was removable when Cameron was in the bath to prevent him from turning the water on.

38 The RPP noted a signed consent by Cameron's parents dated 8 October 2018 which authorised his environmental and physical restraints.

39 On 31 October 2018, Herivel completed a BSP for Cameron. The BSP was to be reviewed in September 2019 and ended on 14 October 2019.

40 The BSP also referenced both Cameron liking water play and that it is included in his daily routines.

41 Cameron's CRP was reviewed on 29 April 2019, after the seizure activity described below. No reference was made to the seizure activity and the risk of seizure was not identified as a risk or area of concern.

42 Progress notes were also to be recorded by his IDS carers in respect of Cameron. This was done to varying degrees. For example, DSW 3 did not

record any electronic notes. DSW 4's notes proved to have been, at least on some occasions, fabricated in that he recorded events in advance of them occurring.

Guardianship

43 On 14 November 2018 the Guardianship Division of the NSW Civil and Administrative Tribunal appointed Adelaida (incorrectly referred to as Adelaide) as Cameron's guardian for 2 years with David noted as the alternative. This order was made with a restricted practices function permitting consent to physical restraint to prevent Cameron from self harm in accordance with his BSP.

Seizure activity

44 Prior to 11 March 2019, Cameron had no reported seizure activity.

45 On 11 March 2019, DSW 2 was driving Cameron and other participants to their activities. There is no written account provided by DSW 2 as to what he saw. His evidence at the inquest was:

(a) Cameron was usually very noisy in the car. On this day, he could see Cameron stretching and could see the whites of his eyes. He remembered seeing foam come from his mouth. He pulled over and jumped out of the car and pulled the door. The driver behind him called the ambulance. He couldn't get Cameron out of the car, but he picked him up and put him in the recovery position. He was very stressed. After a while Cameron "started coming back." Then the ambulance came.

(b) He didn't use the word seizure – he did not know what had occurred. He described to the doctor what he saw, and the doctor said it was a seizure.

46 DSW 5 attended the hospital. He also prepared the 'Significant Incident Report' following the incident. He recorded:

> Antecedent
>
> While on the run, he [Cameron] was heard hitting his foot on the floor of the car.
>
> Behaviour/incident
>
> Staff (DSW2) looked at the in-view mirror and saw CD stretching and having foam coming out of his mouth. DSW 2 quickly pulled over in a safe place along Hawkesbury valley way and DSW 2 called for help. DSW 2 ran, opened the back door and tried calling out to Cameron and put him in a recovery position. CD was said to have stopped breathing for a while and the entire seizure time was approximately 15mins. A certain woman upon hearing DSW 2's call for help stopped and called 000 requesting for an ambulance. DSW 2 put CD in a recovery position while assuring JH that everything would be fine with CD while he waited for the ambulance.
>
> Consequence
>
> [T]he ambulance came, examined Cameron and took CD to Hawkesbury Hospital.

47 DSW 5's record is consistent with the NSW Ambulance Medical Record which noted:

> CIT 20yo mate presenting with seizure like activity. O/A patient in car on side of road post ictal. Carer stated that patient has been having a seizure for the last 15-20min prior to paramedic arrival. carer stated that he has known patient for the last 2 years and has not witnessed or known him to have a seizure in the past.

48 Cameron was diagnosed in the emergency department with, "Nausea and vomiting. Convulsions Afebrile/Seizure".

49 His clinical notes included:

> BIBA with ! seizures, lasted about 10-15 minutes as per carer eyes rolled back, became stiff? Witnessed by carer through a car mirror / was driving nil history of seizures!

50 Cameron's My Health Record was obtained and no prior record of seizures was recorded. His non contrast CVT brain scan was reported as normal.

51 Records refer to Cameron being discharged against clinical advice by his mother later that day. The clinical notes state “Advised to seek further treatment if worried or pt deteriorates”. The notes also record the following:

> 11 Mar 2019 14:26:16 Rachael Spanner
>
> As mother. and carer helping pt into wheelchair leave. Pt vomited dark liquid.
>
> Expressed to mother he is still vomiting and hasn't had any fluid/not tolerating any oral fluids. Mother states he 'is like this all the time, and they manage it at home'. Dr Hamd notified. Carer also advised if pt deteriorates or is concerned to bring back to hospital.
>
> 11 Mar 2019 14:28:23 Gayle Turner
>
> Carer expressed concern to me that mother ?not legal guardian and that she had signed pt out against advise. Carer concerned that pt not well Carers concerns directed to Dr Mohind

52 The ED discharge summary letter to Cameron’s GP, written by Dr M Hamd, stated that Cameron had presented with “? Seizure”. The diagnosis was “? seizure, iron deficiency anaemia”. Treatment was to be “ferrograd C tablets” with a follow up request for a gastroenterologist, as well as a neurologist in the event of more seizures.

53 At 9.32pm, James Londoni made the following IDS shift note:

> Cameron was in the hospital this afternoon (see incident report). he was admitted [sic ?] due to mum refusing for him to be admitted. CD was discharged, when he got home he fell asleep as he was weak. CD spent his afternoon in bed sleep, staff checked [on] him every 5min.

54 On 14 March 2019, Cameron was experiencing another significant vomiting episode and presented to MyHealth Kable Street. He saw Dr Jasper Morrison. His discharge statement from his 11 March 2019 presentation was provided. Dr Morrison arranged for him to return to the hospital for further review. His parents were also present at the hospital. His records noted his 11 March 2019 presentation following a “likely seizure episode.” Cameron was discharged and a letter was written to his GP.

55 On 15 March 2019, Cameron was referred by Dr Morrison to Dr Daneshjoo for "an opinion about anaemia and the need for endoscopy." An endoscopy was performed on 8 May 2019.

56 On 16 May 2019 GP Dr Tran, with input from Cameron's parents and DSW 5, completed a Comprehensive Health Assessment Program (**CHAP**). This was inaccurate and inconsistent. The CHAP did not acknowledge that Cameron regularly regurgitates/vomits or that he had recently had a seizure. Though elsewhere there was a reference to gastroenterological review for vomiting.

57 On 19 June 2019, Adelaida attended on Dr Morrison without Cameron to discuss his gastroscopy result and changes in medication. They discussed Dr Daneshjoo's recommendations, and changed Cameron's regular medications including Pariet, Zantac, and iron and B12 supplements. A plan was made to start iron tablets and repeat the blood test in 6 – 12 months. He recorded "Adelaide feels the seizure was not a true seizure and may be a behavioural response to nausea e.g. much like a grimace. At this stage we have agreed to monitor for further seizures."

Events leading up to Cameron's death

58 DSW 4 was on the 'wake shift' the night before Cameron's death. He was the only carer on shift between 10pm on 30 August 2019 and 7am on 31 August 2019.

59 DSW 2's shift commenced at 7am and he arrived around 6.55am.

60 DSW 1's shift commenced at 8am. He arrived a few minutes early and noted that DSW 4 had already left.

61 DSW 4's evidence at the inquest was problematic. His manner was evasive and his evidence inconsistent. When asked what time he left on the morning of Cameron's death he responded with words to the effect, "it is not a crime to leave work early." When pressed, he conceded in evidence that at least in some

cases, his progress notes were inaccurate as they were entered prior to events occurring. Examples of this include:

(a) 21/08/2019 note made at 6.45am: “He went back to sleep until 7am. He was given shower, medication and breakfast at 7.10”.

(b) 27/08/2019 note made at 6.57am: “he was given shower, medication and breakfast at 7am.”

(c) 31/08/2019 note made at 7am.: “He followed all his morning routine namely showering, breakfast and medication. He behaved well in this shift.”

62 Given DSW 4’s concessions regarding the inaccuracy of his notes – I can not be confident that what was written on Cameron’s progress notes on the morning of his death actually occurred.

63 In his statement to Police DSW 4 said that Cameron woke that morning at around 6.45am/7am. Cameron went to the bathroom so DSW 4 put him in the bath, and after he had been washed, he left Cameron in the bath with the tap on slowly so water could run out for Cameron to play with. Cameron was able to put the plug in and out of the bath. Cameron was in the bath when DSW 2 arrived at 6.55am. DSW 4 said he checked on Cameron every 5 or so minutes and he could hear Cameron making noises. He prepared his paperwork, DSW 2 started to get the participants medications ready and at 7.40am DSW 4 left. Cameron remained in the bath after he left.

64 In his statement to Police, DSW 4 said he left after DSW 1 arrived – I don’t accept this evidence.

65 DSW 4 called DSW 2 after he had left as he remembered he had left the water running on low in Cameron’s bath. DSW 2 told him he had already turned the tap off.

66 In his statement, DSW 4 said that “Cameron loved spending time in the water and I would let him stay there for 10-15 minutes usually.” This appears to be inconsistent with the timeline on the morning of Cameron’s death as it appears Cameron had his first bath from the time he woke up, 6.45am to 7am until after 7.40am when DSW 4 left.

67 In evidence at the inquest, DSW 4 said he gave Cameron his medication. Though it appeared that DSW 2 signed for the medication.

68 DSW 2’s evidence was also problematic.

69 At the inquest DSW 2 said he believed DSW 4 gave Cameron his breakfast and medication. When reminded that he had signed for the medication, DSW 2 indicated he would sign for the medication if he saw it being given. When pressed he confirmed that this practice was not appropriate.

70 Considering the totality of the evidence, I find as a matter of fact that Cameron was in the bath from the moment he woke up until after DSW 4 had left. No one indicated that medication was given whilst participants were in the bath. If his medication was not administered by DSW 2 on the morning of his death, it seems unlikely that it was administered that morning at all. It is also unclear on the evidence whether he was given breakfast.

71 It appears on the evidence that Cameron came out of the bath after DSW 4 left and was dressed and in the lounge. He then soiled himself and so he was taken back to the bathroom, showered by DSW 2 and then Cameron indicated he wanted to go back in the bath. DSW 2 set up the bath and removed the tap. He had filled the bath to waist level. By that time DSW 1 had arrived and they were both cleaning the rooms – vacuuming and mopping. DSW 2 said that Cameron was very loud when he played in the bath. DSW 2 said he went into the bathroom, indicated to Cameron it was time to get out and then he went to get Cameron’s towel and clothes. He then heard DSW 1 yelling and he ran into the bathroom, and saw DSW 1 get Cameron from the bath. DSW 1 started doing CPR and DSW 2 called emergency services. While he had his mobile with him,

he ran back to the office and called from the landline. He then returned to the bathroom and had the phone on loud speaker while they were given CPR instructions.

72 DSW 2 said that Cameron had been in his second bath for about 15 minutes before he heard DSW 1 yelling. He also said he checked on him twice in that period. He couldn't recall if he could see water in the bath when he saw DSW 1 pulling Cameron from the bath.

73 DSW 1 said that Cameron returned to the bath around 8.40/8.45am. We know that the call to emergency services was placed at 9.12am. DSW 1 went into the bathroom and saw Cameron with his legs, one on top of the other and one hand slightly on the edge of the bath. There was water in the bath, he couldn't see how much. The tap was not on. Cameron's eyes were open. His head was near the drain area. He pulled him out of the bath and put him on the floor calling his name, yelling and shouting and he was not responding. He commenced CPR. Cameron did vomit – a bad smelling slimy green liquid.

74 DSW 1 did not recall pulling the plug and emptying the water from the bath though I note that attending ambulance officers recorded the bath being empty.

75 DSW 1 said that he did not do spot checks on Cameron that morning – he believed DSW 2 did. I did not find DSW 2 to be a compelling witness. On the totality of the evidence I cannot make a positive finding as to whether or not Cameron was checked while he was in his second bath.

76 DSW 1 presented as an honest and credible witness.

77 Based on the evidence I can accept, the events leading up to Cameron's death follow.

(a) Cameron woke at around 6.45/7am and was put in the bath by DSW 4. DSW 4 left the tap running at a low level for Cameron to play with the running water.

(b) DSW 4 wrote Cameron's progress notes at 6.57am. They were fabricated in that they referenced Cameron having been showered and given his medication at 7am. The evidence indicates that Cameron was in the bath from when he woke until after 7.40am. If he had his breakfast and medication, which it is not clear that he did, it would not have occurred until after 7.40am when he left the bath.

(c) Cameron had left the bath between 7.40am and when DSW 4 telephoned DSW 2 to remind him to turn the water off in Cameron's bath. Likely around 7.50am. He was assisted to get dressed by DSW 2 and was in the lounge.

(d) While in the lounge, Cameron defecated and returned to the bathroom to get cleaned up. This occurred around 8.40/8.45am. After his shower, he indicated he wanted another bath and DSW 2 complied. The bathwater was filled to waist level and the tap removed.

(e) I am unable to make a positive finding that Cameron was checked while he was in the bath for this period.

(f) Before 9.12am, DSW 1 saw Cameron in the bath with his head near the drain, his eyes open, his legs one on top of the other and one arm on the edge of the bath. He pulled Cameron from the bath and was yelling out. He commenced CPR and DSW 2 called emergency services.

(g) At some point before ambulance officers arrived, the bath was drained. I accept that neither DSW 1 nor DSW 2 recall draining the bath. Given the stress they were under, this is not surprising.

(h) Cameron was not able to be revived and was declared life extinct by ambulance officers at 9.52am.

(i) Cameron was identified by his father, David De Vries at 1pm.

Post Mortem

78 An autopsy was performed on Cameron on 4 September 2019 by Dr Istvan Szentmariay assisted by Lydia Duncan. Dr Szentmariay opined that the direct cause of death was drowning.

79 Dr Szentmariay indicated that the "exact mechanism leading to drowning is not quite clear, however it is likely related to the underlying chronic condition (ASD and GDD)". He acknowledged that "further coronial investigation may reveal additional details of the circumstances of drowning."

80 A markedly elevated level of ranitidine was reported on Cameron's toxicology analysis. Dr Szentmariay indicated that "ranitidine may cause numerous symptoms of various severities which may or may not contribute to drowning. There has been limited clinical experience with ranitidine overdose."

81 Cameron's stomach contained 80ml of content. When asked at the inquest, whether it is likely Cameron was given breakfast, he indicated that 12 hours is a long period of time for gastric emptying but he could not determine how long since Cameron had eaten. His evidence did support the contention that Cameron had eaten since dinner the night before.

82 In his evidence at the inquest, Dr Szentmariay said:

(a) death by drowning is a diagnosis of exclusion, the fact that there were no pathological factors present which support the diagnosis does not exclude it from being made.

(b) the fact that Cameron could ordinarily mobilise in and out of the bath did not change his opinion as to cause of death.

(c) there was no foreign body in Cameron's upper airways which suggests he did not choke.

(d) he could not exclude the possibility that Cameron had a fatal cardiac arrythmia causing him to slide into the water or that he had a seizure which alone caused his death, notwithstanding that, he considered that Cameron had entered the water for his terminal phase.

(e) there was no evidence of brain abnormalities or other injuries including tongue or cheek biting; petechiae which can present in circumstances of seizures.

(f) he would expect to see more physical signs of a seizure in a confined space.

83 In relation to the markedly elevated level of ranitidine, Dr Szentmariay expressed that based on the testing process, he did not consider post mortem re-distribution to be the likely cause. However, he ultimately deferred to Professor Jones as the expert in that area.

84 Having reviewed the expert evidence of Professors Cook and Jones, and been apprised of Cameron's family history, Dr Szentmariay remained of the view that Cameron's death was caused by drowning.

85 Professor Jones, toxicologist, prepared a report dated 17 April 2024. She was not required to give evidence. She reported that:

(a) ranitidine has a large therapeutic window and no more than minimal toxicity is expected even with very large doses in most cases. Despite this, occasionally serious adverse or toxic effects can occur.

(b) the post mortem blood concentration of 5.3mg/L in Cameron was approx. 10 times the normal peak therapeutic level when given orally. However, it is compatible with the order of blood concentrations seen after normal dose IV administration.

(c) whether ranitidine undergoes post-mortem redistribution is unknown – there is insufficient research to determine that.

86 Professor Jones opined that while it is possible that his elevated ranitidine level, if accompanied by central nervous system (**CNS**) depression, could have contributed to his drowning, such CNS depression would have likely been visible to carers prior to him entering the bath. Professor Jones considered that ranitidine is a possible but not a likely contributor to Cameron's death.

87 Additional evidence relevant to cause of death includes evidence given by David that:

(a) Adelaida's father and brother in the Philippines suffered unexplained deaths at an early age; and

(b) another of Adelaida's siblings has ASD and late onset seizures.

Issues

Statutory findings: The cause of Cameron's death, including whether there was a precipitating event (such as a seizure) that led to his drowning, and whether the nature of that event can be ascertained.

Professor Cook

88 In addition to giving evidence, Professor Cook, Neurologist and Epileptologist, prepared reports dated 23 December 2024 and 10 February 2025.

89 Professor Cook reported that:

(a) it is common for no abnormalities to be found in imaging studies or pathological examinations of the brain in people with seizures, even when epilepsy is chronic and recurrent.

(b) epilepsy rates amongst individuals with intellectual impairments are significantly higher than in the general population.

(c) it can be challenging to diagnose epilepsy in individuals with intellectual disabilities, as such, a single unprovoked seizure is often deemed sufficient to initiate treatment. It is considered that the benefits of risk management and prompt seizure control often outweigh the potential risks of antiepileptic drug therapy in this population.

(d) people with epilepsy are disproportionately affected by bathtub drownings due to seizures leading to loss of consciousness or motor control during bathing. This is strongly linked to Sudden Unexpected Death in Epilepsy (SIDEP), which may occur in water based environments.

(e) seizures are a well-received risk factor for bathtub drownings and the circumstances in which Cameron died would be quite typical.

(f) the absence of pathological abnormalities in the brain does not exclude epilepsy as a potential contributing factor.

(g) the literature highlights the importance of supervised bathing in such situations but given that a diagnosis of epilepsy was not established, the carers were likely unaware of these potential hazards.

90 In his evidence, Professor Cook stated that once a person has a seizure, treatment is wise because recurrence is more likely. Generally patients are advised not to drive and not to bath or swim unsupervised for 6 months after a seizure. He confirmed that based on the material provided, he was satisfied that Cameron had a seizure on 11 March 2019.

91 Given this history of a seizure, Professor Cook was asked to comment on the likelihood that Cameron had a seizure in the bath on the morning of his death. Professor Cook opined it was highly likely in circumstances where:

(a) Cameron had a documented history of a seizure on 11 March 2019 which placed him at risk for recurrent seizures.

(b) seizures are a recognised risk factor for bathtub drownings, particularly for individuals with disabilities.

(c) the autopsy did not reveal alternative structural or pathological explanation for sudden loss of consciousness or drowning.

92 Professor Cook opined that the lack of a formal epilepsy diagnosis or treatment following his March 2019 seizure likely left Cameron vulnerable to a recurrence consistent with the circumstances surrounding his death.

Statutory findings

93 The date, place and identity of the deceased is not in contention. It was Cameron De Vries that died on 31 August 2019 at 24 Church Street, South Windsor.

94 Having considered all of the evidence and submissions in this inquest, I find on the balance of probabilities that Cameron died as a consequence of drowning precipitated by a seizure. This finding is made noting the matters that follow.

(a) It is improbable that Cameron drowned without a precipitating event given the evidence of his competence in water including his ability to mobilise in and out of the bath; his ability to remove the plug to drain the water and the modified size of the bath.

(b) While it is possible that the precipitating event was a cardiac arrhythmia, the only support for that contention is the evidence from David as to two unexplained premature deaths in Adelaida's family. Neither Dr Szentmariay nor I considered this evidence to be persuasive.

(c) I accept Professor Cook's opinion that the 11 March 2019 event was a seizure. Having suffered one seizure, Cameron was at an increased risk of further seizures particularly in the first 6 months.

(d) Cameron's positioning in the bath when found was consistent with drowning precipitated by seizure.

(e) While the autopsy did not reveal pathology consistent with either a seizure or with drowning, the circumstantial evidence supporting the fact of a seizure combined with Dr Szentmariay's opinion of drowning based on a diagnosis of exclusion is compelling.

95 As outlined above, the evidence as to what occurred on the morning of Cameron's death is unsatisfactory. However, it is clear that he was, at the time of his death, in the bath unsupervised. I need not make a finding as to how regularly he was checked on the morning of his death in circumstances where it is clear that there was no one in the bathroom with him when he drowned.

96 I find that Cameron's manner of death was drowning in a bathtub in supported accommodation, unsupervised.

Whether the level of ranitidine detected in Cameron's blood in post-mortem toxicology may have resulted in side effects that contributed to his drowning.

97 I am unable to make a finding as to whether the level of ranitidine detected in Cameron's blood post mortem had any impact on his death.

98 There is no evidence indicating that Cameron was given ranitidine above prescribed levels or that he could have accessed ranitidine in circumstances where medication was prepared by a chemist in blister packs.

99 While the most plausible explanation would be post-mortem redistribution, I accept Professor Jones' opinion that there is insufficient literature to draw this conclusion.

100 Unfortunately this issue remains an unusual feature of Cameron's death that cannot be explained.

In relation to IDS

101 The issues in relation to IDS identified prior to the inquest follow.

(1) Whether the risk management and safety plans in place for Cameron's care were adequate and appropriate for his condition(s) - including whether epilepsy or seizure management plans should have been developed and implemented after Cameron's presentation to hospital in March 2019.

(2) Whether existing risk management and safety plans were sufficiently disclosed and effectively communicated to the IDS staff responsible for Cameron's care.

(3) Whether IDS staff received adequate and appropriate guidance from management on the level of supervision Cameron required while bathing.

(4) Whether IDS maintained accurate records - including records of Cameron's recent apparent seizure activity.

102 As is often the case, as evidence is adduced in the course of the inquest, the significance of some issues dissipates while seemingly insignificant issues can play a more significant role.

Seizure management

103 We now have a definitive view from Professor Cook, a leading epileptologist. Professor Cook opined that on 11 March 2019, Cameron experienced a seizure. While he would not have necessarily diagnosed Cameron with epilepsy following that one seizure, given Cameron's combination of GDD, ASD and the

evidence of one seizure, he would have commenced treatment noting the risks of further seizures particularly in the first 6 months.

104 However, this assessment was not made while Cameron was alive. If it had been, IDS had in place seizure policies. Putting aside whether or not their content was appropriate, it is clear that IDS recognised risks posed by seizures and sought to address them. I expect that if Cameron's seizure had been investigated, and someone such as Professor Cook been consulted, IDS would have amended their policies in so far as they applied to Cameron to incorporate the risks posed by seizures.

105 DSW 5's evidence at the inquest included:

(a) when he spoke to Cameron's doctor at the hospital on 11 March 2019, he said that Cameron would not be able to go home as he needed to see a neurologist and gastroenterologist.

(b) he returned to Church St and while he was there, Adelaida arrived with Cameron. When Cameron got out of the car he had to be supported by 2 carers to his room.

(c) he requested Cameron's discharge summary from hospital and noted that it indicated neurological review ought to be considered if further seizure activity was noted. The reference to seizure was also equivocal in that it was noted as "?seizure."

(d) he arranged for 24 hours care for Cameron for his first week home as he was concerned for him.

(e) he considered his concerns were 'shut down' by Adelaida and on receipt of the email from David sent on 12 March 2019. In that email, David said, amongst other things:

> From the discussion that I had with the Dr yesterday, even [he] couldn't believe why someone thinks it's an epileptic fit[s]

> whereby he's driving and just saw Cameron in the corner of his eyes. Anyway, we'll look forward to read what's in the report and decide whether Cameron really needed to be in the hospital. Or, the staff just overreacted and didn't know the signs and what do when Cameron is suffering from his "seasonal chuck up disease."

106 Following Cameron's seizure on 11 March 2019, save for the initial week when DSW 5 arranged for Cameron to have 24 hour supervision, no changes were made to policies and procedures relating to Cameron, to respond to the additional risks associated with future seizures. However, in the context described above, absent a diagnosis or treatment plan, a specialist referral and support of Cameron's parents, I make no criticism of IDS in this regard.

107 In the same vein, this is not a criticism of Cameron's parents either. Given Cameron's GDD and ASD, I appreciate that hospitalisation was distressing for him. It is only with the benefit of hindsight and the expert opinion of Professor Cook that the significance of the 11 March 2019 seizure is fully appreciated.

IDS policies and procedures relating to Cameron

108 Documented policies and procedures in relation to Cameron's care included: undated daily routines, BAR, IPRP, RPP, BSP, CRP and daily progress notes.

109 In her evidence, Herivel acknowledged that the presentation of this important information relevant to Cameron across so many documents was unwieldly. She explained that part of the reason is because IDS relied on templates provided by the NDIS Quality and Safeguards Commission. They no longer use these templates such that a participant would now have their relevant information contained in one document.

110 It was raised with Herivel, that Cameron's carers were not advised of updates to his IPRP until some 6 months after it was updated. Herivel explained that this was a funding issue. Cameron's NDIS funding had run out. The updated IPRP was conveyed to staff once his funding had re-instated. These arrangements both with the NDIS and internally with IDS have now been adapted so as services would not cease while IDS is waiting for NDIS funding to be reinstated.

111 Herivel acknowledged inconsistencies as between Cameron's afternoon (which referred to 'spot checks') routine and his RPP (which referred to 'supervise closely') as to the level of supervision Cameron required while in his bath. She also acknowledged that the use of phrases such as 'spot check' does not provide staff with enough guidance as to the level of supervision required. This was also clear from the evidence of Cameron's carers which was not consistent in terms of what they understood was required of them while Cameron was in the bath.

Jane Burns, registered nurse

112 Burns prepared a report dated 22 January 2025. I appreciate this report was provided by Burns on an urgent basis. Burns' report was problematic for the reasons that follow.

(a) It was based on the assumption that Cameron had suffered a "significant seizure in the past." While on the evidence I accept that Cameron had a seizure on 11 March 2019, he had not been assessed and this had not been confirmed via a medical diagnosis. That absence is significant in assessing the conduct of IDS.

(b) While the incident report regarding the seizure on 11 March 2019 was included in her brief, she did not have regard to it in preparing her report.

(c) In the area of disability support, financial capacity looms large. Burns opines that "all disability support workers should be trained, deemed competent and supervised by a Registered Nurse and have access to clinical advice and regular clinical review of care plans as required." We heard from Herivel that funding is a significant issue which plays into the prioritisation of goals in the provision of disability support services. Burns opinion as to recommendations that could be made, in my view, fails to take this into account.

113 Given the difficulties identified with Burns' report, it is of little weight or assistance to the Court.

114 Michelle Dodd provided a report dated February 2025. She indicated that:

(a) while the IDS policies provided appeared to meet the requirements of the NDIS Practice Standards, in her view, some of Cameron's plans were inadequate, containing significant gaps particularly in relation to identification of risks and accessible and detailed instructions to the staff supporting Cameron. This was apparent in the evidence given by Cameron's cares as it was clear from their evidence that the understanding of Cameron's plans was vague at best.

(b) given Cameron's love of water play and the significant part it played in Cameron's daily routine, Dodd considered there ought to have been a risk assessment undertaken in respect of access to water.

(c) there ought to have been a summary document outlining Cameron's health support requirements.

(d) the number of documents relating to behaviour management strategies for Cameron is confusing making it unclear which document/s carers would have accessed to inform themselves.

(e) there was no personal profile document commonly used as an easy reference for new and casual staff.

115 Dodd acknowledged that:

(a) providers of NDIS support are often unable to pursue matters if the informal or legal substitute decision makers (in this case Cameron's parents) do not agree with the proposed cause of action; and

(b) the absence of funding for specific specialist assessments and reviews in a person's NDIS package may also be a contributing factor in whether action is undertaken.

Findings in relation to IDS

116 I find that the risk management and safety plans in place for Cameron's care were inadequate and inappropriate for the conditions for which he had a known diagnosis. In particular, they were confusing, inconsistent and lacked appropriate detail to provide adequate and useful guidance for those caring for Cameron.

117 I find that while IDS did not review the risk management and safety plans in place for Cameron's care following his seizure on 11 March 2019, this was not inappropriate in the context where Cameron was discharged from the emergency department against clinical advice; the fact of the seizure was not a confirmed diagnosis (it was recorded as ?seizure) and the discharge summary recommended neurological review 'if having more seizures.'

118 I find that the risk management and safety plans were not sufficiently disclosed and effectively communicated to the IDS staff responsible for Cameron's care in that while they were available, they were presented in a confusing and inconsistent manner, and they lacked sufficient detail to enable IDS staff to have a clear and coherent understanding of their obligations to Cameron.

119 I find that the guidance given to IDS staff about the level of supervision Cameron required when bathing was vague and inadequate.

120 I find that IDS records were inadequate and inaccurate. Particular examples include the ad hoc and inaccurate entry of daily progress notes and the failure of the worker administering medication to also sign for it.

Recommendations

121 IDS have engaged positively in the whole of the inquest process.

122 Herivel made appropriate concessions about her practices developing over time with experience; the improvement of documentation templates and changes to how gaps in funding are managed.

123 Thompson was present throughout the inquest and made it very clear in his evidence that he acknowledges the need for improvement and is willing to implement change for the benefit of IDS participants.

124 Thompson outlined changes which have already been implemented or which he intends to implement including:

(a) addressing the issue of fabricated progress notes with the staff involved

(b) ensuring staff are aware that the person that signs for medication must also be the person who administers it

(c) a substantive review of progress notes and ongoing audits

(d) seizure and epilepsy training is provided where a staff member is working with a participant with an epilepsy plan

(e) recognising the need for time frames around bathing supervision

(f) engaging with experts to provide clinical oversight with respect to policy drafting

(g) adopting a new client management software program – Lumary – and requiring all staff to use it.

125 Thompson recognised that sometimes there can be instances of tension between what a participant's family wants, and steps IDS consider necessary in discharge of their own duty of care. Acknowledging that tension, policies are now in place regarding calling of ambulance and notifying families and discharge from hospital without a diagnosis. Thompson acknowledged the

need to consider applications to NCAT where these tensions cannot otherwise be resolved.

126 The recommendations I make in this inquest were developed with input from IDS who are committed to improving the service they provide.

127 I make the following recommendations:

(1) To Interaction Disability Services Pty Ltd (**IDS**):

(a) That, as part of its existing audit processes, IDS conduct an audit of progress note documentation for participants at the 24 Church Street, South Windsor group home (**Church Street**) to ensure that support workers are recording accurate and timely notes.

(b) That IDS conduct a review of the behavioural support documentation for its participants to ensure that:

(i) the behavioural support documentation itself provides clear guidance to staff as to risks and strategies to manage behaviours of concern (including in the format of a single summary document)

(ii) the language employed in documentation in connection with supervision requirements for participants is more precise than terms such as “spot checks” and “periodically” (so as to not require further explanation, including as to the timing, frequency and nature of such checks).

(2) That IDS continue to develop an updated form of ‘Client Personal Profile’ document to ensure it:

(a) includes an “All About Me” support plan based on the participant’s and stakeholders’ input

(b) sets out the participant’s support needs and response strategies in a summary format

(c) accurately references other critical support documents that provide instructions to staff (for example, a behaviour support plan or risk assessment).

(3) That IDS review the medication administration practices within its supported accommodation to ensure that:

(a) medication charts are appropriately completed for participants; and

(b) only support workers who administer medication sign the medication chart.

(4) That IDS engage a neurologist to review current epilepsy and seizure management policies and procedures.

(5) That IDS review its present ‘Family Involvement and Maintenance of Relationships policy’ with a view to including a section that provides guidance in relation to conflict between family members and/or guardians and support workers as to concerns about the participant’s health, including clear guidelines for escalation to IDS management.

Concluding remarks

128 I will close by conveying to Cameron’s family my sympathy for the tragic loss of Cameron.

129 I thank the Assisting team for their outstanding support in the conduct of this inquest.

130 I thank the officer in charge, SC Cox, for his work in conducting the investigation and compiling the brief of evidence.

Statutory findings required by s 81(1)

131 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity: The person who has died is Cameron de Vries.

Place of death: 24 Church Street, South Windsor NSW 2756

Date of death: 31 August 2019

Cause of death: Drowning precipitated by a seizure

Manner of death: Drowning in a bathtub in supported accommodation, unsupervised.

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe
Date 28 February 2025

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