IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001079

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF RODGER BATCHELOR

Deceased:	Rodger David Batchelor
Delivered on:	18 February 2022
Hearing Date:	18 February 2022
Delivered at:	65 Kavanagh Street Southbank Victoria 3006
Findings of:	Coroner Simon McGregor
Assistant to the Coroner:	Nicholas La Mattina

Representation:	Danielle Corden, solicitor, K&L Gates for WHHS

INTRODUCTION

1. Roger David Batchelor was a 57-year-old man who had been living in supported residential care in Nhill for the last 20 years. Mr Batchelor enjoyed keeping busy by doing volunteer work at the local health service and gardening. He enjoyed watching movies, listening to country music and going on outings. He was a member of the Richmond Football Club and enjoyed watching his team play.

2. Following a choking incident on the morning of 26 February 2021, Mr Batchelor was hospitalised on life support at Ballarat Base Hospital.

3. In the days that followed, his condition did not improve. There was a neurological determination of brain death on both 27 and 28 February 2021. On 1 March 2021, his organs were donated for the benefit of others in need and life support was removed, following discussions with his family.

THE CORONIAL INVESTIGATION

4. Roger'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Roger's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Roger David Batchelor including evidence contained in the coronial brief. 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.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

9. Mr Batchelor was second-born child to parents David and Lynette.[2] Together with his two siblings – older sister Karen and younger brother Andrew – he was raised in the South Australian township of Wolseley.

10. Although born a physically healthy child, Mr Batchelor began suffering convulsions at the age of three or four and was diagnosed with an intellectual disability.[3] He required support to undertake daily living and some personal care activities.[4]

11. When he was about 12 years of age, the family relocated to Bordertown, South Australia.[5] David and Lynette continued to care for Mr Batchelor at their new home, but he would commute to Nhill by bus to attend day activities with Cooinda Disability Services (**Cooinda**). Initially a standalone disability service organisation, Cooinda merged with West Wimmera Health Service (**WWHS**) in 1999 and is now a site operated by WWHS. Over a period of ultimately about 50 years, Mr Batchelor received community-based social support and development activities through that service.

12. As he grew older, it became easier for Mr Batchelor to live in Nhill. So, once disability supported residential care became available (in about 2001), he moved into 4 Thomas Street, where he remained since.[6] The accommodation initially was managed by the Department of

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[1] 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.
[2] Statement of Andrew Batchelor.
[3] Statement of Andrew Batchelor.
[4] Statement of Jacqui McCowan, Acting General Manager Outcomes, Melba Support Services.
[5] Statement of Andrew Batchelor.
[6] Statement of Andrew Batchelor.

Human Services (which later became the Department of Health and Human Services) until 18 August 2019, when the disability residential service was transferred to Melba Support Services (**Melba**).[7]

13. Mr Batchelor lived at 4 Thomas Street with three other National Disability Insurance Scheme (**NDIS**) participants.[8] He did, however, have his own unit detached from the main disability residential house, which included his own bathroom and bedroom/living area.[9] He accessed food and meals prepared by staff in the main disability residential house on the property.

14. Mr Batchelor also regularly stayed with his brother in Bordertown – every third weekend or so, as well as on family occasions (such as Christmas).[10]

Mr Batchelor's eating difficulties

15. Since about the age of 30, he began using dentures as a result of losing his own teeth due to poor dental hygiene. He did, however, appear to have difficulty with these and the way they fitted him.[11]

16. Mr Batchelor also had a history of reduced self-regulation as to the amount of food/drink taken in a mouthful; a tendency to eat quickly and not chew his food adequately; and a history of choking.

Establishment of choking management plan

17. In 2009, Mr Batchelor attended general practitioner Dr Gerald O'Brien following an episode of choking.[12] He was referred for, and (in December that year) underwent, a gastroscopy to assess possible causes for the history of choking.[13] The gastroscopy revealed a hiatus hernia, which was noted as capable of causing restrictions of the throat due to reflux.[14] The gastroscopy otherwise revealed no oesophageal pathology.[15]

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[7] Statement of Jacqui McCowan.
[8] Statements of Alexandra Hall, Executive Director, Community Health, West Wimmera Health Service.
[9] Statement of Jacqui McCowan.
[10] Statement of Andrew Batchelor.
[11] Statement of Andrew Batchelor.
[12] Statement of Dr Gerald O'Brien.
[13] Health Care Plan – Choking, Department of Human Services.
[14] Health Care Plan – Choking, Department of Human Services.
[15] Statement of Dr Gerald O'Brien.

18. Consequently, a management plan was devised with three recommendations made by Dr O'Brien. Those recommendations were as follows:[16]

    (a) Somac tablet (40 mg) nightly;

    (b) Staff to ensure that Mr Batchelor cuts food into small pieces to reduce the risk of choking;

    (c) Staff to encourage Mr Batchelor to slow down when eating and to chew prior to swallowing his food.

19. The management plan was to be reviewed annually, or as required, with the first review to be 12 April 2011.

Review of choking risks by GP

20. On 18 September 2018, Mr Batchelor was reviewed by Dr O'Brien in response to concerns raised by staff at Melba Support Services following two incidences of Mr Batchelor choking while eating apples. An updated management plan was devised.[17] In addition to the earlier recommendations, it added that staff encourage Mr Batchelor to finish eating before speaking, monitor him when eating and grate apples to reduce risk of choking.

21. In accordance with the management plan, Mr Batchelor again was reviewed by Dr O'Brien the following year, on 2 September 2019.[18]

First review by speech pathologist at WWHS [19]

22. On 24 May 2019, Mr Batchelor was seen for swallow assessment by speech pathologist Yingying He of the Speech Pathology Department at WWHS upon referral from Dr O'Brien. Ms He noted concerns raised by staff at both Thomas Street and Cooinda regarding Mr Batchelor's ability to self-monitor his bolus size and chew adequately, and tendency to be easily distracted at mealtimes.

[16] Statement of Dr Gerald O'Brien.
[17] See Specific Health Management Plan for Choking for review conducted 18 September 2018.
[18] See Specific Health Management Plan for Choking, dated 28 September 2019.
[19] See West Wimmera Health Service Feedback Report, dated 21 June 2019.

23. Mr Batchelor was independent with set-up and feeding. He had mild oral dysphagia characterised by inadequate bolus preparation when larger mouthfuls were taken, but appeared more cautious when observed at the dining table.

24. Ms He recommended unmodified solids (ensuring food is not tough or dry), regular fluids, assistance with cutting food, and supervision at mealtimes (including intermittent reminders to take small mouthfuls and slow down oral intake).

Second review by speech pathologist at WWHS [20]

25. On 10 June 2020, Mr Batchelor again was reviewed by Ms He for communication and swallow assessment upon referral from Lynette Morrow, Support Coordinator, Just Better Care Western Victoria.

26. In respect of his swallow, Mr Batchelor again was considered independent with set-up and feeding. No oropharyngeal dysphagia was observed.

27. Save for adding that Mr Batchelor required ongoing support from staff and communication partners to maintain conversation topics, Ms He's recommendations otherwise remained unchanged.

Dental review

28. On 17 February 2021, Mr Batchelor attended a dental review at Wimmera Dental Clinic, whereat his dentures were realigned.[21] The next review was to be 12 months later.

Events of February 2021

29. As part of his NDIS program, Mr Batchelor participated in 5-6 hours of social support services with WWHS on up to five days each week.[22] This usually consisted of attending a group activity program (the Cooinda Day Activities Program in Nhill) with other NDIS participants. The activities included leisure and skills-development activities, such as art and craft, walks and outings, cooking, movies and games. The NDIS program also included 1-2 days of volunteering in WWHS's stores department, on which days Mr Batchelor did not attend the group activity program.

[20] See West Wimmera Health Service Feedback Report, dated 22 June 2020.
[21] Statement of Jacqui McCowan, Acting General Manager Operations, Melba Support Services.
[22] Statement of Alexandra Hall.

30. On 26 February 2021, Mr Batchelor attended the Cooinda Day Activities Program. The program ran from about 9:30 a.m. to 3:00 p.m. Three support workers were on duty that day: Joanne Hampson (from 9:30 a.m. to 3:00 p.m.), Bridget Gundry (from 9:30 a.m. to 10:30 a.m.) and Rickie Chequer (from 10:30 a.m. to 3:30 p.m.).

31. Mr Batchelor spent the first part of the morning going for a walk with the five other NDIS participants and playing a boardgame until it was time for morning tea when Ms Chequer arrived at about 10:30 a.m.[23] At that time, he went to the bathroom to wash his hands and returned with his morning tea brought from home, which he had collected from his locker. The food selection was not checked by WWHS staff independently to ensure its suitability prior to consumption.[24] He then took it to the dining room and began eating, all while the other participants were still using the bathroom.

32. Having then finished supervising the participants in the bathroom area, one of the support workers (Ms Hampson) went into the office to complete the mandatory security check-in.[25] Meanwhile, the other two support workers were in the hallway at the entrance to the dining room completing an informal handover while supervising the participants eating in the dining room.[26] Most of the participants were in clear view from the dining room entrance; however, Mr Batchelor was just out of direct line of sight due to the position of his table and the direction he was facing (i.e. away from the hallway).[27]

33. As the first support worker was emerging from the office, just after 10:30 a.m., Mr Batchelor had stood up from his chair and was walking towards the kitchen area, clutching his throat.[28] He was not coughing and did not appear in any obvious distress.[29] It did become apparent, however, that he was choking and he was met at the kitchen sink by the three support workers.

34. The support workers began administering choking first aid, striking Mr Batchelor's back to try to dislodge the food, while Mr Batchelor also attempted to remove his dentures and make himself sick. These attempts proved unsuccessful, for he collapsed and was lowered to the floor and placed on his side.[30] He was unresponsive.[31]

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[23] Statement of Joanne Hampson.
[24] Statement of Alexandra Hall.
[25] Statement of Joanne Hampson.
[26] Statements of Alexandra Hall and Joanne Hampson.
[27] Statement of Alexandra Hall.
[28] Statement of Joanne Hampson.
[29] Statement of Alexandra Hall.
[30] Statements of Alexandra Hall and Joanna Hampson.
[31] Statement of Constable Leigh Ashmore.

35. Further back-hits were administered and attempts at resuscitation were commenced under the guidance of the triple-zero operator.[32]

36. When paramedics arrived at 10:55 a.m., Mr Batchelor was blue in colour, not breathing and without a pulse.[33] They continued attempts at resuscitation and removed what appeared to be a large piece of orange obstructing the upper airway (glottis) using Magill forceps. Once removed, the remainder of the airway was clear and Mr Batchelor was intubated. He had been without oxygen for appropriately 25 minutes, but there was return of spontaneous circulation. He had a Glasgow Coma Score of 3/15, and his pupils remained fixed and dilated throughout.

37. Once stable, at 12:39 p.m., he was transported to Nhill Airport and, at 1:35 p.m., airlifted to Ballarat Base Hospital, where he was admitted to the intensive care unit.[34] Mr Batchelor did not improve neurologically and his Glasgow Coma Score remained at 3/15.

Condition in hospital

38. Upon arrival, Mr Batchelor was sedated and placed on life support. Although a CT scan showed no intracranial abnormalities,[35] Mr Batchelor's condition did not improve.

39. At about 8:30 a.m. the following day (Saturday 27 February 2021), Mr Batchelor became hypertensive (180/90) and his pupils were non-reactive. Examination over the course of the day revealed that pupils remained dilated and non-reactive, and the absence of gag and cough reflexes. There was no response to stimuli.

40. At 5:58 p.m. that afternoon, then again at 7:51 a.m. on Sunday 28 February 2021, there was neurological determination of brain death. However, Mr Batchelor remained on life support until the following day, Monday 1 March 2021, for donation of his organs to assist others in need.[36]

[32] Statement of Joanne Hampson.
[33] Patient Care Record, Ambulance Victoria.
[34] Statement of Alexandra Hall.
[35] Statement of Constable Leigh Ashmore.
[36] Statement of Andrew Batchelor.

Review of systems and work practices at WWHS

41. Although he had experienced prior instances of choking, this was the first such incident that Mr Batchelor had experienced at WWHS.[37] WWHS also was not aware of any prior issues with food that Mr Batchelor had brought with him to the Cooinda Day Activities Program.

NDIS certification audit

42. WWHS underwent an NDIS certification audit on 1 and 2 February 2021 regarding its community-based services (which include the day activities program) and on 5 March 2021 regarding residential aged care.[38] The audit identified that WWHS had well-established systems and processes in place to support the provision of services to NDIS participants, and the auditors considered WWHS to meet all assessed standards. The auditors concluded that WWHS's systems and processes had been established for delivery of high-intensity daily personal activities to NDIS participants and was well supported by WWHS's clinical framework and practices.

43. That notwithstanding, following the incident, WWHS identified areas for improvement in the care provided to Mr Batchelor and has undertaken preventative steps to ensure the risk of any similar incident in the future is as low as it reasonably can be.

Support plan process and information sharing

44. All participants attending the Cooinda Day Activities Program have an annually reviewed 'Support Plan' document that is kept on file and alerts staff to key issues to be mindful of when caring for that participant.[39]

45. At the time of the incident, there was an expectation that, where a participant had swallowing difficulties and a choking management plan was in place, the participant's support plan would address those swallowing difficulties and the steps for staff to manage those risks.

46. Mr Batchelor's support plan for 2021-22 was established on 21 January 2021 and had been updated as required since 2014. Although a copy of his choking management plan (devised by Dr O'Brien in September 2018) was provided to WWHS by the accommodation provider and kept on file, it was not addressed specifically in his support plan.

[37] Statement of Alexandra Hall.
[38] Statement of Alexandra Hall.
[39] Statement of Alexandra Hall.

47. Further, WWHS was reliant upon the accommodation provider supplying any updated health assessments. For example, although WWHS is an integrated health service, at the time of Mr Batchelor's incident, there was no system to ensure that information was always shared between the various services (acute, aged care, allied health and NDIS and home care services). Therefore, although Mr Batchelor subsequently had undergone speech pathology assessments with the speech pathologist at WWHS in May 2019 and June 2020, these were sent to the referrer (Dr O'Brien and Ms Morrow, respectively) and copied to the accommodation provider. They were not available to, or accessible by, staff at the Cooinda Day Activities Program. This, however, is no longer WWHS's practice.

48. Following Mr Batchelor's incident, WWHS now is ensuring that support plans are updated every time there is a significant change to the needs of a participant, rather than upon annual review only. For example, creation of a choking management plan or swallowing assessment now would trigger review of a support plan. Its policies having been amended, WWHS proactively seeks out any updated assessments as part of the annual review process. Further, all WWHS allied health staff have been directed to forward any reports relating to NDIS participants to the program manager to ensure (a) that they are added to the participant's file; and (b) that any required updates to the participant's support plan and staff task instructions are actioned.

49. WWHS has reviewed the support plans of all NDIS group activity participants to ensure all recommendations from medical and allied health assessments are included and associated staff guidelines are clearly stated.

50. WWHS is also phasing out the use of physical participant files in favour of the electronic client file management system (Home Care Manager). As such, there are now alerts to staff as to any health and safety issues for participants on as well as for the annual review of support plans.

Client risk information sheet

51. WWHS has developed a 'client risk information sheet' for each participant who attends the Cooinda Day Activities Program to be used in addition to the support plan. It serves as an additional reference tool that clearly highlights any particular needs or risks for a participant. For example, it may alert staff of the need to sit with a participant whilst they are eating, check the food brought with them to ensure its appropriateness, or cut up their food.

Review of disability services provided by Melba Support Services

52. On 3 March 2021, Melba Support Services conducted a review of the disability services provided to Mr Batchelor at the time of his death. The review, completed 6 April 2021, identified two shortcomings:

    (a) Staff did not notify Victoria Police of Mr Batchelor's death. Additionally, that omission was inconsistent with the organisation's policy and procedure upon the death of a resident.

    (b) Mr Batchelor had a mental health care plan and was prescribed *pro re nata* (PRN) medication for chemical restraint; however, that medication was not noted in all relevant documentation. There was also no behaviour support plan developed for him and there were no reporting arrangements in place for the medication.

53. In the review, Melba Support Services identified what actions would be taken to remedy these shortcomings into the future. It indicated that:

    (a) a specific delegate would be tasked with reporting deaths to Victoria Police to ensure that that notification occurs;

    (b) all chemical restraint (including PRN) medication would be listed on residents' mental health care plans; and

    (c) all mental health care plans would be reviewed to confirm whether a behaviour support plan is needed and, if so, to ensure one is completed by an NDIS registered behaviour support practitioner.

Identity of the deceased

54. On 28 February 2021, Mr Batchelor, born 16 May 1963, was visually identified by the House Supervisor at 4 Thomas Street, Ms. Dianna Corsi.

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

Medical cause of death

56. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an examination of Mr Batchelor on 3 March 2021 and provided a written report of her findings dated 5 March 2021.

57. A post-mortem CT scan showed cerebral oedema and pseudosubarachnoid haemorrhage.

58. Dr Baber concluded that a reasonable cause of death was hypoxic ischaemic encephalopathy secondary to prolonged downtime due to upper airway obstruction.

59. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

60. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Roger David Batchelor, born 16 May 1963;

    b) the death occurred on 28 February 2021 at Ballarat Health Services Ballarat Base Hospital, 1 Drummond Street, Ballarat North, Victoria, 3350, from HYPOXIC ISCHAEMIC ENCEPHALOPATHY; and

    c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

61. Mr Batchelor's care was reasonable and appropriate for a person in his circumstances.

62. WWHS is to be commended for nonetheless taking the opportunity to improve their systems and practices in line with the NDIS certification audit, and having had the opportunity to review that acquittal, I am satisfied that they have taken reasonable measures aimed at reducing the risk of repetition of an event such as this.

63. I am also satisfied, that whilst Melba Support Services identified ways in which the care they provided to Mr Batchelor could have been improved, these areas for improvement did not cause or contribute to Mr Batchelor's death. Melba Support Services have nonetheless implemented responsive measures that will benefit the comfort, safety and dignity of other persons they provide care to, and they are to be commended for this.

I convey my sincere condolences to Mr Batchelor's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Andrew Batchelor, Senior Next of Kin

Darren Welsh, WWHS

Constable Leigh Ashmore, Coroner's Investigator

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 18 February 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 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.