IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003021

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of John Kamps

Delivered On:	16 March 2022
Delivered At:	65 Kavanagh Street, Southbank, Victoria
Hearing Dates:	16 March 2022
Findings of:	Coroner John Olle
Representation:	Kellie Dell'Oro of Meridian Lawyers for the Speech Pathologist. Peter Ryan for Monash Health.
Coroner's Assistant:	Leading Senior Constable Dani Lord (PCSU)

I, John Olle, having investigated the death of John Kamps, and having held an inquest in relation to this death on 16/03/22

at 65 Kavanagh Street, Southbank

find that the identity of the deceased was John Kamps born on 11/06/1956

and the death occurred on 14/06/2019

at Dandenong Hospital, Dandenong, 3175.

from:

1a: Hypoxic ischaemic encephalopathy complicating acute upper airway obstructions by food bolus.

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:[1]

1. John Anthony Kamps **(John)** was born on 11 June 1956, the second child of John and Elisabeth Kamps. John had one older sister named Betty and two younger sisters named Anita and Wendy. In his early life, John lived with his family in the Mornington area.

2. At approximately two and a half years of age John began having epileptic seizures and was later diagnosed with a moderately severe intellectual disability. John was autistic, non-verbal, lived with anxiety, and was diagnosed with diabetes later in his life.

3. When John was 11 years, his family made the difficult decision to place him in full time care. John was first placed in Kew cottages and was cared for and resided there for 35 years.

4. In 2002 when Kew Cottages were closed, John moved into a group home at 22 Rutherglen Street in Noble Park. The home was run by the Department of Health and Human Services **(DHHS),** and John lived at the address with four other male residents who also received full time care from the staff on site.

[1] This summary is informed by that read in open court by Leading Senior Constable Dani Lord on 16 March 2022.

5. John was reported to have been content with his living situation and his family were grateful for the continued efforts and care by the staff at the Rutherglen Street home. During the day, John would participate in activities in the community through SCOPE.

6. Importantly there were two meal plans, as explained by the supervisor, which caused staff confusion.[2] While John was able to eat independently, he had swallowing difficulties, and a propensity to eat and drink very fast putting him at risk of choking. On occasion, John would also take food from other residents and so staff needed to supervise him during mealtimes and would need to tell him to eat slowly.

7. John was assessed by a Speech Pathologist, **("the Speech Pathologist"**) on 21 November 2018 at the Rutherglen Street home. The Speech Pathologist summarised John as 'presenting with mild oro-pharyngeal dysphagia, characterised by reduced lip seal with anterior spillage on regular fluids, rapid rate of intake, oral residue, and signs of penetration and/or aspiration with a regular diet'. The Speech Pathologist recommended that John eat a soft, cut-up diet (Texture A) and prepared a mealtime plan for him.

8. Materials provided to staff providing guidance on 'Texture A' preparation included reference to '*solid* foods'[3] which can be broken down. There were other references which described 'Texture A - soft diet' as 'Consistency to be soft, easily broken up with a fork. No hard pieces, all food should be cut into no larger than 2cm pieces.' John also had a 'sipper cup' to assist in the control of fluids when he drank.

9. John's mealtime plan prepared by the Speech Pathologist was accessible to staff in his file and was also displayed in the Rutherglen Street home's kitchen.

10. On Saturday 8 June 2019, the residents at Rutherglen Street were being cared for by two staff on duty at the home, Disability Support Workers who will be identified in this Finding as **Carer A** and **Carer B**. Also at the home that day was Supervisor, **CT**. CT did not normally work at the location but was filling in as a supervisor and completing paperwork in the office. The Rutherglen Street home was preparing for a change of management in the following weeks from DHHS to Home@Scope.

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[2] Statement provided by Supervisor.
[3] *Coronial Brief* p89-1.

11. At approximately 9.30am, John had woken and was in the dining area with the other residents ready for breakfast. Carer B states that Carer A told her because it was the weekend the residents could have a treat and have toast for breakfast. Carer A prepared John's breakfast and handed John small pieces of toast for him to consume.[4]

12. While eating the toast, John has begun to cough, and Carer A encouraged him to 'slow down'. She then obtained water from the kitchen but on her return John's condition was worsening. John refused the water, became agitated, and started walking around the room. Carer B noted John's lips were turning blue and she said that she thought John was choking. Carer A began back blows to John, without any success clearing his airway.

13. TC was called from the office to assist, and as they prepared to lay John on the floor, he began to collapse and lose consciousness. Carer B called 000 and the call taker gave instructions for staff to begin CPR. All three members of staff then began CPR and an attempt was made by Carer A to clear John's mouth and airway, again without success.

14. Mobile Intensive Care Ambulance (MICA) paramedic Gregory Nicholls described observing and removing a large amount of 'masticated toast'. He described it as having completely obstructed John's airway but proved difficult to remove as it was breaking apart.

15. John was then conveyed to the Dandenong Hospital at 10.46am.

16. On arrival at Dandenong Hospital, John was admitted to the Intensive Care Unit (ICU) where he was placed on life support. Several tests were conducted which showed John had sustained a severe hypoxic brain injury and that there were no signs of neurological recovery.

17. Life support was withdrawn and John died at the Dandenong Hospital on 14 June 2019 at 9.15am. John's family consented to organ donation and John was then conveyed to the Victorian Institute for Forensic Medicine (VIFM).

[4] *Coronial Brief,* Statement of CT, p22.

CORONIAL INVESTIGATION

Jurisdiction

18. John's death constituted a *'reportable death'* pursuant to section 4 of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and immediately before his death, John was a person placed in care, as defined in the Coroners Act.

Purpose of the Coronial Jurisdiction

19. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

20. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

21. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

22. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

23. Coroners are empowered to:

    (a) report to the Attorney-General on a death;

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

[5] Section 89(4) *Coroners Act 2008.*

(c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

These powers are the vehicles by which the prevention role may be advanced.

24. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[6] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7]

25. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or mere background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behavior or a recognised duty. If that were not the case many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common-sense basis they have not contributed to death.

26. When assessing the actions of a professional person regard must be had to the prevailing standards of his or her profession or specialty. For example, it would be unfair and unreasonable to expect a nurse to have the same skills and knowledge as an emergency-medicine physician.

27. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person has acted appropriately. This is particularly important in this case because there might otherwise have been a temptation to impermissibly reason that because John died the care was necessarily flawed. I am conscious of the need to judge

[6] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[7] *Keown v Khan* (1999) 1 VR 69.

the actions of all involved prospectively, having regard to the information then known to them.

Standard of Proof

28. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[8] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[9]

29. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[10] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

30. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[11] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[12]

Coronial Inquest

31. Section 52(2)(b) of the Coroners Act provides that a coroner must hold an inquest into a death if the death occurred in Victoria and the deceased was, immediately before death, a person placed in care.

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[8] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[9] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mson CJ, Brennan, Deane and Gaudron JJ.
[10] (1938) 60 CLR 336.
[11] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

32. The inquest proceeded on 16 March 2022, with interested parties appearing via Webex and Coroner's Assistant, Leading Senior Constable Dani Lord, appearing in person.

IDENTITY OF DECEASED

33. On 13 June 2019, John Kamps was visually identified by his sister, Anita Mundy. John's identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

34. On 17 June 2019, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine performed an external examination on the body of John Kamps. Dr Lynch provided a written report of his findings dated 17 June 2019.
35. The post-mortem examination was essentially consistent with the history recorded, being cardiac arrest following choking on food. John Kamps sustained significant hypoxic brain injury and later died in hospital after showing no significant neurological recovery.
36. Toxicological analysis of post-mortem specimens were consistent with medical interventions.
37. Dr Lynch concluded the cause of death to be Hypoxic Ischaemic Encephalopathy Complicating Acute Upper Airway Obstruction by Food Bolus.
38. I accept and adopt Dr Lynch's opinion as to the medical cause of death.

CORONIAL INQUEST

39. In preparation for my findings at this inquest, I have considered the matters in the context which follows.

Relevant issues arising from the Coronial Investigation

40. Police had been notified of the initial choking incident at Rutherglen Street and Senior Constable Pigdon attended the Dandenong Hospital and began an investigation on my behalf. DHHS also conducted an internal investigation into the incident.

41. Carer A provided a statement to Police, in which she maintained that she had prepared food in accordance with John's mealtime plan. She stated she had given him Coles Multigrain bread that was frozen but warmed up in the toaster. The evidence of Carer B described the meal provided to John as 'toast'. CT recalled seeing toast on the plate where John had been sitting and described it as having been cut into small pieces. Paramedic Nicholls described removing large amounts of masticated toast, completely obstructing John's airway.

42. I find that Carer A did prepare toast for John's breakfast, albeit cut into small pieces. Further, I am satisfied he remained under the direct supervision of Carer A. Sadly, John commenced to consume the toast very fast and despite Carer A's best endeavours, he commenced to choke. Carer B overheard Carer A imploring John to slow down.

43. There is also no suggestion that the mealtime plan prepared by the Speech Pathologist was in any respect lacking or incorrect in her interpretation of Texture A soft food diet, pursuant to the Australian Standard food descriptions, and templates utilised by the Speech Pathology industry at the time of John's assessment. The Speech Pathologist's descriptions of a soft food diet for John were consistent with available definitions at the time and there were no definitive lists available to her, or care staff, describing food that fell specifically within or were excluded from the 'Texture A' definition.

44. My investigation has however, revealed that the definition of 'Soft food diet – Texture A' used in the sector at the time, inadvertently caused Rutherglen Street staff confusion as to what John could be fed and as to whether toast and bread was appropriate for John. The records reveal that although John had been served bread, sandwiches, and toast on previous occasions, staff remained confused. I note without criticism of the specialists involved, John's mealtime plans did not specifically exclude toast or bread.

45. The Acting House Supervisor of the Rutherglen Street residence at the time provided evidence of staff confusion prior to John's death. And, that staff had sought clarification from the department and engaged a Nutritionist to conduct a review.[13] There was also a

[13] *Coronial Brief,* Statement of Acting House Supervisor, p129.

view expressed by another staff member that there was no clear definition of 'Texture A' and that it was 'perhaps assumed that the staff knew' [14]what foods were suitable.

46. It transpires that staff confusion in respect to Texture A foods, was not unique to staff at Rutherglen Street. Indeed, the confusion was subsequently identified across the sector.

47. The Department of Families, Fairness and Housing **(DFFH, formally DHHS)** detailed their participation in roundtable discussions convened by the Disability Services Commissioner in late 2019 after John's death. These discussions were in response to the prevalence of choking and aspiration pneumonia as causes of death in people with disability, and long-term systemic issues, particularly in group home settings.

48. The resulting report 'Influencing Mealtime Supports in Disability Services' references minutes of a subgroup where there was discussion around implementing a practise standard for mealtime supports in disability services. In discussing potential implementation of any new standardised description of food textures and modified diets, minutes noted that this would require a coordinated effort as 'support staff often have difficulty understanding current texture descriptions.'

49. Shortly after the choking incident involving John, DHHS management of the Rutherglen Street home was transferred to Home@Scope. DHHS advise that they continued their review of the circumstances. Following this, several issues were addressed and changes implemented by DHHS, incoming Home@Scope management and through the sector:

    (a) The Departments Nutrition and Dietetics adviser, Sue Gebert, attended the Rutherglen Street home and assessed all the other residents to ensure their safety, and meal plans were reviewed by a Speech Pathologist in 2019.

    (b) A Home@Scope team was formed to focus on mealtime supports, provide advice and support for house supervisors, urgent dysphagia assessments and interim mealtime plans if required. Oversight and delivery of mealtime training for Home@Scope staff was also provided.

[14] Statement of former House Supervisor.

(c) A Scope 'Mealtime Assistance Support Guide' was developed in line with NDIS practise standards, and a section on choking first aid included. The guide was implemented organisation wide.

(d) Staff training now includes Mealtime Level 1 online training for all staff, on-the-job multi day induction for all new staff, and Mealtime Level 2 face to face training for staff involved in any adverse mealtime events.

(e) Personal Development Sessions (PDS) have been implemented by Home@Scope, consisting of a monthly one on one meeting between staff and house supervisors to identify any training needs and professional development required.

(f) Issues arising at group homes are now addressed by the forming of an 'Issue Response Group' (Consisting of a Manager, Operations Manager, and the relevant business partner). A 'Risk Register' is also now maintained.

(g) Disability Services Commissioners (in consultation with DFFH) posters on Safe Mealtimes are also clearly displayed in group homes.

(h) New training for staff and providers called 'Co-creating Safe and Enjoyable Meals'; delivered by the University of Technology Sydney and funded by DFFH as part of a broader project funded under the NDIS Quality and Safeguards Commission. This has the aim of reducing the incidence of choking, hospitalisation, and preventable deaths in people with disabilities in care. This is a new standard of training specific to the issues around choking incidents and has been delivered to direct support workers.[15]

50. Most significantly, in respect to staff comprehension of food texture description, Home@Scope advises that the Scope group has addressed the matter by implementing the International Dysphagia Diet Standardisation Initiative **(IDDSI)**, This standard is now being used in all training, mealtime plans as well as policies and procedures at Scope. The transition from the previous Australian Standards to IDDSI was undertaken from the

[15] DFFH advised the Court that this training commenced in April 2021 and was delivered to direct support workers from five transfer providers through to September 2021 with a total of 101 staff having received the training. In March 2022, those training resources were made available online to all disability service providers, officially to be launched in April 2022.

beginning of 2020, and updates have been provided to staff across the organisation throughout this process.

51. I am informed the IDDSI is an effort to standardise descriptions of food textures and modified diets, and to align providers and practitioners to international standards of food description. The Speech Pathologist notes in her statement that since its release in 2019, IDDSI is now endorsed as best practise by Speech Pathology Australia.

52. The IDDSI descriptions of food texture and consistency would appear much clearer, and there is not the level of 'interpretation' of textures and plans required in the previously used Australian Standard. The IDDSI framework utilises more quantifiable food tests, audit methods and guidance for staff to enable them to ascertain whether any type of food is suitable and fits the diet level recommended for the resident.

53. There are numerous educational resources - videos, handouts, posters, audit/food test guides and a dedicated phone app, which can be sourced by families, staff, carers, speech pathologists, and managers at any time on the relevant website. This enables care givers and supervisor's immediate access to guidance, and a practical way to address any confusion or uncertainty.

54. Of note, within the IDDSI – the closest equivalent of Texture A, IDDSI Level 6 - 'soft and bite size', is very clear on the exclusion of bread, toast and sandwiches. It also highlights the risk that these pose to a person on this level of diet.

55. John's death is particularly distressing for his family, those who provided advice on his care, and for the dedicated staff who cared for and were involved in this incident. It's accepted that on this occasion staff and care givers were providing the best level of care that they were able within the plans and framework being utilised at the time.

56. I consider the key learning from this tragic event is found in the significant efforts it has brought about to assist staff, by removing confusion in respect to the definition of Texture A food.

57. I applaud Home@Scope's embracing the clearer IDDSI food description standard and the other organisational and systemic changes made in the sector since this tragic event.

COMMENTS

I make the following comments connected with the death under section 67(3) of the Act:

58. John's death represents a category of case where the death, though preventable, does not owe to a failure of any of the institutions nor people involved in John's care.

59. I acknowledge the commitment and effort evident in the care John received throughout his life, particularly during his time at the Rutherglen Street House. It is significant that John's family have expressed their appreciation for the care John received.

60. Further, the evidence before me suggests there was nothing wanting in the Speech Pathologist's service to John and that she provided a definition of the appropriate food texture in the orthodox format at the time.

61. Nonetheless the investigation into John's death has highlighted that improvements can and have been made. The definition 'Texture A' Standard was nebulous and the evidence is that this caused confusion amongst the staff about the fundamental principles of John's soft food diet.

62. I am encouraged by the introduction of the IDDSI in Home@Scope facilities and my expectation is that this will provide significantly more practical guidelines for carers on food texture standards in the future.

I order that this finding be published on the Internet.

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

Anita Mundy, Senior Next of Kin

Department of Families, Fairness and Housing (DFFH)

Legal Representative for the Speech Pathologist

Monash Health

Donatelife Victoria

Coroner John Olle
Date: 16 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.