IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5516

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	**JOANNE CALLAHAN**
Delivered on:	10 March 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	23 February 2022
Findings of:	**KATHERINE LORENZ, CORONER**
Counsel assisting the Coroner:	**Mr Dylan Rae-White, Senior Coroner's Solicitor, Coroners Court of Victoria**
Other matters:	*Person placed in care*

HER HONOUR:

INTRODUCTION

1. Joanne Avis Callahan (**Joanne**) was born on 5 March 1975. She was 43 years old and a resident of a Community Residential Unit (**CRU**) which, at the relevant time was operated and managed by the Department of Health and Human Services, now the Department of Fairness, Families and Housing (**the Department**)[1] Disability Accommodation Services at 16 Last Street, Beechworth (**Last Street**) at the time of her death.

2. On 1 November 2018, Joanne died in hospital after choking on a food bolus while participating in a day program operated by Gateway Health at the Yarrunga Community Hub.

THE CORONIAL INVESTIGATION

3. Joanne's death was reported to the Coroner as she was considered to be a *person placed in custody or care* under section 3(1) of the *Coroners Act 2008* (**the Act**) and so fell within the definition of a *reportable death* under the Act. When a person dies 'in care' an inquest into the death is mandatory unless it is a death from natural causes. The Act recognises that people 'in care' are vulnerable and affords them protection by requiring that the circumstances of their death are investigated by a coroner, irrespective of the medical cause of death, and by mandating that as part of that investigation there should be an inquest or formal public hearing.

4. Joanne's care arrangements fell within this definition because she resided in CRU housing provided by the Department at Last Street, at the time of her death. On 26 May 2019, management of this CRU was transferred from the Department to a community services organisation, Home@Scope (**Scope**).

5. A coroner independently investigates 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.

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[1] As of 1 February 2021, the Department of Health and Human Services was separated into two new departments: the Department of Health (**DH**) and the Department of Families, Fairness and Housing (**DFFH**).

6. Victoria Police assigned a Coroner's Investigator for the investigation. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from family, witnesses including staff from Gateway Health, paramedics, the forensic pathologist who examined her and investigating officers, as well as other relevant documentation as set out below. The Court also obtained Joanne's medical records.

7. 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. Coroner Darren Bracken directed this coronial investigation until my appointment as a coroner on 8 February 2021, when I assumed the responsibility for it.

BACKGROUND

9. Joanne moved to Last Street after transitioning from living at home with family at the end of 2006 after the death of her mother. Joanne has three sisters and a brother with whom she was close and maintained regular contact throughout her life.

10. Joanne was described as a social person with a caring, loving nature and good sense of humour. Joanne was much loved within her residence; she would help with the chores, was chatty, loved to sing and to have a 'cuppa'. She was well known in the Beechworth community, frequently vising the local doctors, pharmacy and businesses, and would often stop and chat to people in the town.

11. Joanne had an intellectual disability with autism. She also suffered from epilepsy and high blood pressure and was well managed with medication.

12. Joanne communicated verbally in short sentences and often made repetitive statements. Her communication was limited but she could respond to clear, simple instructions and yes/no questions. She would use photographs, pictures and gestures to augment her communication.

13. Joanne attended the Disability Day Program operated by Gateway Health three days per week. Gateway Health is a registered Community Health Service and registered National Disability Insurance Scheme provider, that provides a range of health and wellbeing services to the community.

14. The Disability Day Program is coordinated through Gateway Health's Community Inclusion Program and offers centre-based activities at Yarrunga Centre in Wangaratta, community participation activities and outings in small groups and one-to-one support for social and recreational activities, community participation and skill development. Joanne would travel

to and from the programs by taxi with two other residents. The taxi would pick them up just after 8 am and return them home between 3.30 pm and 3.45 pm. Joanne had been attending these programs since she moved into her Beechworth residence in 2006. She also attended Park Lane Nursery in Wangaratta one day per week.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

15. On Thursday 1 November 2018, Joanne arrived at Yarrunga Community Hub, Wangaratta at 9.00 am to participate in the Women's Wellness activities with other clients as part of her Gateway Health day program. In the morning, the participants (including Joanne) took part in a women's pampering session and had their nails painted. There were four Gateway Health staff members directly supervising Joanne's group at the relevant time. They were:

    a. HSG[2], Disability Support Worker.

    b. UGM[3], Allied Health Assistant.

    c. ZTL[4], Program Support Officer.

    d. NHV[5], Disability Support Worker.

16. Other staff members were working in the other activity room and at Gateway Health's Mackay Street office on that day.[6]

17. Joanne had morning tea at approximately 10.30 am and during that time Joanne ate half of her sandwich. The other half was put aside by HSG for lunch.

18. At about 11:40am, NHV left the Yarrunga Centre. She was rostered on to work with Joanne's group between 9:00 am and 12:00 pm. However, she was also rostered to work at another location, commencing at 12:00 pm, and needed to depart early.

19. Just before 11.45 am when the group was in the process of sitting down to lunch, ZTL left to walk two clients over the road to the Open Door Neighbourhood House. HSG and UGM remained to support the 13 client participants at lunch time

20. At approximately 11:45 am, Joanne was seated on a chair at a small table to one side of the room eating the remainder of her sandwich. UGM was assisting another client to eat while

[2] A pseudonym.

[3] A pseudonym.

[4] A pseudonym.

[5] A pseudonym.

[6] Statements of Maria Gigliotti and Leigh Rhode, CB.

seated at a large table with many other clients. At this time HSG left the room to get her own lunch, before returning and taking a seat at the large table with her back to Joanne. HSG put her lunch down and looked around, noting Joanne was seated in the chair nearby.

21. She then saw Joanne get up and walk 'around the long way' to the toilet, past HSG and other clients. HSG saw that Joanne's lips were blue. According to HSG, Joanne made a 'squeaky sound in her throat' as she walked towards the toilets. HSG asked UGM to watch her lunch while she went to check on Joanne. HSG then heard another client say that Joanne had something in her mouth. She followed Joanne into the toilet. Joanne had pulled her pants down and sat on the toilet. HSG asked Joanne what was in her mouth. Joanne put her fingers in her mouth. HSG asked Joanne to spit out what was in her mouth and cough.

22. HSG then called UGM for assistance. UGM attended and again asked Joanne to cough up her food. According to UGM, Joanne looked at them with 'big eyes' and made a 'faint, wheezing type of noise'. UGM stood behind Joanne and attempted giving three to four thrusts to her back, resulting in a small amount of food coming up, which she scooped out of Joanne's mouth.

23. UGM and HSG then stood Joanne up, pulled up her pants and considered doing further thrusts to her back, however as they did this Joanne went limp and her legs gave way. UGM and HSG lowered Joanne to the floor, placing her momentarily in the recovery position. HSG went to call an ambulance while UGM commenced cardiac pulmonary resuscitation (**CPR**).

24. According to the Ambulance records, the call received at 11.53 am and the ambulance was dispatched at 11.54 am, arriving at the Yarrunga Centre at 12.00 pm.

25. Whilst UGM continued CPR, ZTL returned to the Yarrunga Centre and assisted UGM by putting a mask on Joanne and attempting to blow air into the mask. According to ZTL, some of the trapped food came out of Joanne's mouth but the food blockage was preventing sufficient air flow past her throat.

26. When ambulance officers examined Joanne she had food caught in her airway causing a complete airway obstruction. She was unconscious, not breathing and had no heartbeat. Ambulance officers continued CPR and Joanne was intubated and several doses of adrenaline were administered. At approximately 12.47 pm, Joanne had a return of cardiac output. At approximately 1.15 pm, Joanne was transported by ambulance to Northeast Health Wangaratta where she was put on life support.

27. After consultations between medical and nursing staff and Joanne's family, in view of Joanne's poor prognosis, Joanne was extubated, and adrenaline was ceased. She passed away at approximately 2.43 pm.

FAMILY CONCERNS

28. On 30 December 2018, Joanne's sister, Ms Sharon Dellora wrote to the court expressing concerns about Sharon's death. Broadly, the correspondence set out concerns about the care provided to Joanne on the day of her death, whether key staff had been interviewed by police and setting out the matters for which the family hoped the coronial investigation would make findings and recommendations. These concerns included the staff/client ratio at the day programs, supervision and the apparent lack of awareness by Gateway Health staff about Joanne's specific needs.

DSC INVESTIGATION AND FINDINGS

29. As part of this investigation, I have considered the Investigation Report into disability services provided by the Department and Gateway Health to Ms Callahan issued on 13 November 2019 prepared by the Disability Services Commissioner (**DSC**) (**Investigation Report**) which was provided to the Court on a for the purpose of the coronial investigation and inquest. The DSC investigation was conducted under the Disability Act 2006 with a different scope to that of a coronial investigation (although it can overlap).

30. On 13 November 2019, a copy of the Commissioner's report was provided the Court with a copy of its Investigation Report and Notices to Take Action issued to the Department and Gateway Health. The DSC investigation revealed concerns about the adequacy of the provision of disability services provided to Joanne.

31. With respect to Gateway Health, the DSC made the following findings:

    a. Gateway Health did not adequately supervise Joanne during mealtimes, placing her health and wellbeing at risk.

    b. Gateway Health staff failed to recognise signs of choking from Joanne, such as her lips changing to purple in colour and making unusual high-pitched noises in a mealtime context, which compromised the timeliness of first aid support.

    c. Gateway Health did not proactively seek information about Joanne's mealtime support requirements.

32. In relation to the Department, the DSC found:

a. It failed to communicate essential support information to Joanne's day service provider, which contributed to putting her health and wellbeing at risk.

b. It administered routine and PRN medication to Joanne for the purpose of chemical restraint in breach of the Disability Act.

c. It did not fulfil its record-keeping obligations under the Disability Act and the Residential Services Practice Manual.

33. As a result of these findings, the DSC issued each of the Department and Gateway Health with a Notice to Take Action to implement necessary improvements and changes with respect to the disability services it had investigated.

34. On 6 January 2020, the Secretary of the Department responded to the DSC Investigation Report and the Notice to Take Action. It included an Action Plan dated 16 December 2019 specifically developed to address the 'Notice to Take Action' following the DSC investigation. In summary, the Department undertook to work with Home@Scope to:

a. Conduct an audit of all relevant health documents related to the residents at Beechworth group home to identify critical documents that should be provided to the relevant day program providers.

b. Review and improve procedures for sharing critical client information, such as health risks and mealtime support strategies, with residents' other disability service providers.

c. Ensure there was no unauthorized use of chemical restraints.

d. Ensure staff were trained on the requirements for proper record keeping.

35. On 20 January 2020, Gateway Health responded to the Investigation Report and the Notice to Take Action and included an Action Plan for Service Improvement dated 20 January 2020.

DIRECTIONS HEARING

36. On 9 August 2021, I held a directions hearing to update the interested parties about the particular issues I was investigating and the evidence required to prior to deciding if the matter was ready to proceed to inquest. I flagged two primary issues of concern which appeared to be causally connected to the circumstances of Joanne's death :

a. The adequacy of communication between the Department and Gateway Health regarding Joanne's mealtime and choking risks.

b. The adequacy of supervision of Joanne during mealtime immediately prior to the choking episode and the immediate response by Gateway Health staff during and afterwards.

37. Following the directions hearing, I received additional material from Gateway and the Department responsive to the issues raised.

INQUEST

38. After reviewing all the material, I determined that the circumstances of Joanne's death were adequately revealed by the coronial brief and the additional documents and hence no witnesses were required to give evidence at the inquest.

39. Further, prior to the inquest, at the invitation of the Court, the Department and Gateway made written submissions, mainly related to the communication of Joanne's choking risk between the providers.

Communication about choking risk

40. In evidence, Gateway Health conceded that its staff had knowledge that Joanne ate too quickly, sometimes took food from others and required supervision at mealtimes. However, Gateway Health maintained that its staff did not know, and had not been provided with information to indicate that one of the reasons that Joanne required mealtime supervision was to mitigate the risk of choking.

41. In her statement to the Court, Gateway Health's Chief Executive Officer, Ms Rhode set out in detail the information the Department had provided to Gateway about Joanne's mealtime needs. These documents included:

a. Behavioural Support Plan (**BSP**) dated 8 February 2017. The BSP was formulated and periodically revised by the Department and was primarily designed for use in Joanne's home environment. However, it also provided useful and practical guidance for Disability Day Program staff in how best to support Joanne in reducing the likelihood or consequences of her behaviours of concern and supporting positive behaviour. The BSP provided to Gateway contained a reference to a Speech Pathology communication assessment on 30 May 2013, and a Speech Pathology swallowing assessment and report from the Rural Allied Health Service Wodonga of 18 December 2014 which was stated to be contained in Joanne's "health folder"". According to Ms Rhode, Gateway was not provided with a copy of either the Speech Pathology communication assessment or the Speech Pathology swallowing assessment.

b. Disability Client Services Client Profile. The Client Profile includes a five-point rating scale of the level of client support required for daily living skills. Joanne's level of support for all daily living skills, including eating, was rated as "minimal" (verbal prompting) on a good day to "some" (verbal prompting with some level of physical prompting required) on a bad day. This rating was consistent with the level of support available through the Disability Day Program at the funded ratios. If, for example, the rating provided on the Disablity Client Services Client Profile had been listed as Substantial or Total, Joanne would have been unlikely to have been considered suitable for the Disability Day Program, unless she had higher levels of funded support.

c. A Menu Plan formulated by a dietician provided by the Department in March 2018. The Menu Plan set out a food regime for Joanne to manage her weight. It did not provide any guidance regarding the management or supervision of Joanne's eating behaviours or level of supervision required during mealtime.

d. A "My Support Plan" dated 30 November 2013. The document stated "*My food is usually cut up for me as I sometimes have difficulty cutting my food up to bite size portions and as I am sometimes a rapid eater I require some supervision and redirection with my eating speed*". Further, the document stated that Joanne requires "*certain foods to be of bite size portions for safer ingestion*". The My Support Plan refers to an 'Eating Plan' which, according to Ms Rhode, was not provided to Gateway by the Department.

e. Daily Communication Book. The Daily Communication Book was the means by which information is conveyed about daily matters between Joanne's residence and her Disability Day Program provider(s). The Daily Communication Book did not form part of Joanne's client record with Gateway, nor was it the means by which the Department would communicate Joanne's mealtime supervision needs to Gateway Health. The type of notes entered in the Daily Communication Book by Gateway staff would be reminders to the house staff to pack a change of clothes or to report that Joanne had a good day/not so good day.

42. Notably, **none** of the documents the Department provided to Gateway Health indicate that Joanne was at risk of choking.

43. According to the evidence given to the Court, the Department produced voluminous documents regarding Joanne's personal and health needs, some of which included references to Joanne's swallowing issues and risk of choking. These documents were listed in the statement of Ms Carley Northcott, the Director, Disability and Complex Needs Branch, Operations Support Group, Community Services Operations Division at the Department and

provided as part of this coronial investigation. Notably, in her statement, Ms Northcott did not assert that the listed documents had been provided to Gateway Health.

44. In her statement, Ms Rhode stated that Gateway Health staff were not aware of any issues related to Joanne which would have raised concerns that Joanne could choke. Gateway Health staff had not observed Joanne to gag on food or to 'hoard' food in the back of her mouth, but were aware of Joanne's tendency to take food from other clients or from surfaces if food was left unattended. Accordingly, the Yarrunga Mealtime Assistance Schedule contained an instruction to staff to "*watch that she doesn't steal other people's food*".

45. Department employees, UED[7] and NWF[8] both asserted in their respective statements to the Court that relevant documents regarding choking risk were provided to Gateway Health, but neither witness provided any evidence to support their assertions that such documents had been provided. NWF stated that "*I am positive that I regularly provided Gateway with Joanne's documentation. My manager, UED, was the type of boss that expected they be provided. She was a stickler for documentation and made sure the resident's plans and documentation was always up to date*."[9] NWF admitted, however, that "[u]*nfortunately there is no way I can 'prove' I sent them. All I can say is that I am very confident I did and that Joanne's need for supervision was well documented*."

46. UED supplementary statement dated 22 October 2021 outlined several documents which she believed "*would have been provided to Gateway*" but that she could not be sure. In relation to the Eating Plan, UED stated:

> *"The Eating Plan is a document that would have been sent to Gateway. Joanne's key worker at the time was Tom Nicol and it would have been his responsibility to undertake this task. I have no memory of when this happened. I do not think Tom would have sent it by email. His practice was to provide documents in hard copy with the communication book, by post, or personally during a meeting."*

47. The Department did not produce any cover letters, emails, file notes notes or other contemporaneous documents which might have otherwise given credence to their claims that they gave Gateway Health information about Joanne's choking risk. Indeed, the Department conceded that the communication used for client's paperwork during the time Joanne was in care was "not ideal".

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[7] A Pseudonym

[8] A Pseudonym

[9] NWF, p 3 of statement.

48. The weight of the evidence, including the lack of contemporaneous documentation demonstrating that information about Joanne's choking risk was either provided by the Department, and/or received by Gateway Health coupled with the witness statements and the concession by the Department that its communication protocols were not 'ideal', favours a finding that the Department did not notify Gateway Health of Joanne's choking risk.

49. Further, I conclude that Joanne's choking risk was not obvious to Gateway Health and, on the information available to it, Gateway Health could not reasonably have been expected to infer that a choking risk existed.

50. Further, the Department had primary responsibility for Joanne's care and with the vast information it had about Joanne's needs, including her specific clinical risk of choking, it was incumbent upon Department staff to ensure that such relevant information was positively and formally conveyed to other providers, such as Gateway Health.

Supervision of Joanne during the meal

51. The other key issue in the investigation into to Joanne's death was the supervision by Gateway Health during the meal. In her statement, Ms Rhode was candid about the factors that may have impacted on the ability of Gateway Health staff to supervise or attend to Joanne's needs on 1 November 2018. These included:

    a. A rostered staff member leaving the Yarrunga Centre 20 minutes earlier than the end of her shift to commence her afternoon shift at another location, resulting in one less staff member being available to provide supervision during lunch time. Gateway Health acknowledged that this staff shortage during the lunch shift could have been avoided if the rostering had allowed for travel time between shifts so that staffing levels were maintained until the arrival of the afternoon shift at 12 pm.

    b. Lunch being brought forward earlier than usual. Lunch was usually taken at 12 pm when the afternoon staff have arrived. If lunch had been taken at the usual time, the afternoon shift staff member would have been on-site and ZTL would have would have returned from escorting clients across the road. This would have maintained the staffing levels (1:4) during the lunchtime break.

    c. The seating arrangements of staff and clients at lunch time did not provide line of sight visibility for all clients, including Joanne. If staff had line of sight visibility for Joanne, signs of her choking might have been identified earlier. Direct line of sight might have been achieved if:

• Staff had placed themselves in a location in the room where all clients could be observed.

• Joanne had been sitting at the table with the other clients and staff.

• There had been more staff in the room (see (a) to (c) above).

d. Staffing ratio for standard care (1:4) not being adjusted to account for the one client who required 1:1 supervision with meals.

Emergency response

52. In her statement, Ms Rhode confirmed that the staff members present responded to Joanne's presentation, which was suspicious of choking, by following her into the bathroom, asking Joanne to remove food from her mouth, attempting to assist her to clear her airway and commencing appropriate first aid procedures. These actions complied with the First Aid training and the Basic Life Support Refresher Training the relevant staff had completed in 2018. Gateway Health accepted, however that the recognition that Joanne was choking may have been identified earlier if Joanne had been in direct line of sight of Gateway Health staff at the time she was eating her lunch.

GATEWAY'S REMEDIATION PLANS

53. Gateway Health has implemented a number of changes since Joanne's death to prevent deaths like Joanne's in the future and generally to improve the safety of clients. These actions included the necessary changes to rostering to ensure that staff ratios are maintained throughout the shifts and handover periods. In her statement, Ms Rhode further elaborated on issues with the care provided to Joanne and the immediate and long-term remediation steps it identified as being necessary to ensure that the safety of clients in its care is maintained to a high standard in the future.

54. Gateway Health has accepted the DSC findings regarding shortcomings in supervision of Joanne at lunchtime on 1 November 2018 and implemented an Action Plan for Service Improvement dated 17 January 2020 addressing specific recommendations made by the DSC. Gateway Health have confirmed with the Court that all strategies listed on the Action Plan have now been completed.

55. In addition, Gateway Health has introduced further changes and improvements to its systems and procedures including the following:

a. Implemented changes to rosters to ensure that one staff member is never alone with a group of clients.

b. Reviewed and updated the Disability Day Program Model of Care.

c. Revised policies for group and community inclusion activities for both groups and individuals.

d. Updated client intake information processes to ensure that an issue such as risk of choking is identified at intake and improved communication systems with all relevant staff to ensure that they are alert to such a risk.

e. Audited all client's mealtime information to find and fill any gaps with documents from other services.

f. Undertaken new training programs about dysphagia and swallowing.

g. Audited all staff for first aid training.

h. Invested in a new system and practice of risk assessment.

i. Co-operated with Home@Scope to develop a Memorandum of Understanding which is currently being drafted.

DEPARTMENT'S RESPONSE

56. The Department has taken several steps since Joanne's death to improve practice:

a. It has worked with Home@Scope to develop and initiate an action plan, addressing each of the Notice to Take Action issued by the Disability Services Commissioner (the Commissioner). This included implementing a strategy to ensure that any updates to residents' critical information documents are shared with disability service providers who support them.

b. It has provided input into the Commissioner's Safe mealtime's poster which was distributed to the five transfer providers in October 2020 for display in their group homes. The aim of the poster is to increase awareness of swallowing and choking risks and the importance of following a resident's mealtime management plans.

c. It funded a project in 2021 to deliver training called 'Co-Creating Safe and Enjoyable Meals' to direct support workers from the five transfer providers. Along with training to the direct disability support workers, the training included a 'train the trainer' component to increase the capacity of the service provider to continue to provide this training to their staff. The aim of the project was to reduce the incidence of choking and hospitalisation and preventable deaths of people with disabilities in care who have swallowing risks, and to improve their mealtime-related quality of life and enjoyment of

meals. The project is part of a larger national project funded by the NDIS Quality and Safeguards Commission.

IDENTITY

57. On 1 November 2018, Kevin Callahan visually identified his sister Joanne Avis Callahan, born 6 March 1975.

58. Identity is not in dispute and requires no further investigation.

CAUSE OF DEATH

59. On 8 November 2018, Dr Joanna Glengarry, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine, performed an examination and provided a written report of her findings dated 11 November 2018. In that report, Dr Glengarry concluded that a reasonable cause of Joanne's death was *'choking on a food bolus'*.

60. I accept and adopt Dr Glengarry's opinion as to Joanne's medical cause of death.

COMMENTS

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

61. Joanne had complex physical and intellectual disabilities and required assistance with all the activities of daily life, including assistance in accessing medical attention and treatment. She was entirely dependent others for her care and wellbeing.

62. In June 2018 the Disability Services Commissioner published a report titled: *A review of disability service provision to people who have died 2017-2018*.

63. The report noted that people with intellectual disability are well known to be at higher risk of choking. This is due to physical factors such as difficulties with chewing and swallowing (known as dysphagia), and behavioral factors such as gorging or pica (eating non-food items.)

64. The report noted that poor management of choking and aspiration risk have been identified as common contributors to premature death in people using disability services.[10]

65. At the Inquest, counsel for the Department and Gateway Health both acknowledged the known risk of choking by clients in the disability sector and referred to practice alerts and

[10] Disability Services Commissioner, *A review of disability service provision to people who have died 2017-2018*, p 25

other information and alerts which have been widely disseminated in the sector in recent years.

66. Since the transition to the National Disability Insurance Scheme, the Department retains the management of only seven group homes in Victoria. For those remaining group homes managed by the Department, paper-based communications are being digitised with the aim of enhancing record keeping practices. However, a process is occurring to transfer the management of these remaining seven group homes to a non-government provider by March 2022, at which point the Department will no longer be managing disability group homes. For this reason, there is no utility in making recommendations to the Department about its record keeping practices as the Department will not have jurisdiction to implement such recommendations.

FINDINGS

Having investigated the death of Joanne Callahan and having held an Inquest into her death, I make the following Findings pursuant to s 67(1) of the Coroners' Act 2008 (Vic):

67. The identity of the deceased is Joanne Avis Callahan, who was born on 6 March 1975, and who died on 1 November 2018 at North East Health, Wangaratta, Victoria.

68. Joanne Callahan resided in a 'group home' provided by the Department at 16 Last Street, Beechworth. As such, I find that she was 'in care' immediately before her death pursuant to the definition contained within section 3 of the Coroners Act 2008 (Vic).

69. The weight of evidence before the Court indicates that the Department failed to provide information about Joanne's choking risk to Gateway Health but I am unable to determine if Joanne's death would have been prevented if such information had been provided.

70. The supervision of Joanne on the day of her death during lunch time was inadequate. However, I am unable to determine whether the choking incident could have been prevented had such supervision been adequate.

71. I have not identified any concerns about the care provided to Joanne by the immediate staff who were working at Gateway Health on the day of Joanne's death. The evidence indicates that the staff at the Centre were caring and diligent and did their best to provide first aid, including CPR to Joanne.

72. I am satisfied that that the changes implemented by Gateway Health will address the inadequacies in Gateway Health's procedures related to supervision and rostering.

PUBLICATION

Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

I convey my sincere condolences to Joanne's family.

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

Ms Ditty Dale, Senior Next of Kin

Secretary, Department of Health and Human Services

The Disability Services Commissioner

Ms Leigh Rhode, CEO and Company Secretary, Gateway Health

Signature:

KATHERINE LORENZ

CORONER

Date: 10 March 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.