IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 4770

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of MAURICE BENEDICT COSTELLO

without holding an inquest:

find that the identity of the deceased was MAURICE BENEDICT COSTELLO

born 14 May 1927

and the death occurred on 7 October 2016

at Angliss Hospital 39 Albert Street, Upper Ferntree Gully, Victoria 3156

from:

1 (a) COMPLICATIONS OF CHOKING ON A FOOD BOLUS IN A MAN WITH MULTIPLE MEDICAL COMORBIDITIES

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Maurice Benedict Costello was 89 years of age and resided in Boronia at the time of his death. Mr Costello was married to Maria Costello and they had three adult children, Laurie Costello, Nicholas 'Nick' Costello and Penny-Sue McMahon.

2. On 2 September 2016, Mr Costello was admitted to Angliss Hospital due to severe exacerbation of chronic obstructive airways disease and community acquired pneumonia complicated by delirium. These issues were treated and resolved.

3. On 14 September 2016, Mr Costello was transferred to a specialty unit in Box Hill Hospital for a gastroscopy which identified that he had a hiatus hernia, reflux oesophagitis and a duodenal ulcer. On 16 September 2016, he was transferred back to Angliss Hospital Geriatric Evaluation and Management (**GEM**) Ward for reduced mobility and discharge planning.

4. At approximately 8.25am on 4 October 2016, Mr Costello fell while attempting to reach his nurse-call bell which was placed in a drawer near to his bedside. A Medical Emergency Team (**MET**) call was initiated and he was transferred to the Emergency Department (**ED**) at approximately 8.50am. During the fall, he sustained a laceration to his forehead and was given four stitches in the ED.

5. After receiving the stitches, Mr Costello was returned to his room at approximately 10.25am. At 12.27pm, a nurse documented that Mr Costello was eating his "soft ward diet" meal while sitting upright in his chair. The nurse left Mr Costello's room and returned at 12.30pm, finding him unresponsive with no cardiac output.

6. Mr Costello was resuscitated and food was removed from his mouth however he did not recover neurologically. Mr Costello's family and Angliss Hospital staff discussed possible future treatment and decided to provide him with palliative care.

7. On 5 October 2016, Mr Costello's regular medication was ceased.

8. At 6.28pm on 7 October 2016, Mr Costello was declared deceased.

REPORTABLE DEATHS

9. A person's death is reportable to the Coroner if it is unexpected or occurs as a direct or indirect result of an accident or injury.[1]

[1] *Coroners Act 2008* (Vic) s 4(2)(a).

10. On 5 February 2017, the Angliss Hospital reported Mr Costello's death to the Coroners Court of Victoria by an *E-Medical Deposition Form*. Treating staff believed the cause of Mr Costello's death may have been aspiration leading to an intracranial bleed.

11. The Angliss Hospital also notified Victoria Police of Mr Costello's death. Police officers attended the hospital and completed a *Victoria Police Report of Death for the Coroner* (**Form 83**).

12. Mr Costello's body was transported to the Victorian Institute of Forensic Medicine (**VIFM**) after the Coroners Court received the notifications of his death.

INVESTIGATIONS

Forensic pathology investigation

13. Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VFIM**), performed an external examination upon the body of Mr Costello, reviewed a post mortem computed tomography (**CT**) scan, referred to the Victoria Police Report of Death, Form 83 and the E-Medical Deposition.

14. Dr Francis reported a vertical laceration measuring 45 millimetres on Mr Costello's frontoparietal scalp and the sutures which evinced some measure of healing. Dr Francis noted that the CT scan identified calcified coronary arteries and increased right lung markings. She reported that there was no evidence of skull fracture or intra-cranial haemorrhage.

15. Dr Francis formulated Mr Costello's cause of death as complications of choking on a food bolus in a man with multiple comorbidities.

Police investigation

16. Constable Damien Brinkies was the nominated Coroner's Investigator.[2] At my direction, Constable Brinkies conducted an investigation of the circumstances surrounding Mr Costello's death, including the preparation of the coronial brief. The coronial brief

[2] A Coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's investigator receives directions from a coroner and carries out the role subject to those directions.

contained, *inter alia*, statements made by Nick Costello, Penny-Sue McMahon and Geriatrician Dr Jonathan Marriott.

17. In their statements, Nick Costello and Penny-Sue McMahon both stated that they were grateful for the exemplary care provided by the majority of treating staff at the Angliss Hospital. Nick Costello commented that they made his father's death as gentle as possible in the circumstances. However, both had concerns about the events leading to Mr Costello aspirating on a food bolus.

18. Dr Marriott provided specialist care to Mr Costello as part of the GEM multidisciplinary team at Angliss Hospital, under the auspices of Eastern Health. My Investigator requested a statement from Eastern Health to address any assessment of Mr Costello's swallowing issues and associated medical management. Dr Marriott provided a detailed statement concerning Mr Costello's medical management between the date of his admission and his death.

19. Mr Costello was assessed by speech pathologists on the first day of his admission, 2 September 2016. At that time, he was kept nil by mouth due to his other illness.

20. On 5 September 2016, Mr Costello was diagnosed with mild to moderate oropharyngeal dysphagia. Speech pathologists recommended that he required distant supervision, crushed medication, smooth pureed food and mildly thickened fluids.

21. On 7 September 2016, a speech pathology review identified that Mr Costello was coughing on food but he improved when he ate more slowly. Consequently, speech pathologists recommended close supervision of Mr Costello while eating.

22. On 8 September 2016, Mr Costello was transferred to the Angliss West GEM 1 Ward with the aim of functional recovery. However, he was ultimately transferred back to the Acute Medical Wards and subsequently to Box Hill Hospital where it was determined that he had developed an upper gastro intestinal bleed. This was treated successfully and Mr Costello returned to the Angliss West GEM 1 Ward for recovery on 16 September 2016.

23. Between 9 September 2016 and 12 September 2016, Mr Costello's dysphagia management ISQ[3] indicates that he is for "distant supervision" while eating.

24. On 12 September 2016, Mr Costello's supervision requirements were updated to "close supervision" in the Angliss Hospital Acute Ward. He was recommended for smooth pureed foods and mildly thickened fluids. Speech pathologists also recommended that he cease eating when fatigued. A speech pathologist discussed the recommendations with Mr Costello, his family, the kitchen staff, patient flow manager and nursing staff. The same was documented on Mr Costello's bedsign.

25. On the 19th, 21st and 22nd of September 2016, Mr Costello was re-reviewed by speech pathologists and no changes were made to recommendations. On 22 September 2016, Mr Costello was noted to be coughing when eating food.

26. On 26 September 2016, a speech pathology review identified that Mr Costello could be upgraded to soft food,[4] rather than pureed, and still required mildly thickened fluids. Full supervision was recommended to ensure Mr Costello engaged safe swallowing practices.

27. On 29 September 2016, Mr Costello was recommended for close supervision when eating. Under full supervision, he was also allowed small sips of unthickened liquids 30 minutes after meals.

28. Mr Costello was treated for gout and participated in ongoing conditioning therapy to undertake daily activities independently, such as walking. As his condition was improving, Mr Costello was planned for discharge on 4 October 2016.

29. On 4 October 2016, Mr Costello was reviewed in the Angliss Hospital ED while receiving treatment for his fall. Speech pathologists documented that hospital staff and Nick Costello had noted that he was coughing while eating and drinking during the previous weekend. Mr Costello was recommended for full supervision while eating and to be provided with soft food and mildly thickened fluid. The review notes document that Nick Costello said his father seemed to cough less if he ate while seated upright.

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[3] "ISQ" is an abbreviation for "In Status Quo" which means the current state of things.

[4] According to Eastern Health's policies, soft food may be naturally soft or cooked…soft foods can be easily chewed. Minimal cutting is required and foods are easily broken up with a fork.

Family Concerns

30. Nick Costello queried whether his father:

    a. Was in his chair while eating his food;

    b. Ought to have eaten so soon after his head injury;

    c. Was under observation by a nurse while he was eating; and

    d. Was able to reach the nurse-call bell from his position while eating.

31. Penny-Sue McMahon had similar concerns to her brother. She mentioned that a nurse had informed her that, prior to 4 October 2016, a staff member had always been with her father while he was eating.

Coroners Prevention Unit Investigation

32. In light of his family's concerns, I asked the Coroners Prevention Unit (CPU)[5] to review Mr Costello's medical records from Eastern Health and consider the circumstances of his death. In particular, I requested that they contemplate whether Mr Costello's oropharyngeal dysphagia was appropriately managed.

ED Admission

33. The CPU review identified that Mr Costello was in the ED for one and a half hours on 4 October 2016. During this time, Mr Costello underwent a CT scan which did not identify any abnormalities. Observations were conducted every thirty minutes and no adverse nor abnormal changes were identified.

34. The CPU opined that Mr Costello's CT scan results and normal observations diminished any requirement that he stay in the ED for four hours. I note that the post mortem VIFM CT scan detected no evidence of intracranial haemorrhage nor skull fracture.

[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Management of Oropharyngeal Dysphagia

Swallowing Assessment

35. Dr Marriot's statement identified that Mr Costello had a number of speech pathology reviews during admission. At my request, Director of Speech Pathology at Eastern Health Christine Bruce provided a chronology of Mr Costello's speech pathology assessments, actions and recommendations.

36. During admission, Mr Costello required varied supervision which is documented to be between "distant" and "full". In the period immediately prior to and inclusive of 4 October 2016, Ms Bruce identified that staff treating Mr Costello were instructed to provide the following levels of supervision:

    a. On 29 September 2016, Mr Costello had a speech pathology review which determined that he required "close" supervision while eating. The documented speech pathology action was for *'swallow review in context of planned discharge 4/10/2016, view to upgrade fluids'*;

    b. At 8.35am on 4 October 2016, a speech pathologist spoke with Nick Costello who reported that his father had not been coughing over the weekend when he was positioned correctly. However, Nick Costello's notes document that he had been coughing when attempting to swallow both fluids and food; and

    c. On 4 October 2016, speech pathology recommendations were for '*soft, finely cut up foods, mildly thick fluids with caution. Close supervision, alert and fully upright for oral intake*'. Underneath the recommendation, a speech pathologist made a hand written note for '*full supervision if eating/drinking*'.

37. The CPU informed me that, Mr Costello's "dysphasia sticker"[6] indicated that he required "close" supervision when eating or drinking on 4 October 2016.

[6] These stickers are used to inform treating staff of the outcomes of speech pathologists reviews. In Mr Costello's case, this meant actions and recommendations in relation to management of his dysphagia.

Terminology

38. Ms Bruce made the following statement in relation to "close" and "full" supervision:

> *Both words imply a high level of scrutiny with the supervising clinician in close proximity to the patient... The requirement for full supervision was expanded in the context of ensuring Mr Costello adhered to the listed safe swallowing strategies in the entries of 26/09/2016. The same recommendations for ensuring adherence to safe swallowing strategies were made in the entries of 21/09, 22/09 and 4/10 with the recommendation of "close supervision".*

39. Levels of supervision are not defined in Eastern Health's Policies, including Policy 2462: 'Provision of Texture Modified Foods and Fluids to Individuals with Dysphasia'.

Mortality and Morbidity Review

40. Dr Marriott stated Mr Costello's death was discussed at a Mortality and Morbidity Review (**MMR**) on 24 November 2016. This meeting was attended by senior medical and nursing staff of the Continuing Care Program at Eastern Health. The Program includes the Geriatric Evaluation and Management Wards.

41. The MMR identified that current handover processes between speech pathology assessments and ward staff were problematic. Eastern Health recommended that the speech pathology department review their current handover process.

42. Ms Bruce said that the Speech Pathology Leadership Team discussed the MMR's recommendation in February 2017. The Leadership Team considered the expectations of speech pathologists making a recommendation for supervision. These recommendations were disseminated at an all staff forum in March 2017:

    a. Ensure the individual patient's circumstances, needs and wishes were considered as a recommendation for supervision is not universal in application;

    b. Understand the rationale behind the supervision recommendation;

    c. Discuss the need for supervision with a senior nurse involved in the patient's care and to inform them of the required outcomes or risks;

d. Discuss the capacity of nursing staff to provide the level of supervision required on any given shift;

e. Discuss an oral intake plan in collaboration with the multi-disciplinary team if the level of supervision required is not available; and

f. Document all discussions on the patient record.

Discussion of Contributing Factors

Opportunities for Prevention

43. The CPU opined that Mr Costello's post-fall care and management was timely and appropriate, including the time elapsed between his fall and next meal.

44. The CPU informed me that, on 4 October 2016, Mr Costello was in an appropriate position to eat his meal. He was provided a "soft ward diet" for the week preceding the aspiration event. The CPU review reported that Mr Costello's supervision requirements had been similar throughout his admission.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. The MMR Recommendations acknowledged the importance of speech pathologists effectively communicating the results of clinical assessments and consequent outcomes to other treating staff.

2. The Recommendations also recognise that treating staff must be able to action speech pathology review outcomes and, if they are unable to do so, that an alternate process must be established.

3. I endorse the MMR Recommendations.

4. According to his speech pathology dysphagia management sticker, Mr Costello was for "close supervision" on 4 October 2016. It was also recommended that he was alert and fully upright while he ate. He was to be provided soft, finely cut up food and drink mildly thickened fluid.

5. A handwritten note on the sticker indicated that Mr Costello was for "full supervision" while eating and drinking.

6. Ms Bruce submitted that both "close" and "full" supervision required a high level of scrutiny and that, in Mr Costello's case, both terms had periodically included the imperative that staff ensure he followed safe swallowing practices. Ms Bruce has informed me that Eastern Health does not have a policy which defines the terms.

7. The investigation has indicated that Mr Costello required varying levels of supervision between "distant" and "full" throughout his admission to Angliss Hospital. Primarily, the recommended level of supervision for Mr Costello's eating and drinking fluctuated between "close" and "full" supervision, depending on the outcome of the most recent review.

8. Evidently, the recommendations for supervision of Mr Costello differentiated between the two terms. A plain English reading indicates that "full" supervision requires constant supervision.[7] In that context, "close" supervision would mean something less than that but still requiring a *'high level of scrutiny'*, as suggested by Ms Bruce.

9. Mr Costello was apparently recommended for "full" supervision and aspirated on his food while eating unsupervised. However, given the unclear nature of the speech pathology recommendation, I make no adverse comment in relation to the treating staff member.

[7] The Oxford English Dictionary defines "full" as an attributive adjective: *'not lacking or omitting anything; complete'*.

RECOMMENDATIONS

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

1. In the interests of improving public health and safety and preventing like deaths, **I recommend** that Eastern Health create policy to define the levels of supervision required for patients during oral intake.

2. And **I further recommend** the development of such a policy be done in consultation with the Eastern Health Speech Pathology Leadership Team and nursing staff, with the aim of articulating the policy in clear, unequivocal language that is common to both disciplines.

FINDINGS

The investigation has identified that Mr Costello was left unsupervised when he aspirated on a food bolus, an event which is causally linked to his death. The investigation has also identified that whilst a speech pathology review recommended that he be under full supervision while eating, the recommendation was unclear.

I accept and adopt the cause of death formulated by Dr Victoria Francis and I find that Maurice Benedict Costello, a man with multiple comorbidities, died from complications of choking on a food bolus.

Pursuant to sections 72(5) and 73(1) of the *Coroners Act 2008* (Vic), I direct that these Findings be published on the internet.

I direct that a copy of this finding be provided to the following:

Marie Costello
Nick Costello
Penny-Sue McMahon
Dr Jonathon Marriot
Ms Christine Dawson
Ms Chris Bruce
Yvette Kozielski
Safer Care Victoria CEO Professor Euan Wallace

Signature:

AUDREY JAMIESON
CORONER
Date: **26 July 2018**