IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2296

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**KATHRYN O'ROURKE**
Delivered on:	23 June 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	21 June 2021
Findings of:	**SARAH GEBERT, CORONER**
Counsel assisting the Coroner:	Vicki Toong, Coroner's Solicitor, Coroners Court of Victoria

HER HONOUR:

INTRODUCTION

1. Kathryn O'Rourke[1], born on 18 March 1970, was 48 years old at the time of her death. Kathryn is survived by her parents Claudia and Peter O'Rourke.

2. At the time of her death she resided at 1 James Street, Noble Park in a Department of Health and Human Services (**the Department**) Residential Support Care Unit (**the James Street residence**). The James Street residence housed six female residents with high level care needs, which were varied and specific, and they required 24-hour care. The facility was subsequently transferred to Home@Scope.[2]

3. Kathryn's medical history included severe intellectual disability, type 2 Diabetes Mellitus, hypercholesterolemia, Obsessive Compulsive Disorder and Bipolar Affective Disorder. She had regular reviews with her psychiatrist and was on a mental health plan. She also had regular reviews with her general practitioner (**GP**) and six-monthly reviews with her neurologist. Kathryn had limited verbal language and communicated using a few keys words in short sentences and by using gestures, facial expression and body language. She attended a day service which she had participated in since she was a child.

4. Kathryn enjoyed swimming, animals, knitting, jewellery making, family visits, cooking, eating, having her nails polished, talking to her mother, collecting shells/feathers at the beach and *being all dressed up to go out*.[3]

5. On the morning of 10 May 2018, Kathryn choked on a piece of toast which she had taken from the breakfast table. She was transported by ambulance to the Dandenong Hospital but died on 16 May 2018 in the Critical Care Unit at 11.21am having suffered a hypoxic brain injury.

The Coronial Investigation

6. Kathryn's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. Kathryn was also *a person placed in custody or care* under section 3(1) of the Act. Therefore, her death was also reportable under this category.

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[1] Referred to as Kathryn unless more formality is required.
[2] 23 June 2019.
[3] Person Centred Plan dated May 2017.

7. 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.

8. 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.

9. Victoria Police assigned Leading Senior Constable Allie Goff (**LSC Goff**) to be the Coroner's Investigator for the investigation. LSC Goff conducted inquiries on my behalf[4], including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Kathryn's father, disability workers who cared for her, ambulance paramedics, treating physicians, Kathryn's GP, other relevant health professionals, the forensic pathologist who examined her and investigating officers, as well as other relevant documentation.

10. The Court also obtained Kathryn's medical records from the Dandenong Hospital and the Pakenham Medical Centre, where she had been a patient.

<u>Disability Services Commissioner</u>

11. I also considered the *Investigation Report into disability services provided by Department of Health and Human Services to Ms O'Rourke* prepared by the Disability Services Commissioner (**DSC**) which was provided to the Court on a confidential basis. The DSC investigation was conducted under the auspices of the *Disability Services Act 2016* with a different scope to that of a coronial investigation (although it may overlap). In this regard the Act provides that a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[5]

12. I also sought a statement from the Department regarding a range of a matters relevant to the investigation. A comprehensive statement was subsequently provided by Carley Northcott, Director, NDIS Service Delivery, Operations Support, Community Services Operations Division dated 20 July 2020.

[4] The carriage of the investigation was transferred from Deputy State Coroner English.

[5] S.7 of the Act.

13. After considering all the available evidence, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

14. As Kathryn died *in care* a mandatory inquest is required[6] but following consideration of Ms Northcott's statement I determined that no witnesses were required to be called.

15. The Court consulted with Kathryn's family regarding this proposal and I was content that it was appropriate to proceed in this manner.

16. This finding draws on the totality of the coronial investigation into the death of Kathryn O'Rourke. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[7]

Background

17. Kathryn's father said that Kathryn was born short of Chromosome 21 or 22 and this condition became apparent when she was around 5 years old. Kathryn had lived with her parents until aged 40 when they sought alternate residence for her given their advancing age. Mr O'Rourke said that she was first at a residence in Narre Warren (April 2010 until June 2013) following which she spent about 6 months at a psychiatric ward at Casey Hospital. He said that her personality changed dramatically after her admission, and they thought this was due to her medication being too strong.

18. Kathryn moved into the James Street residence in 2014 requiring 24-hour supervision, which her father said she had not needed before.

19. Kathryn had very specific needs with food, including the consumption of only small soft pieces and thickened fluids otherwise, there was a risk she would aspirate. A 'Swallowing and Meal Assistance Care Plan' (reviewed in February 2018) was available as part of the evidence before the Court. The Plan set out that Kathryn should be discouraged from putting too much food into her mouth at once and to eat slowly. She required assistance during meals, but when she became unwell, one on one assistance was needed.

20. Her Nutrition Review dated 20 September 2017, noted that Kathryn,

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[6] S52(b) of the Act.

[7] 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.

tends to not chew and eats very fast if she isn't supervised by staff whenever she is eating. Staff have been sitting by her left side and giving her verbal prompts to slow down. Currently Kathryn is eating more textured food that is finely cut up.

21. Kathryn's 'Speech Pathology Dysphagia Assessment Report' dated 5 February 2018 noted that she required limited assistance with self-feeding however does require monitoring throughout her meals to ensure she does *not overstuff.* The assessment results recorded that she presented with *mild-oropharyngeal phase dysphagia*[8] characterised by hypoid elevation for fluids along with limited pacing abilities causing overstuffing.

22. The care needs of Kathryn were otherwise described by her disability workers as high, requiring assistance with all areas of her life including her personal care needs.

23. In the weeks leading to her death, Kathryn's mental health had been unstable. When *experiencing episodes of mania* Kathryn would remain awake and become overactive. According to Dr Lanka Cooray, Consultant Psychiatrist, in correspondence dated 12 April 2018 to her GP,

    She has been gradually deteriorating in her mental state for the past six months with significant depressive and manic episodes.

24. Her psychiatrist adjusted her medication and staff had been administering clonazepam, as required (2mg up to 3 tablets per 24 hours, when necessary).

25. On 8 May 2018, Kathryn's file notes recorded, *Kathryn needed to be picked up this pm from work due to her state of escalation. She required PRN on getting home as she started food theft of others & going through wardrobes.*

26. On 9 May 2018, Kathryn did not attend her day service as staff felt that it was not safe for her to travel in a taxi as she was unsettled (*Running around the house, removing items from her room, going into other residents' rooms*).

27. At a staff meeting on 9 May 2018, the subject of Kathryn *grabbing other residents' food and eating it,* was discussed following which staff decided to trial a new seating plan. The arrangement meant that Kathryn did not sit directly next to other residents. This would be mean that if Kathryn did reach over the entire width of the table to take food from other residents, it would take a little longer to reach so staff had a few more seconds to move food away.

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[8] 'Dysphagia' is difficulty with swallowing.

28. The notes record,

Kathryn to be trailed [sic] *sitting in the opposite position than usual at the dining table (between* [A] *and* [B]*) this would give Kathryn less opportunity to grab food from the plates during meal time. Staff to sit at the table with the ladies during meal times.*

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

29. On 10 May 2018, there were two disability workers rostered to care for the six residents. The House Supervisor of the James Street residence was attending a training session which commenced at 9.00am.

30. Both staff present were employed by the Department as disability workers on a casual basis and worked at various care facilities.

31. Between 8.00am and 9.00am, five of the six residents of the care facility were in the dining room. The sixth resident was in the shower with one disability worker assisting her.

32. Four of the five residents in the dining room, including Kathryn, had already eaten their breakfast. Kathryn was able to feed herself. The fifth resident, referred to as Annie to protect her privacy, required assistance to be fed. She usually ate her medication at the same time as her food (chocolate custard mixed with the medication in between bites) which would take about five minutes. The disability worker assisting her said that Annie hunched over while she was eating which meant that she was also hunched over while giving her the medication. She said that Annie had soiled herself which she immediately attended to as she knew Annie would be uncomfortable.

33. The disability worker then made a further piece of toast for Annie to eat and also on the dining table was a piece of pumpkin toast she had refused earlier.

34. According to the worker, while she was attending to Annie, Kathryn took the pumpkin toast off the dining table and put it in her mouth without her noticing. Kathryn was seated at the dining table beside the worker, but she was facing the other resident.

35. The worker said that, *Kathryn loves food and this type of opportunistic behaviour is not out of character for her. The toast she took was close by to me, I have no idea how she managed to get hold of it. I had the toast close to me due to this behaviour.*

36. The worker immediately called for assistance from her colleague, who was in the shower area which was some way from the dining/kitchen so was not immediately able to hear. She tried to force the toast out by putting her arms around Kathryn from behind. She continued to perform *first aid* whilst the other worker called Triple Zero. Cardiac Pulmonary Resuscitation (**CPR**) was performed under the guidance of the call taker operator after that time.

37. Approximately *3-4 balls of chewed food* were removed whilst Kathryn was being assisted.

38. During this time, there was concern for the other residents, *including* [the resident] *who was still naked in the shower.*

39. The CFA arrived followed by two units of ambulance paramedics (units arrived at approximately 8.55am after the call was received at approximately 8.45am), when further rounds of CPR were conducted. On their arrival, Kathryn was reportedly in cardio-respiratory arrest. Paramedics continued CPR including endotracheal intubation and 3 bolus amounts of intravenous Adrenaline after which she returned circulation after a downtime of approximately 30 minutes.

40. At around 9.00am, the house supervisor was contacted following which she left to attend the James Street residence and advised her managers of the situation.

41. Kathryn was transported to the Dandenong Hospital and admitted to the Intensive Care Unit (**ICU**) via the Emergency Department. Despite continuing care, she was diagnosed with a severe hypoxic brain injury and clinical brain death was confirmed on 16 May 2018 at 11.25pm. Kathryn was an organ donor following consent being given by her family.

IDENTITY

42. On 16 May 2018, Peter O'Rourke visually identified his daughter, Kathryn O'Rourke, born on 18 March 1970.

43. Identity is not in dispute and required no further investigation.

CAUSE OF DEATH

44. Specialist forensic pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 18 May 2018 and provided a written report of the same date.

45. Dr Dodd noted that the immediate cause of death is best regarded as Hypoxic/Ischaemic Encephalopathy (brain death) in a person who has aspirated food, culminating in respiratory arrest.

46. Dr Dodd noted that Kathryn suffered from baseline intellectual disability and required 24-hour care, and further that she suffered from bipolar disorder and also the extrapyramidal side effects from antipsychotic medication as well as Type 2 diabetes.

47. Toxicological analysis showed the antipsychotic medications clonazepam[9] and olanzapine[10] in therapeutic quantities.

48. Dr Dodd noted no suspicious circumstances as part of his examination.

49. Dr Dodd provided an opinion that the medical cause of death was *1(a) Hypoxic/Ischaemic Encephalopathy, 1(b) Aspiration of Food with Respiratory Arrest* with *Contributing Factors – Intellectual Disability.*

50. I accept Dr Dodd's opinion.

FURTHER INVESTIGATIONS

51. Ms Northcott's statement addressed a number of key queries raised as part of the investigation including:

    - The qualifications and role of each staff member involved with the incident;
    - Whether the staff members had undergone training or education regarding appropriate care of residents who require assistance / supervision and modified consistency food and fluid.
    - Whether there were an adequate number of staff present and available during mealtime on the morning of 10 May 2018 to manage Kathryn's choking risks.
    - Whether Kathryn's choking risks were appropriately managed on the morning of 10 May 2018 during mealtime.
    - Had the staff members undergone training in basic life support/cardiopulmonary resuscitation (CPR) / first aid.

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[9] Clonazepam is a nitrobenzodiazepine clinically used for treatment of seizures.
[10] Olanzapine is indicated for the treatment of schizophrenia and related psychoses.

- Was a basic life support competency or CPR / first aid certificate a standard requirement for the staff members attending the incident.
- Whether there have been any changes to DHHS practice as a result of Kathryn's death.

52. It was noted that on 11 July 2019, DSC provided the Final Investigation Report to the Department which highlighted concerns about the adequacy of the disability services provided to Kathryn and included a Notice to Take Action in respect of five matters. The response to those concerns were set out and provided to the Court by the Department.

Staff qualifications and training, staffing levels

53. Both staff members present on 10 May 2018 were engaged as Disability Development and Support Officers and one held a Certificate IV in Disability which is the nationally recognised qualification for disability support workers (although not required for employment in the sector). Neither of the staff had specific training or education relating to the care of residents who required assistance/supervision and modified consistency food and fluid, but they had undergone a 3-day Induction Program. As part of this program, the Court was advised that staff are required to become familiar with their obligations as set out in the Department's Residential Services Practice Manual. This manual provides staff with *clear practice advice on how to manage specific health conditions, including swallowing and choking risk, safe meal-time management and best practice in the area.*[11]

54. Both staff members had undergone regular annual training in CPR/First Aid. This training is mandatory for all staff working in Disability Accommodation Services with the Department and as per the National Guidelines, CPR is required to be renewed annually and First Aid every three years.

55. Ultimately, the staff were considered by the Department to be adequately equipped, noting that resident *need is continually assessed, and the level adjusted accordingly.*

Whether Kathryn's choking risks were appropriately managed on the morning of 10 May 2018 during mealtime?

56. The staff present had worked with Kathryn for a number of years and were aware of her *Swallowing and Meal Assistance Plan* in place at that time.

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[11] https://providers.dhhs.vic.gov.au/residential-services-practices-manual.

57. On the morning of 10 May 2018, she was provided her meal in accordance with the plan that was in place and had finished her meal.

58. A WorkSafe report described that Kathryn was seated along the long side of the table, next to her was the staff member, and next to the staff member was another resident (on her right side) to whom she was administering medication.

59. According to Ms Northcott's statement it was unable to be established whether the staff present were aware of the trial seating arrangement that had been put in place on 9 May 2018, but it was acknowledged that,

when the choking incident occurred, there was only one staff member in the room, whose attention was not focused on Ms O'Rourke. This was not in line with the trial proposed during the staff meeting on the day prior.

60. In her statement to the Court, the House Supervisor said in relation to the trial seating arrangement that had been developed during the meeting on 9 May 2018, that if Kathryn,

did reach over the entire width of the table to take food from other residents ... it would take a little longer to reach so staff had a few more seconds to move food away. This decision had been noted in the staff meeting minutes however, the staff on duty that morning had not seen the minutes as they had not been typed up yet.

61. I note that having made the acknowledgement noted above, Ms Northcott said,

The department wishes it to be noted that during the interviews with staff, it was not felt that the incident was reflective of a careless attitude or approach on behalf of the staff or House Supervisor at the time. The staff involved had worked with Ms O'Rourke for a period of five years and knew her well and were familiar with her behavior. Significant steps had been taken to try and address the choking risks faced by Ms O'Rourke. The outcome is tragic and traumatic for all involved.

62. I accept the acknowledgement made on behalf of the Department.

63. The evidence in this matter suggests that there was an escalation of Kathryn's behavioural issues identified by the staff, and a new eating trial was developed in response by the staff the day before the choking incident which led to Kathryn's death. The new trial was not communicated to staff and as such it was not adhered to on 10 May 2018.

64. Had the trial been in place it would have reduced the risk of the tragic outcome, but I am not able to say that the risk of choking on that day would have been completely eliminated.

Changes to Department's practice as a result of Kathryn's death.

65. Ms Northcott outlined a number of changes which occurred after Kathryn's death.

66. These included that the Department undertook a review of all Health and Wellbeing records for every resident at the St James Street residence and an 'Improvement Action Plan' was implemented on 11 May 2018. Also following receipt of the DCS Notices to Take Action, the Department worked with Home@Scope to address the concerns raised and implemented a number of improvement actions, including ensuring that,

   - staff are provided training about active supervision and their duty of care obligations in relation to the management of mealtime safety; and
   - residents requiring one-on-one support at mealtime are not left unattended, or under the supervision of staff assisting more than one resident.

67. Each staff member also attended training which focused on safe mealtime supports, which included reducing the risk of choking,

noting that people with an intellectual disability are more likely to choke on food and drink than the general population. This covered critical issues such as the alertness of the resident before eating, following the meal plan, ensuring food is of the right texture, ensuring that food is consumed in small mouthfuls and residents sit upright when eating and the importance of monitoring throughout the eating process.

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The importance of one to one support with the resident was also discussed and emphasised with the staff team to ensure that no resident is left unattended during meal times.

68. Reference was made to further statewide improvements noting the NDIS transition and the NDIS Code of Conduct which includes a requirement to take all reasonable steps to prevent and respond to all instances of violence, exploitation, abuse and neglect of people with disability.

69. The Department also undertook and participated in a number of activities in conjunction with other agencies which concerned improving safer eating practices for persons with disability, such as the development of an e-learning package for disability support workers.

70. I note that there is a range of material and supports in this area including the development of the DSC Safe Mealtimes Poster dated 15 September 2020 and the NDIS Quality and Safeguards Commission, *Dysphagia, safe swallowing, and mealtime management* Practice Alert dated November 2020.

71. Importantly the Safety Alert highlights a number of steps to provide safe and competent supports to people with dysphagia to reduce the risks of choking or aspiration pneumonia (noting that every person will have different support needs for their dysphagia) including, ensure staff know dysphagia symptoms and risks; support participants with possible swallowing difficulties to be assessed for dysphagia; support participants with dysphagia to have a mealtime management plan; support people with dysphagia to eat and drink safely during mealtimes; ensure mealtime management plans are regularly reviewed and ensure medications are regularly reviewed.

FINDINGS AND CONCLUSION

72. Having investigated the death of Kathryn O'Rourke and having held an inquest in relation to her death on 21 June 2021, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the Deceased is Kathryn O'Rourke, born on 18 March 1970;

    (b) Kathryn died on 16 May 2018 at the Dandenong Hospital, 135 David Street, Dandenong, Victoria from *1(a) Hypoxic/Ischaemic Encephalopathy, 1(b) Aspiration of Food with Respiratory Arrest* with *Contributing Factors – Intellectual Disability*; and

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

73. I convey my sincere condolences to Kathryn's parents for their loss and I acknowledge the tragic circumstances in which her death occurred.

74. Mrs O'Rourke expressed the following words at the inquest on behalf of the family,

It has been a long and emotional three years. Kathryn's passing has helped make changes for clients in CRUs with better support at meal times. With us donating Kathryn's organs and tissues, the recipients now have a better life and Kathryn lives on through them.

We are very proud of our baby girl. Kathryn's life did matter.

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

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

Mr Peter & Mrs Claudia O'Rourke, senior next of kin

Department of Health and Human Services

Monash Medical Centre

Leading Senior Constable Allie Goff, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

Date: 30 June 2021

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 investigation. 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.