IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6394

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Amended pursuant to *Section 76 of the Coroners Act 2008* on 22 April 2020[1]

Findings of:	Simon McGregor, Coroner
Deceased:	**Dorothy May Nelson**
Date of birth:	16 October 1936
Date of death:	20 December 2017
Cause of death:	Complications of choking on a food bolus in a woman with dementia
Place of death:	Austin Health, Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084

[1] The finding dated 24 March 2020 contained grammatical errors in paragraph 68 which have been corrected.

INTRODUCTION

1. Dorothy May Nelson was an 81-year-old woman who lived at the residential aged care facility, Kerala Manor located at 203 Broad Gully Road, Diamond Creek Victoria 3089 at the time of her death.

2. Mrs Nelson died at Austin Health, Austin Hospital located at 145 Studley Road, Heidelberg Victoria 3084 from complications of choking on a food bolus in a woman with dementia on 20 December 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mrs Nelson's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. The Coroner's Investigator, Senior Constable Matthew Isaac prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mrs Nelson, treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

9. In considering the issues associated with this finding, I have been mindful of Mrs Nelson's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

10. Mrs Nelson lived at Kerala Manor for approximately one month prior to her death. She commenced her stay as a temporary respite resident on 24 November 2017 before transferring to a permanent resident on 8 December 2017.[3]

11. Mrs Nelson had a medical history that included glaucoma, Alzheimer's dementia and depression. Her dementia was managed by specialist geriatrician, Dr Alicea Kyoong and later by consultant psychiatrist, Dr Jennifer Torr.[4]

12. Mrs Nelson's treating clinician, Dr Kathryn Roberston, states that there is nothing on Mrs Nelson's medical file(s) indicating she suffered difficulty in swallowing.[5]

13. Kerala Manor staff have described Mrs Nelson as very alert, 'considering her diagnoses of dementia and Alzheimer's'.[6]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 20 December 2017 at around midday, Kerala Manor registered nurse, Nalina Tamang states that she was alerted by the Chief Operations Officer (COO), Shoba Samuel, that Mrs Nelson did 'not look right'.[7]

15. Ms Tamang alleges that Mrs Nelson was seated at the table 'drinking water'. Ms Tamang approached Mrs Nelson and noticed she had turned blue in the face. Ms Tamang proceeded to call out Mrs Nelson's name 'to get her attention' but she did not respond.[8]

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[2] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[3] Statement of Kay Samuel dated 28 June 2019, Coronial Brief.
[4] Statement of Dr Kathryn Mary Roberston dated 27 June 2018, Coronial Brief.
[5] Ibid.
[6] Statement of Nalina Tamang dated 11 May 2018, Coronial Brief.
[7] Ibid.
[8] Ibid.

16. Ms S Samuel called emergency services and requested an 'urgent' ambulance[9] at 12.24pm.[10]

17. Ms Tamang states that she believed Mrs Nelson was choking, so she 'patted her on the back'. Mrs Nelson is alleged to have continued drinking water throughout this process. Ms Tamang states that Mrs Nelson then placed the cup of water on the table before going limp and falling back into her chair. Ms Tamang formed the view that Mrs Nelson had suffered a transient ischaemic attack (TIA).[11]

18. Ms Tamang's account is inconsistent with that of personal care worker, Vilma Santiago, who details that at approximately 12.05pm, she was standing behind Mrs Nelson when she saw her collapse into her chair and fall forward. It was at this point that Ms Santiago states she knew something was wrong and saw Ms Tamang walk toward Mrs Nelson.[12]

19. The above two accounts are inconsistent with Ms S Samuel's statement, which details that at approximately 12.05pm, she saw Mrs Nelson attempting to reach a cup of water. As Mrs Nelson appeared to be struggling, she instructed Ms Santiago to assist Mrs Nelson. Ms S Samuel states that Ms Santiago assisted Mrs Nelson to grasp the cup of water.[13]

20. The abovementioned three statements give varying accounts of the point at which staff became aware that Mrs Nelson was experiencing a medical episode, the assistance that was provided, in what sequence and by whom. Whilst discrepancies such as this might on occasion be a subject on which some variation might reasonably be expected, in this case it has laid the foundation for the further investigation and recommendations that I make below.

21. As required by the principles of natural justice, a draft of this finding was sent to Kerala Manor via Ms S Samuel for comment. Ms S Samuel recognises the inconsistencies in the statements from staff and provided the following clarification:

> It is common practice at Kerala Manor for lunch to commence at 12 noon every day. It takes approximately 15 minutes for all residents to have received their lunch.
> The assertion by staff that the incident concerning Mrs Nelson commenced at 12.05 pm is incorrect. At this time, Mrs Nelson would not have been in receipt of her lunch.
> …

[9] Statement of Nalina Tamang dated 11 May 2018, Coronial Brief.
[10] Statement of Dr Jane Elizabeth Lewis dated 25 June 2018, Coronial Brief.
[11] Statement of Nalina Tamang dated 11 May 2018, Coronial Brief.
[12] Statement of Vilma Santiago dated 23 May 2018, Coronial Brief.
[13] Statement of Shoba Samuel dated 14 May 2018, Coronial Brief.

…. The reality was that staff noticed and responded to Mrs Nelson at approximately 12.18pm and an ambulance was subsequently called at 12.24pm…[14]

22. I am satisfied that the supplementary information provided to the Court affords a more accurate account of timing pertaining to when Mrs Nelson would have received her lunch and settled down to eat. I note Ms S Shoba's assertion that at the time of calling emergency services, she does not consider Mrs Nelson to have been displaying signs of choking.[15] This assertion is contrary to the evidence contained in the recording of the emergency services call, discussed below.

23. Ms Tamang states that, after Mrs Nelson collapsed, she left to get the oxygen cylinder from the medical room. When she returned, the director of nursing (DON), Kay Samuel, was present.[16]

24. Ms S Samuel's statement details that after calling emergency services and going to the nurse's station to get Mrs Nelson's file, she gave the phone to Ms Tamang. She then went 'to get' Ms K Samuel.[17] Ms Tamang's statement supports the assertion that the phone was handed to her however, Ms Tamang states that while she was on the phone she was the one to go to the nurse's station to collect Mrs Nelson's file.[18]

25. Ms S Samuel further details that when Mrs Nelson started receiving oxygen her colour returned and she became responsive.[19] I note that the emergency services call recording records the caller[20] asking the operator if staff are allowed to administer oxygen at approximately six minutes and 19 seconds into the call, approximately 12.30pm. This request is made after the assertion that Mrs Nelson looked as though she was improving.[21]

26. Ms Tamang states that she spoke with the emergency services operator, who instructed staff to move Mrs Nelson to the floor. According to Ms Tamang's account, staff laid Mrs Nelson on her back as Ambulance Victoria arrived.[22] This is inconsistent with Ms S Samuel's account, which details that paramedics moved Mrs Nelson from the chair to the floor and

[14] Statement of Shoba Samuel dated 6 November 2019, Coronial Brief.
[15] Ibid.
[16] Statement of Nalina Tamang dated 11 May 2018, Coronial Brief.
[17] Statement of Shoba Samuel dated 14 May 2018, Coronial Brief.
[18] Statement of Nalina Tamang dated 11 May 2018, Coronial Brief.
[19] Statement of Shoba Samuel dated 14 May 2018, Coronial Brief.
[20] I am unable to determine with certainty at what point which Kerala Manor staff member was on the phone to emergency services. Noting that there appear to have been several people communicating with the operator at different stages throughout the duration of the phone call, I have chosen to refer to the person(s) communicating with the operator in the singular as 'the caller'.
[21] Emergency Services Telecommunications Authority, Audio 7917063 obtained 11 December 2019, Coronial Brief.
[22] Statement of Nalina Tamang dated 11 May 2018, Coronial Brief.

that it was at this point that she lost consciousness.[23] Consistent with Ms Tamang's written statement, the end of the emergency services call records the operator instructing the caller to lay Mrs Nelson flat on her back. As this is happening, the caller advises that Ambulance Victoria have arrived and the call is ended.[24]

27. Ambulance Victoria notes detail that paramedics arrived at 12.36pm and found Mrs Nelson unconscious. She was being held up in a chair by staff. She was moved to the floor and advanced cardiac life support was commenced. After a period of resuscitation, Mrs Nelson experienced return of spontaneous circulation. She began to breathe spontaneously and was initiated on sedative medications and transferred by Ambulance Victoria to the Emergency Department (ED) at Austin Health, Austin Hospital.[25]

28. Mrs Nelson was 'critically ill' upon her arrival at the ED at 1.47pm.[26] She was found to be profoundly unconscious, acidaemic and in a state of advanced shock. Treating clinicians considered it likely that Mrs Nelson would die from a hypoxic brain injury in the setting of choking on a food bolus complicated by cardiorespiratory arrest.[27]

29. Ongoing physiological support and assessment occurred in the ED before Mrs Nelson was transferred to the Intensive Care Unit in the late afternoon of 20 December 2017. Mechanical ventilation was ceased at 6.55pm and Mrs Nelson died at 7.25pm.[28]

EMERGENCY SERVICES CALL

30. Both Mrs Nelson's senior next of kin, Kathryn Siede and Ms S Samuel requested that the emergency services call recording be obtained by the Court, and I agreed that this step was appropriate in light of the inconsistencies outlined above.

31. I am unable to determine with certainty at what point which Kerala Manor staff member was on the phone to emergency services. Given the inconsistency throughout the various statements and noting that there appear to have been several people communicating with the operator at different stages throughout the duration of the phone call, I have chosen to refer to the person(s) communicating with the operator in the singular as 'the caller'. [29]

[23] Statement of Shoba Samuel dated 14 May 2018, Coronial Brief.
[24] Emergency Services Telecommunications Authority, Audio 7917063 obtained 11 December 2019, Coronial Brief
[25] Statement of Dr Jane Elizabeth Lewis dated 25 June 2018, Coronial Brief.
[26] Coroners Court of Victoria, E-Medical Deposition Form, Case Reference Number: 2017006394, Coronial Brief.
[27] Statement of Dr Jane Elizabeth Lewis dated 25 June 2018, Coronial Brief.
[28] Ibid.
[29] See footnote 19.

32. During the call, just after 12.24 pm, the caller states 'I've got a resident choking'. The operator continues to ask the caller to tell her 'exactly what happened'. The caller replies, 'I've got a resident, she's choking and she's just collapsed'.[30]

33. After several minutes, the caller tells the operator, 'she actually… we've got her up and then, yeah… she's looking better now… yeah. We gave her some back thrusts. She was having lunch'. When asked if she can breathe, the caller confirms that Mrs Nelson can, albeit with very shallow breaths.[31]

34. The operator remains on the phone while Ambulance Victoria make their way to Kerala Manor. During this period, Mrs Nelson is alleged to have still been purple but regaining consciousness. The caller clearly states several times that Mrs Nelson is breathing but is not able to talk. The caller again states that Mrs Nelson choked. The operator asks the caller what she choked on. The caller replies that she was having meat so, 'probably meat'.[32]

35. At around five minutes and 17 seconds into the call recording, the caller tells the operator that Mrs Nelson is turning purple, wheezing and that her breathing is very shallow. At around six minutes, the caller states that Mrs Nelson is 'foaming a bit on her mouth' but that her eyes are open. The caller asks the operator if they can administer oxygen at around six minutes and 25 seconds. The operator checks with the paramedics. Before the operator returns, the caller tells the operator that Mrs Nelson has gone cold and clammy. Mrs Nelson then starts gasping. The caller states that she is still breathing but that her eyes are shut. At nine minutes and five seconds into the call, Ambulance Victoria paramedics arrive.[33]

POST-INCIDENT DE-BRIEF WITH SENIOR NEXT OF KIN

36. Mrs Siede states that she was told by Kerala Manor staff over the phone that 'there is an ambulance here, your mother was choking'. Mrs Siede's husband was also told that Mrs Nelson had 'choked on something at lunch' by Kerala Manor staff. However, when she spoke with Ms K Samuel, she was informed that her mother had suffered a 'heart attack'.[34]

37. Mrs Siede recalled that during a de-brief meeting the following day, Ms K Samuel denied that Mrs Nelson had choked, and when Mrs Siede queried why she was being told a different account of events to the day prior, Mrs K Samuel could not explain. Mrs Siede

[30] Emergency Services Telecommunications Authority, Audio 7917063 obtained 11 December 2019, Coronial Brief.
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Statement of Kathryn Mary Siede dated 19 May 2018, Coronial Brief.

states that staff went to great lengths to 'convince' her that Mrs Nelson had not choked, making inconsistent statements that Mrs Nelson had 'not even taken a bite of her meal' and that 'she had not even had half a bite of the food on her fork'.[35] Mrs Siede goes on to state that Ms K Samuel called an unnamed staff member who was allegedly present at the incident. She requested that the staff member tell Mrs Siede that her mother did not choke and this staff member did as instructed.[36]

38. The subsequent statement provided to the Court by Ms S Samuel refutes that Ms K Samuel denied that Mrs Nelson had choked, instead saying it was said that it did not *appear* she was choking as 'Mrs Nelson did not display the types of symptoms associated with choking. There was no coughing, no wheezing or whistling, no clutching at the throat and the like'.[37] As detailed above, this is inconsistent with the evidence contained in the emergency services call.[38]

39. According to the Ambulance Victoria notes, which were taken at handover from Kerala Manor staff, those staff told them that Mrs Nelson was eating steak when she started coughing and choking. Specifically, she appeared to be experiencing difficulty breathing and was given water to assist clearing her airway.[39] As detailed above, the emergency services call recording is evidence confirming that Kerala Manor staff knew, or at least suspected, that Mrs Nelson was choking on red meat and had contacted emergency services for Ambulance Victoria assistance in treating the medical episode.

40. In the supplementary statement provided to the Court, Ms S Samuel makes note that 'on the arrival of the paramedics, they suctioned Mrs Nelson and that suction did not disclose any food particles.' I note that the Ambulance Victoria electronic Patient Care Record[40] lists 'airway partial obstruction >> lots of white sputum seen' at 12.36'. The form details that at 12.42pm, airway clearance was attempted with 'nil obvious obstruction, suctioning thick sputum, via yankauer[41]'. While I appreciate that Ambulance Victoria were not able to dislodge the bolus from Mrs Nelson's airway, I do not consider that it was appropriate for Kerala Manor to form the conclusive view that this was evidence that Mrs Nelson had not choked.

[35] Statement of Kathryn Mary Siede dated 19 May 2018, Coronial Brief.
[36] Ibid.
[37] Statement of Shoba Samuel dated 6 November 2019, Coronial Brief.
[38] Emergency Services Telecommunications Authority, Audio 7917063 obtained 11 December 2019, Coronial Brief
[39] Statement of Dr Jane Elizabeth Lewis dated 25 June 2018, Coronial Brief.
[40] Ambulance Victoria electronic Patient Care Record, Case No. 10618 dated 20 December 2017, Coronial Brief.
[41] Yankauer suction tip is an oral suctioning tool used in medical procedures.

41. I do not consider the inconsistent accounts given by Kerala Manor staff during the de-brief to be an accurate description of what happened prior to Mrs Nelson's death. The emergency services call recording is sufficient evidence for me to be satisfied to the requisite standard that Kerala Manor staff knew, or suspected that Mrs Nelson was choking.

FOOD BOLUS

42. Kerala Manor have taken issue with the various references throughout the coronial brief to the word 'steak'. Ms S Samuel states that 'Mrs Nelson was eating diced beef in a casserole that was cooked until the meat was tender'. She further states that the facility purchases their meat pre-diced to no larger than 2 centimetres by 2 centimetres. Kerala Manor spoke with their supplier who assured them that their quality standards require that no piece is larger than the above measurements.[42]

43. I appreciate that there is a difference between steak and casserole and accept that Mrs Nelson was not eating steak at the time of her medical episode but rather, diced beef in a casserole. As the cause of death has been given as 'complications of choking on a food bolus in a woman with dementia', I do not consider the reference to steak in the autopsy report and Ambulance Victoria notes to affect the outcome of my investigation.

44. I do not accept Kerala Manor's contention that the piece of beef concerned could not have been larger than two centimetres by two centimetres. As detailed below, the forensic pathologist found there was a food bolus (piece of meat measuring approximately 4 centimetres in maximum extent) lodged in the trachea at the level of the carina.

45. I note that, as per Mrs Nelson's functional assessment, she did not require assistance to feed herself. Namely, that she had the capacity to eat without assistance. This issue is not in dispute.

[42] Statement of Shoba Samuel dated 6 November 2019, Coronial Brief.

IDENTITY AND CAUSE OF DEATH

46. On 20 December 2017, Kathryn Mary Siede visually identified the body of her mother, Dorothy May Nelson, born 16 October 1936. Identity is not in dispute and requires no further investigation.

47. On 22 December 2017, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mrs Nelson's body and reviewed a post mortem computed tomography (CT scan), E-Medical Deposition Form from Austin Health, Austin Hospital, the Greensborough Road Surgery medical records and the Police Report of Death for the Coroner.

48. Dr Bouwer referred Mrs Nelson for a neuropathology examination.

49. On 26 December 2017, Mrs Nelson's brain was examined by Dr Linda Iles. Dr Iles commented that no acute changes were identified.

50. Toxicological analysis of post mortem samples taken from Mrs Nelson identified the presence of morphine[43], midazolam[44] and olanzapine[45].

51. Dr Bouwer provided a written report, dated 4 May 2018, in which he formulated the cause of death as '*I(a) Complications of choking on a food bolus in a woman with dementia'*.

52. Dr Bouwer commented that at autopsy, there was a food bolus (piece of meat measuring approximately 4cm in maximum extent) lodged in the trachea at the level of the carina. Smaller meat fragments were also present in the larynx.

53. Dr Bouwer further commented that there was no other significant natural disease or injury detected that may have caused or contributed to Mrs Nelson's death.

54. I accept Dr Bouwer's opinion as to cause of death.

[43] Morphine is a narcotic analgesic used to treat moderate to severe pain. It is also a metabolite of codeine.
[44] Midazolam is a short acting benzodiazepine used intravenously in intensive care patients.
[45] Olanzapine is indicated for the treatment of schizophrenia and related psychoses. It can also be used for mood stabalisation and as an anti-manic drug.

REVIEW OF CARE

55. From the statement evidence initially provided to me, it appeared likely that Mrs Nelson was only afforded limited first aid in the form of 'back pats'.[46] I subsequently reviewed the emergency services call in which the caller noted performing 'back thrusts', which is the correct immediate response to a choking episode. However, this evidently did not successfully dislodge the bolus and there was an unascertained delay of some 5 to 10 minutes before staff recognised the gravity of her situation.

56. Having accepted the supplementary statement of Ms S Samuel detailing that the event likely happened at approximately 12.18pm, I am satisfied that the delay in Ambulance Victoria arriving and administering appropriate care, would have been no more than 20 minutes.

57. I note that out of hospital cardiac arrests in older persons generally have very poor outcomes however, choking should always be considered a preventable cause of death. For this reason, I referred this matter to the Coroners Prevention Unit (CPU)[47] for an assessment of the care afforded to Mrs Nelson. Specifically, the CPU have reviewed Kerala Manor's immediate response to Mrs Nelson's medical episode.

Preventative measures

58. Mrs Seide raised concerns about the absence of a defibrillator at Kerala Manor. This investigation has confirmed that Kerala Manor does not have defibrillator, however, the ambulance records indicate that Mrs Nelson did not have the type of cardiac arrest for which a defibrillator would have been used. I am satisfied that the absence of a defibrillator at Kerala House was not contributory to Mrs Nelson's death.

59. Kerala Manor have stated that their menu is developed annually by a dietician in conjunction with their residents and chef. Any modifications to residents' diets are advised by the speech pathologist, dietician and/ or treating clinician.[48] It was noted that there were no assessments for any modifications for Mrs Nelson 'as she did not require one'.[49] It was

[46] Whilst 'patting' and 'rubbing' were described by witnesses, management of choking requires quiet forceful back blows to be effective.
[47] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.
[48] Statement of Kay Samuel dated 28 June 2019, Coronial Brief.
[49] Ibid.

also noted that Mrs Nelson fed herself[50] and that she was able to independently cut up her meals.[51] According to Mrs Nelson's Kerala Manor care plan summary, she was allowed thin liquids and normal consistency of her main, vegetables and dessert.

60. In an additional statement obtained by the Court, Ms S Samuel states that on 20 December 2017, Mrs Nelson was served 'diced beef' in the form of beef and vegetable casserole for her lunch time meal. The size of the beef pieces was stated to have been cut into pieces measuring 2 centimetres by 2 centimetres. It was also stated that Mrs Nelson had further cut her meal up into smaller pieces again. Ms S Samuel states that Mrs Nelson was eating independently, consistent with her care plan.

61. As already discussed, the above statement is inconsistent with the autopsy findings, which found the bolus to measure approximately 4 centimetres in maximum extent. This statement is also inconsistent with the account provided to Mrs Siede, who states she was informed by Kerala Manor that Mrs Nelson had not commenced eating at the time of her medical episode.

Failure of nursing staff to institute cardiopulmonary resuscitation (CPR) or other appropriate emergency measures for the management of choking

62. Kerala Manor's statement details that their registered nurses are required to have annual CPR training competency. They also state that they have policies and procedures for the management of choking.

63. Along with Ms S Samuel's subsequent statement, copies of these policies were provided to the Court. Specifically, *RHL-D26 CHOKING.* A flaw in this policy was identified by Kerala Manor, who stated that they 'are now aware that choking can occur without such symptoms, particularly if the obstructing bolus of food is as far down as the carina of the trachea'.[52]

64. I note they have provided the Court with the updated version of this policy. Having reviewed the document, I will be making a recommendation that this new policy be further reviewed and, if necessary, amended by an Australian Health Practitioner Regulation Agency (AHPRA) approved third-party provider who is best placed to give guidance on best practice for the management of a choking event.

[50] Statement of Vilma Santiago dated 23 May 2018, Coronial Brief.
[51] Statement of Kay Samuel dated 28 June 2019, Coronial Brief.
[52] Statement of Shoba Samuel dated 6 November 2019, Coronial Brief.

65. Kerala Manor have maintained that there was no gap in staff management of the incident. Namely, that Mrs Nelson was considered to be suffering a TIA and administering oxygen was the appropriate course of action. As already discussed at length, there is a considerable amount of evidence indicating otherwise.

66. As already noted, the information provided by witnesses from Kerala Manor is both internally and externally inconsistent. Due to the conflicting information, I am unable to determine the exact moment that Mrs Nelson progressed to cardiac arrest or whether she was administered oxygen. I can only conclude that it appears likely that there was a delay in recognising or acting on Mrs Nelson's cardiorespiratory arrest, hence the failure to commence CPR.

67. Mrs Nelson's lack of improvement, despite immediate CPR by paramedics and return of circulation after 11 minutes, suggests that she had a more prolonged 'downtime'[53].

68. I am satisfied to the requisite standard that Kerala Manor staff did not administer CPR because they did not recognise that Mrs Nelson had entered cardiorespiratory arrest, which had proceeded from her choking episode. I am also satisfied that they failed to administer appropriate first aid to address Mrs Nelson choking and that this failure is what led to her cardiorespiratory arrest.

69. For these reasons, I will be forwarding this finding onto the Aged Care Quality and Safety Commission, Safer Care Victoria and the Royal Commission into Aged Care Quality and Safety for follow-up, should they find it appropriate to do so.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

70. Mrs Siede raised concerns regarding several administrative shortcomings on behalf of Kerala Manor, and some of these warrant comment under the Act.

Kerala Manor staff witness statements

71. Kerala Manor was given several opportunities throughout the coronial process to address the identified inconsistencies in their evidence.

72. In the subsequent statement provided to the Court by Ms S Samuel, she stated that staff were interviewed approximately six months after the event at Heidelberg Police Station and that

[53] Common vernacular for the period of time for which the brain was without adequate blood supply without CPR. A down time of over six minutes is likely to cause significant brain damage.

this process was 'unusual and intimidating for staff'. I take this opportunity to note that, depending on the complexity of the matter and the forensic requirements, namely whether an autopsy is required, the coronial process can take some time. I do not consider the timing of events throughout the investigative process to have been outside of acceptable limits. The assertion that staff were intimidated by the investigative process does not excuse the provision of inconsistent information. The inconsistencies throughout the statements are not minor in nature and are found amongst the narratives of the first responders to Mrs Nelson's medical episode.

73. I do not consider that a delay of six months would affect an individual's memory to such an extent, that they would not be able to remember the specifics of first aid assistance that they either did or did not provide in an emergency situation.

74. I also note that Ms S Samuel states that staff were not provided 'with a copy of their statement' and that this 'made it very difficult for them to ensure …that their recollections were [not] flawed after 6 months'.[54] I note that the statements in the coronial brief have all been signed and pages initialled to indicate that the information was correct at the time of signing. Statements, including Ms S Samuel's, should not have been signed if there was any doubt in the mind of the witness that the information was not correct. This assertion by Kerala Manor management raises concerns about the administrative standards therein. I take this opportunity to make the point that going forward, legal documents should not be attested as true and correct if the signatory is uncertain about any the information contained within them.

<u>Kerala Manor's DON, Kay Samuel's qualifications and cooperation with the coronial investigation</u>

75. Mrs Siede questioned whether Ms K Samuel, as DON had the appropriate training or skill level to take charge of the situation which preceded her mother's death. The Court obtained confirmation that Ms K Samuel is a registered nurse with the AHPRA. I find that as a result of the minimum qualifications and experience entailed by this registration, Ms K Samuel ought to have had sufficient clinical skill to be able to make a timely assessment of whether Mrs Nelson was experiencing a choking or cardiac event.

76. The Court directly forwarded a series of statement questions for response by Ms K Samuel. A response statement was sent as an unsigned attachment from Ms S Samuel. Ms S Samuel

[54] Statement of Shoba Samuel dated 6 November 2019, Coronial Brief.

later confirmed that Ms K Samuel was the author of this material.[55] Ms K Samuel has since acknowledged that her communication with the Court could have occurred in a more efficient and direct manner.[56]

Confusion over whether Mrs Nelson was subject to a 'not for resuscitation' order, potentially delaying resuscitation efforts

77. Mrs Siede's concerns regarding Kerala Manor's administrative disarray are valid. The failure of staff to promptly identify whether Mrs Nelson was subject to a 'not for resuscitation' order is unacceptable.

78. Despite Kerala Manor not identifying this as the reason why CPR was not commenced, it is noteworthy that first aid measures should not be withheld merely because a person is subject to a 'not for resuscitation' order.[57]

79. I am not satisfied to the requisite standard that the confusion over Mrs Nelson's resuscitation status was the cause of the delay in Mrs Nelson receiving CPR. I do however, consider this system failure in promptly identifying the correct resuscitation status of residents to pose ongoing risk to current and future residents.

80. For this reason, I will be forwarding this finding onto the Aged Care Quality and Safety Commission, Safer Care Victoria and the Royal Commission into Aged Care Quality and Safety for follow-up, should they find it appropriate to do so.

Staff failing to contact Mrs Siede because they had two listed contact numbers, one of which was incorrect. It was the incorrect number that they continued to call.

81. Mrs Siede's concern regarding the contact number error is valid. While I do not consider the delay in contacting her to have altered the outcome, I do highlight the importance of accurate record keeping, and the considered use of all the available information, such as the alternate phone number.

82. The relationship between an aged care facility and senior next of kin is one based on trust. Administrative failings jeopardise this trust and can result in delays and confusion, as was the case with Mrs Nelson.

[55] Ibid.
[56] Statement of Kay Samuel dated 15 January 2020.
[57] If the person has progressed further to cardiorespiratory arrest, then this represents a difficult clinical situation for care staff to navigate.

83. For this reason, I will be forwarding this finding onto the Aged Care Quality and Safety Commission, Safer Care Victoria and the Royal Commission into Aged Care Quality and Safety for follow-up, should they find it appropriate to do so.

Size of the food bolus

84. Despite evidence to the contrary, Kerala Manor have maintained that the beef Mrs Nelson was eating at the time of her medical episode was no larger than two centimetres by two centimetres. They state that have spoken with their supplier who assured them that their quality standards require that no piece is larger than the above measurements.

85. This could not have conceivably been the case, as was proven at autopsy.

86. To prevent future events of a similar nature, I would suggest that Kerala Manor reassess and alter the way they satisfy themselves that meat being provided to residents meets their size requirements. Their reluctance to accept empirical scientific evidence on this issue raises concerns about the rationality of their managerial decision making processes.

87. For this reason, I will be forwarding this finding onto the Aged Care Quality and Safety Commission, Safer Care Victoria and the Royal Commission into Aged Care Quality and Safety for follow-up, should they find it appropriate to do so.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

88. I recommend annual drills for staff around responding to a choking incident be included as part of First Aid Response training at all residential aged care facilities, including those at Kerala Manor.

89. I recommend all staff at Kerala Manor receive education in assisting residents with eating at meal times, including how to manage the safe delivery of modified texture foods.

90. I recommend that Kerala Manor submit their policy, *RHL-D26 CHOKING,* for review and amendment by an AHPRA approved third party provider to give guidance on best practice for the management of a choking event.

FINDINGS AND CONCLUSION

91. Choking has been identified as a major risk in residential aged care facilities.[58] In light of this risk, staff responses to these situations is of upmost importance. The death of Mrs Nelson raises concerns regarding the professional practice of the nursing staff and the DON at Kerala Manor.

92. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

93. I express my sincere condolences to Mrs Nelson's family for their loss.

94. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Dorothy May Nelson, born 16 October 1936;

    (b) The death occurred on 20 December 2017 at Austin Health, Austin Hospital located at 145 Studley Road, Heidelberg Victoria 3084 from complications of choking on a food bolus in a woman with dementia; and

    (c) The death occurred in the circumstances described above.

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

    (a) Mrs Kathryn Siede, senior next of kin;

    (b) Mrs Pauline Chapman, Austin Health, interested party;

    (c) Chief Executive Officer, Safer Care Victoria, interested party;

    (d) Aged Care Quality and Safety Commission, interested party;

[58] Ibrahim, J. 2017. Recommendations for prevention of injury-related deaths in residential aged care services. Monash University: Southbank.

(e) Royal Commission into Aged Care Quality and Safety, interested party;

(f) Ms Shoba Samuel, Kerala Manor, interested party;

(g) Ms Kay Samuel, Kerala Manor, interested party; and

(h) Senior Constable Matthew Isaac, Coroner's Investigator.

Signature:

SIMON McGREGOR

CORONER

Date: 22 April 2020