FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1781/08

Inquest into the Death of JESSE LEE MCGANN

Delivered On:	20th September, 2010
Delivered At:	Level 1, 436 Lonsdale Street, Melbourne 3000
Hearing Dates:	26th, 27th March, 2009 at Melbourne Magistrates Court, Melbourne 22nd, 23rd and 24th July, 2009 at Southbank
Findings of:	PETER WHITE
Representation:	Middletons for Peninsula Access Support & Training Access Law for Ms Debbie Duncan
Place of death:	Mornington Peninsula Hospital 1527 Nepean Highway, Rosebud 3939
PCSU:	Leading Senior Constable Tania Cristiano

FORM 37

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FINDING INTO DEATH WITH INQUEST

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

Court reference: 1781/08

In the Coroners Court of Victoria at Melbourne

I, PETER WHITE, Coroner

having investigated the death of:

Details of deceased:

Surname: MCGANN
First name: JESSE
Address: 100 Aquaduct Road, Langwarrin 3910

AND having held an inquest[1] in relation to this death on 26th and 27th March, 2009 at Melbourne Magistrates Court, Melbourne and 22nd, 23rd and 24th July, 2009 at Southbank find that the identity of the deceased was JESSE LEE MCGANN
and death occurred on 26th April, 2008

at Mornington Peninsula Hospital
1527 Nepean Highway, Rosebud 3939

from
1a. HYPOXIC BRAIN INJURY
1b. ASPIRATION OF FOOD BOLUS

in the following circumstances:

1. Jesse Lee McGann was born on the 17th of September 1988 and came to be diagnosed as suffering from severe autism, aspergers syndrome and attention deficient disorder. It is also relevant that Jesse had an enlarged tongue, which contributed to his swallowing difficulties.

2. After attending Dandenong Valley Special School, for a period of 14 years Jesse was granted government funding in 2006, to attend the Peninsula Access Support and Training organization (PAST), at 108-120 Young Street, Frankston.[2] He began there on the 17th of January 2007, at the age of 17.

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[1] The Court heard evidence at the Melbourne Magistrates Court on the 26th and 27th of March 2009 and between the 22 and 24th of July, 2009. Final written submissions were received from interested parties on the 11th of December 2009.

[2] See evidence of Mrs D Duncan, the mother of Jesse McGann, at transcript page 12.

3. He was in daily respite care at 'Langwarrin B' on the 24th of April 2008, when he suffered a choking episode after eating food that led to a cardiovascular collapse. Ambulance officers were immediately called to the scene and were able to resuscitate Jesse through CPR and he was then transported to the Emergency Department at Frankston Hospital.[3]

4. Notwithstanding the efforts of Langwarrin B staff, Ambulance and Frankston Hospital Emergency Department staff, Jesse was later found to have suffered a severe hypoxic brain injury. Following consultation between medical staff and his family, life support was withdrawn and he passed away at Frankston Hospital on the 28th of April, 2008.[4]

5. At the time of the swallowing incident, on April 24th 2008, Jesse was in the care of PAST for which service payment was made through the Department of Health. The funding was to allow specifically for one to one supervision for Jesse and this arrangement was subject to review, every three months. [5]

6. His care plan was also revealing as to how he was to be managed by staff at this time.[6]

7. Over the relevant period, Jesse attended 'Langwarrin B', 5 days per week, Monday to Friday, between the hours of 9 and 4.

8. On the day in question, Jesse left home as usual in a happy and excited state.[7] He arrived by supervised bus at Langwarrin B at approximately 9 am. During the morning, he was taken by staff, with other clients, to a local basketball centre where he appeared to be his normal self and engaged in the various activities provided. At approximately 12 noon, Jesse and the others returned to Langwarrin B.

9. It is also relevant to note that on the day of this accident Jesse was apparently in good health, this following an earlier two week period in which he had not been so well.

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3 See statement of S/C Adam Dixon at Exhibit 14 at page 1.
4 Ibid at page 2.
5 See statement of Therese Carol, Chief Executive Officer at PAST, Exhibit 5 at paragraph 10.
6 See Jesse's Behavioural Support Plan at Exhibit 7 pages 4 and 5 which sets out the nature of his disability and details of his obsessive eating practice and his propensity to engage in food theft.
These include reference to,
'He will eat food off the ground and/or floor if not stopped. Jesse will also try and put as much food in his mouth as possible; this has led him to choking.'
See also Sect 2.2 of the BHS at page 10 under Positive Strategies where it is noted that,
2) Strategies related to Jesse's food and eating habit.
a) Jesse requires 1:1 assistance at meal times.
b) Jesse should be fed his lunch away from other clients Eg. Downstairs at the red sofa or outside.
c) 1:1 should take their time feeding Jesse his lunch.
d) Attempts should be made to engage Jesse in an alternative activity immediately after finishing his meal.
e) Team member should ensure that benches and floor are cleaned immediately after meals are finished.'
7 Evidence of Mrs D Duncan at transcript page 10.

10. Mr Herbert Krab supervised Jesse during his lunch. According to Mr Krab, Kate Clifton was also meal-assisting Susan in the kitchen area. (Client) Chris Perdios was also in the room, at this time.[8]

11. Paula Haussman testified that she was in fact in the meals area assisting Chris with his lunch at this time. According to Mr Krab, Chris was refusing his food.

12. After lunch, Mr Krab testified that he took the remains of Jesse's lunch into the kitchen and put them away. He later left the kitchen to assist a colleague 'Ed' in the downstairs lounge area. He believes this occurred at 12.38 pm.

13. According to his recollection, only Kate and her client Susan remained in the meal area at this time.

14. Jesse also remained and was later observed by Mr Krab going up and down the ramp. Later, Kate came down to join Ed and himself.[9] At this time, Mr Krab stated that he sought Kate's approval to take lunch, knowing that Jesse had finished his own lunch and was free to move around the facility as he saw fit.

15. In the period immediately following Jesse's lunch and after Mr Krab's departure, Ms Haussman testified that she noticed Jesse take one of the sandwiches she had provided to Chris, whom she was supervising at this time. After recovering this sandwich from Jesse, Ms Haussman stated that she placed the remainder of this sandwich in the bin which, she states in her third statement, was located within a locked cupboard.[10] Jesse was present while Ms Haussman took this action, and according to Ms Haussman responded by, (laughing).

> '*He grabs the sandwich. He thinks it is a game. It's a funny thing*'.[11]

16. I note here however that Ms Haussman's evidence concerning this matter of throwing out the sandwich appears to rely heavily upon what she felt she would do, rather than a specific recollection of what she did do.[12]

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8 Evidence of Mr Krab at transcript page 79.

9 Transcript page 85.

10 See Exhibits 10A and 10B. Ms Haussman's evidence and last two statements, were seen to be in marked contrast to each other and to the first statement she gave in which she made no mention at all to Jesse taking food from Chris, (in her presence). See discussion at transcript page 369.
It is also the case that the incident was not included in the incident report, Exhibit 10C, notwithstanding her claim that she mentioned this matter in her debrief with her then manager Ms Jenny Kerr, in the period following these events.

11 See Ms Haussman's evidence at page 371.
Mr Krab testified that he was not aware of this incident, which evidently occurred after he had left the meals area. Her further testimony was that this incident occurred at approximately 12.20 pm, (transcript page 365).

12 See transcript at page 373 to 376.

17. Later Ms Haussman saw Jesse leave the kitchen and head downstairs (this observation being confirmed by the evidence of Mr Krab).

18. We know that at approximately 12.40 pm, Jesse was found in the adjunct room, at the rear of the meal area, lying unconscious on the floor.

19. At the time that section of the building (unintentionally) permitted clients to isolate themselves from the sight of all but those staff who were either standing in the doorway of this kitchen adjunct room or watching from a close proximity through the garden facing window, whilst standing near this building's external wall in the garden outside.[13]

20. According to the evidence of Mr Krab, Jesse was last seen downstairs at approximately 12.40 pm.

21. From this, I note the possibility that after Mr Krab and Ms Haussman's departure from the area and following Jesse's return, he had gone into this (adjunct) room[14] to seek to consume food which he had earlier taken from an uncertain place in the kitchen area. I further note the possibility that he chose this room to consume the food intending not to be interrupted by Mr Krab, Ms Haussman or indeed any other staff member(s).

Level of supervision.

22. According to the evidence of PAST Chief Executive, Therese Carroll, a change or modification to Jesse's level of supervision was implemented by PAST around October 2007, i.e. some 6 months before his death, with the changed arrangements reducing the level of supervision.

23. The common procedure after the level of supervision was so reduced was that Jesse would only be monitored on a one to one basis during meal times and during changing and toileting.

24. This change in arrangements was said to have been effected because of an improvement in Jesse's behaviour. [15]

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[13] See Exhibits 5A and 9. The evidence generally established that staff sometimes used this garden as a refuge for the purpose of the occasional cigarette.

[14] See Plan at Exhibit 9 where the room in question is described as a meeting room and the photographs of the area at Exhibit 3(b).

[15] Evidence in support of his changed behaviour concerning food consumption was not found in the meeting notes made concerning Jesse's care.
Ms Carroll gave evidence that the decision was not something that she had decided herself, but rather a collective assessment by staff. See also the conflicting views of key worker and team leader, Brett Bean, discussed below at Footnote 21.

25. As a result of these arrangements, Jesse was permitted to move within the facility without direct supervision, which meant that from time to time he might be out of sight of PAST staff, for uncertain periods. [16]

26. It is also relevant that from the evidence of Mr Bean we know that at the time of the injury to Jesse, there was no lunch time staff roster in operation.

27. The arrangements at Langwarrin B on the 24th of April 2008, were that 10 staff were on duty to supervise 10 clients and that not all of the clients required one on one supervision. At the time of the discovery of Jesse's injury, 6 of these 10 staff were having their lunch or were otherwise privately engaged, with the result that the BSB direction in regard to Jesse's care was comprehensively frustrated.

28. I further note, that it was in these circumstances, Mr Krab was called away from the meal area after supervising Jesse's lunch. I also note Mr Krab's concession that, before leaving Jesse in the meal area, he had not attempted to engage Jesse in an alternative activity. [17]

29. It is also the case that there was no evidence suggesting that he had delegated that duty, or observed any other member of staff, attempt to supervise Jesse in his absence.

The use of a feeding chair

30. A further issue raised by Jesse's family concerned Jesse's potential to cause harm to himself and others and the suitability of a feeding chair to reduce the risk of such harm during meal times.

31. In Victoria, Part 7 of the Disability Act 2006, governs the use of restrictive interventions such as a feeding chair by a disability service provider.

32. For such a restraint to be used an approval must be obtained under Section 135 of the Act.

33. In summary, the form of the restraint must be necessary to prevent the person from causing physical harm and must be the least restrictive form of restraint possible in the circumstances.

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16 Notwithstanding these strategy changes, the matter of the change was not formally recorded in writing (transcript page 190), or communicated to Jesse's family. (See the evidence given by Mrs Duncan following her recall to the witness box from transcript page 263).
It is also common ground that there were never any formal changes to Jesse's Behavioural Support Plan, with his plan continuing to stipulate that one to one supervision was required, (transcript page 196).
It is also relevant that up to the date of Jesse's death, funds were being paid by the Department of Health Services, for continued funding on a 'one to one' level whether inside or outside the facility.

17 See transcript page 82 and 83.

34. In this regard, I note that the evidence discloses that Jesse's physical activity during mealtimes, which included disruption of others involved in supervision or as clients, might lead to injury.

35. I am also satisfied that Jesse's family had informed management at Langwarrin B that Jesse enjoyed being in the feeding chair and that the experience caused him to focus more clearly on meal times, than when he was not so restrained.[18]

36. It follows that this particular strategy might reasonably have been viewed as having the potential to reduce the risk of unintended self-harm or harm to others by Jesse during meal times.

37. Rather than exploring this possibility under the terms of the Disability Act, however, it appears that nothing was done by PAST to test the lawfulness of the family's suggestion. It is also the case that the failure of management to apply for an appropriate approval to allow Jesse the use of his feeding chair aid, became an ongoing issue for Jesse's mother.[19]

Autopsy Report

38. The autopsy report and the evidence of Dr Linda Isles, together with all of the rest of the evidence, establishes to my satisfaction that immediately prior to his demise, Jesse ingested food, at least one piece of which, he was not been able to swallow. As a result, his upper airway became blocked, stopping the flow of oxygen to his brain and causing an hypoxic brain injury.

Findings

39. Having regard to all proven facts, I am satisfied that shortly after leaving the kitchen area and going downstairs that Jesse returned to the kitchen and in the absence of members of staff, obtained or recovered a supply of food from either the bin, the meal area or from the pantry area.[20] Thereafter, he immediately retreated to the kitchen adjunct room, intending to consume same without interruption.

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[18] This was supported by a DVD of Jesse at home which, together with the feeding chair, had also been earlier provided or in the case of the chair, offered to PAST by Jesse's mother.

[19] See the evidence of Mrs Duncan at transcript page 36. That is not to say that PAST management should have been driven by a desire to keep Jesse's family satisfied, but rather that his family's persistence concerning the introduction of the chair, should at least have caused their suggestion to be examined more thoroughly than was the case.

[20] The evidence of witnesses referred to above, which seeks to exclude the possibility that foodstuffs were there available, was generally inconsistent and lacking in conviction (and fell short of establishing that matter). The result is that the evidence does not establish that all such possibility was removed by the time staff members had left the area.

40. I further find that while alone he ate hurriedly, without properly chewing his food and that he choked when he attempted to swallow a large bolus of unknown origin, earlier obtained in the uncertain circumstances described above.

41. As a result, he lost consciousness and slumped to the floor. It is not known precisely how long he remained in this state before he was located by staff member, Leanne Miller, following which emergency services were immediately notified.

42. After the arrival of ambulance staff, Jesse was resuscitated to the point where he resumed breathing, this more than 15 minutes after he was first discovered unconscious.

Comment

43. It is clear that from the time Herbert Krab left the kitchen after feeding Jesse, apparently in accordance with Jesse's then supervision arrangements, Jesse's well-being was put at increased risk, as he remained unsupervised in the meal room while other staff then present within the room were distracted by other clients and other responsibilities.

44. It is also the case that Jesse remained at risk when he later returned to the room and surreptitiously obtained food from an uncertain source and hurriedly attempted to consume same and that this situation of heightened risk continued until he was found lying unconscious on the floor.

45. I further consider that the manner of the change of the arrangements applicable to Jesse discussed above, was unsatisfactory and that it was introduced with no clear instruction provided to staff as to how to deal with Jesse's presentation in the periods surrounding his taking of food.

46. Meal times had always been and remained problematic, with special arrangements having previously been made to feed Jesse at the end of mealtime, and in a location away from others. This, to reduce the possibility of his taking food from other clients and otherwise interfering.

47. It is also relevant that Jesse had to be admonished by Ms Haussman for food theft shortly before his choking on the 24th and, quite evidently, there was an ongoing and perceived risk about his behaviour surrounding mealtimes.

48. I find then that the need for ongoing supervision, isolation and attempted distraction of Jesse during and after meal times, which strategy was set out in his BSB, should have been maintained and that a retreat from this strategy was ill conceived.[21]

[21] The evidence of team leader, Mr Bean, of his interpretation of the BSB and his view that no change in

49. I also consider that his family and the Department of Health should have been formally consulted, with the pros and cons of the matter fully discussed before any such change was decided upon, or instituted.[22]

50. In all of the circumstances, I also find that PAST management had earlier erred in failing to seek approval to try out the use of Jesse's feeding chair, in accordance with his mother's wishes.

51. Finally, I find that the failure to ensure direct supervision of Jesse, while he remained in and later returned to the meal area and its near precinct (and the failure to attempt to engage him in other post meal activities), led to an increased risk of injury to Jesse and contributed to what then occurred and also directly reduced the possibility of a timely intervention.

Conclusion

52. While I have found that there was error in regard to certain strategy decisions taken concerning Jesse, I wish to state my view that the evidence as a whole supports a finding that PAST staff including Mr Bean, Mr Krab and Ms Haussman, were very caring of Jesse and conscientious in the ongoing day to day performance of what were extremely challenging duties.

53. I further note, with approval, the changes instituted at Langwarrin B following Jesse's death, particularly as they relate to the consistent location of staff at strategic points in the facility, and the need for staff to remain at their posts until replaced.

54. In conclusion, I also note the matter of Mrs Duncan's concern about the allegedly dismissive attitude of staff to her claims concerning the use of Jesse's feeding chair.

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arrangements actually occurred, is noted. See also the discussion of these matters in the evidence of PAST Chief Executive, Ms Terri Carroll.
Having directed myself concerning the appropriate burden and standard of proof, I find that I accept that there was in effect a relaxation of arrangements concerning this matter. Putting this to one side I find that any such departure authorised or otherwise, from the strategies set out in the BSB, referred to at Footnote 6, for dealing with Jesse over any period in and around mealtimes, was always likely to result in an increase in the risk to both Jesse and to others).

[22] There is dispute as to whether there had indeed been any meaningful improvement in Jesse's behaviour. Even allowing for improvement, there is no evidence that PAST management gave particular consideration as to whether any such general improvement also included, a changed attitude to his particular issues with food consumption, and as to whether improvement in his general behaviour warranted a relaxation of his supervision, in the periods surrounding meal time.
His behaviour immediately prior to this choking incident, in the presence of Ms Haussman, is suggestive of the fact that there had been at most, only inconsistent improvement in his mealtime behaviour.
Having regard to all of the evidence, I consider that a retreat from the particular strategies set out in the BSB, referred to above at Footnote 6, was ill advised.

55. Should this situation again arise, I would urge PAST management to ensure that the matter is presented for consideration to the Secretary to the Department of Human Services who is directly responsible for the administration of the Disability Act 2006, rather than again setting upon a course, which was always at risk of leading to unnecessary conflict.

Signature:

Peter White
Coroner
20th September, 2010

Distribution:
The family of Jesse Lee McGann.
The Peninsula Access Support and Training Organization.
Mr Brett Bean.
Mr Herbert Krab.
Ms Paula Haussman.
The Attorney General in the State of Victoria.
The Secretary of the Department of Health in the State Of Victoria.
The Secretary of the Department of Human Services in the State of Victoria.