IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 2618

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**DARREN J. BRACKEN, CORONER**
Deceased:	**STUART ANTHONY WILLS**
Delivered on:	1 October 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	15 July 2020
Counsel assisting the Coroner:	Senior Constable Jeffrey Dart
Appearances:	Ms Pilipasidis appeared on behalf of Calvin Wills Mr R. Harper Appeared on behalf of Yooralla Ms F. Ellis appeared on behalf of Independence Australia and David Moncrieff
Catchwords:	In care, choking, food bolus, Yooralla, Department of Health and Human Services

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HIS HONOUR:

INTRODUCTION

1. On 20 May 2014, Stuart Anthony Wills was 45 years old when he died at Footscray Hospital. At the time of his death, Mr Wills resided in a supported accommodation facility in Alfrieda Street, St Albans, managed by the Yooralla Society of Victoria. Mr Wills moved to the facility approximately five years prior to his death.

2. The Yooralla Alfrieda Street facility has capacity to accommodate a maximum of five clients with complex physical needs. Staff at the facility are required to undertake manual handling due to the high-level care required by all residents with their activities of daily living. At the time of Mr Wills' death, the Alfrieda Street facility was not at capacity and Mr Wills was one of three residents.[1]

BACKGROUND

3. Mr Wills' medical history included cerebral palsy, Charcot Marie Tooth syndrome (a degenerative neurological condition) and an associated intellectual disability. Mr Wills was non-verbal and required full assistance with personal care and mobility, and for transfers to and from his bed.[2]

4. Mr Wills was supported to attend day placement programs with Scope on Mondays and Fridays each week. At the time of his death, there was a plan to increase his individual support package funding so that he could be supported in the community on a daily basis.[3]

5. Due to difficulties associated with swallowing, Mr Wills received one-on-one assistance with his meals and was spoon-fed. The specifics of Mr Wills feeding regime in respect of the necessary consistency of food will be explored further in this finding, save to say that Mr Wills was unable to eat solid food and gravy was often added to his meals to moisten them and make food easier for him swallow.[4]

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[1] Statement of Preet Kiran dated 22 August 2014.
[2] Statement of Bonnie Miliankos dated 19 August 2014.
[3] Statement of Preet Kiran dated 22 August 2014.
[4] Statement of Preet Kiran dated 22 August 2014.

6. According to disability support worker Linda Parsons, at the time of his death, Mr Wills was the only resident who required assistance with eating. In her statement to police, Ms Parsons recalled that Mr Wills required additional support when he was fatigued.[5] Mr Wills' mother, Maureen Marshall, expressed a similar view in her statement as she recalled staff advised her that her son experienced "*less trouble swallowing and coughing up his food*" earlier in the day when not tired.[6]

7. In the 12 months leading up to his death, Mr Wills' experienced a significant deterioration in his condition. He required additional support for pressure wound prevention and in October 2014, he used an alternating air mattress and concave.[7]

8. On 31 October 2013, Mr Wills' suffered a choking incident for which emergency services were contacted but from which he recovered within a few minutes.[8] He was subsequently taken to hospital for treatment of aspiration.[9]

9. In December 2013, Mr Wills underwent dental surgery and treatment of an abscess. While in hospital, he underwent an assessment by a speech therapist who recommended that his fluids be thickened and his meal time assistance profile be reviewed on return to Alfrieda Street.[10]

10. In her statement to police, Ms Marshall recalled that her son previously had "*quite a good coughing reflex*" but observed that in the weeks leading up to his death, he experienced difficulties coughing up food and clearing his throat.[11] In discussions that took place between clinicians at Footscray Hospital and Ms Marshall following Mr Wills' death, it was documented that he suffered "*decline in function over time and progressive aspiration risk*". Despite his aspiration risk, Ms Marshall reportedly requested that PEG feeding not be introduced "*due to his ongoing enjoyment from eating*".[12]

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[5] Statement of Linda Parsons dated 17 September 2014.
[6] Statement of Maureen Marshall dated 9 August 2014.
[7] Statement of Bonnie Miliankos dated 19 August 2014.
[8] Statement of David Relf dated 6 August 2014.
[9] Statement of Bonnie Miliankos dated 19 August 2014.
[10] Statement of Bonnie Miliankos dated 19 August 2014.
[11] Statement of Maureen Marshall dated 9 August 2014.
[12] Coronial brief, E-Medical Deposition completed by Dr Mark Daley dated 20 May 2014, p.97.

11. In March 2014, Mr Wills suffered a fractured tibia. Due to a breakdown in communication between Yooralla staff between shifts, the circumstances that gave rise to the fracture were unknown and there was a delay in Mr Wills receiving medical attention.[13]

12. At the time of his death, Mr Wills' participation in Scope day placements was reduced due to his increased fatigue and risk of pressure sores.[14]

THE PURPOSE OF A CORONIAL INVESTIGATION

13. Mr Wills' death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**) as his death occurred in Victoria and was one or more of unexpected or unnatural.

14. The Act requires a Coroner to investigate reportable deaths such as Mr Wills' and, if possible, to find:

    a) The identity of the deceased;

    b) The cause of the death; and

    c) The circumstances in which the death occurred.[15]

15. For coronial purposes, "*circumstances in which the death occurred*"[16] refers to the context and background of the death including the surrounding circumstances. Rather than being a consideration of all the circumstances which might form part of a narrative, culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

16. The Coroner's role is to establish fact, rather than to attribute or apportion blame for the death.[17] It is not the coroner's role to determine criminal or civil liability[18] nor to determine disciplinary matters.

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[13] Statement of Preet Kiran dated 22 August 2014.
[14] Statement of Bonnie Miliankos dated 19 August 2014.
[15] *Coroners Act 2008* (Vic) preamble; s 67.
[16] *Coroners Act 2008* (Vic) s 67(1)(c).
[17] *Keown v Khan* [1999] 1 VR 16.
[18] *Coroners Act 2008* (Vic) s 69(1).

17. One of the broader purposes of coronial investigations is to reduce the number of preventable deaths in the community and Coroners may:

    a) Report to the Attorney-General on a death;[19]

    b) Comment on any matter connected with the death including matters of public health or safety and the administration of justice;[20] and

    c) Make recommendations to any minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[21]

18. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities applying the principles of such proof set out by the Chief Justice in *Briginshaw v Briginshaw*.[22] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[23] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the finding, and effect.[24]

19. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[25] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[26] Such a description should be interpreted in the context of the coronial jurisdiction being inquisitorial and having nothing to do with guilt or innocence.

[19] *Coroners Act 2008* (Vic) s 72(1).
[20] *Coroners Act 2008* (Vic) s 67(3).
[21] *Coroners Act 2008* (Vic) s 72(2).
[22] (1938) 60 CLR 336, pp. 3662-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte; Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 9, 95.
[23] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[24] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[25] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[26] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

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

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

20. On 22 May 2014, Joanne Hine, group manager at Yooralla, visually identified the deceased as her client, Stuart Anthony Wills, born 23 March 1969.

21. Mr Wills' identity is not in dispute in this matter and therefore requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

22. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination of Mr Wills body on 23 May 2014 and provided a written report of his findings dated 29 May 2014. I note that Mr Wills' family expressed a strong preference against an autopsy.

23. Dr Burke reviewed a post-mortem computed tomography (**CT**) scan, which revealed marked faecal loading with dilated bowel and increased lung markings consistent with aspiration.

24. Dr Burke provided an opinion that Mr Will's medical cause of death was 1(a) Aspiration of food bolus and 1(b) Cerebral palsy.

25. I accept Dr Burke's opinion.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

26. At approximately 4.10pm on 20 May 2014, Yooralla staff member David Moncrieff was assisting Mr Wills with his meal of sausages and mashed potato when he began to choke. Mr Moncrieff immediately alerted Preet Kiran, the acting service manager,[27] and David Relf, the newly appointed service manager, who immediately returned to the kitchen with Mr Moncrieff.[28]

27. In his statement to police, Mr Relf recalled observing Mr Wills' seated in a comfort chair at a 90-degree angle "*audibly choking*". Mr Relf found that Mr Wills' teeth were clenched and

[27] At the time of Mr Wills' death, Ms Kiran had been in the role of acting service manager for approximately six weeks, having taken over the role from Bonnie Miliankos. Mr Relf was due to commence in his new role as service manager on 1 July 2014.

[28] Statement of Joanne Hine dated 26 May 2014; Statement of David Relf dated 6 August 2014; Statement of Preet Kiran dated 22 August 2014.

Mr Relf was unable to manually dislodge the food. He began striking Mr Wills' back while Ms Kiran contacted emergency services. Under instruction from the operator, Mr Relf performed the Heimlich manoeuvre but Mr Wills' stopped breathing and began to turn from blue to white in colour.[29]

28. Mr Relf and Mr Moncrieff then moved Mr Wills from his chair to the floor, where his mouth relaxed and Mr Relf was able to remove a piece of sausage from his airway. Mr Relf recalled that the piece was approximately the size of a 10-cent piece. Mr Relf and Mr Moncrieff then commenced cardiopulmonary resuscitation (**CPR**) while Ms Kiran contacted emergency services.[30]

29. Members from the Metropolitan Fire Brigade (**MFB**) arrived at approximately 4.43pm, shortly followed by Ambulance Victoria paramedics at approximately 4.46pm. Responders identified and removed pieces of sausage from Mr Wills' airway via suction and forceps. A defibrillator was applied and an oropharyngeal airway inserted for mechanical ventilation.[31]

30. MICA[32] paramedics arrived at approximately 4.53pm and administered 1mg adrenaline boluses every three minutes and achieved return of spontaneous circulation, after which three mg midazolam doses were administered for increased heart rate.[33] At approximately 5.34pm, Mr Wills was loaded into a MICA ambulance for transport to Footscray Hospital.[34]

31. In her statement to police, Ms Kiran recalled that she observed Mr Wills' dinner plate before leaving in the ambulance with him. She recalled that the pieces of sausage and potato were dry, not mixed with gravy and had not been vitamised.[35]

32. According to various Alfrieda Street staff members who spoke with Mr Moncrieff later that evening, he stated words to the effect "*I should have minced his food*"[36] and "*I know I should have vitamised his food*".[37] These asserted statements and circumstances as outlined

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[29] Statement of Joanne Hine dated 26 May 2014; Statement of David Relf dated 6 August 2014; Statement of Preet Kiran dated 22 August 2014.
[30] Statement of Joanne Hine dated 26 May 2014; Statement of David Relf dated 6 August 2014; Statement of Preet Kiran dated 22 August 2014.
[31] Statement of John Taylor dated 20 January 2017.
[32] Mobile Intensive Care Ambulance (MICA) Paramedics are trained in performing more advanced medical procedures, such as advanced airway management and administration of osseous drugs and fluids.
[33] Coronial brief, Electronic Patient Care Report dated 20 May 2014, p.85.
[34] Statement of Matthew Rose dated 11 October 2016.
[35] Statement of Preet Kiran dated 22 August 2014.
[36] Statement of Joanne Hine dated 26 May 2014; Statement of Bonnie Miliankos dated 19 August 2014.
[37] Statement of David Relf dated 6 August 2014.

above are largely consistent with the content of the Client Incident Report Form to the then Department of Human Services completed by Mr Relf on 21 May 2014.

33. Mr Wills arrived at the emergency department (**ED**) of Footscray Hospital at approximately 6.00pm. While in the ED, his condition stabilised but he did not regain consciousness.[38]

34. Following discussions between Mr Wills' treating clinicians and his family about his poor prognosis, a decision was made to cease active treatment and implement measures for his comfort.[39] At approximately 7.30pm, his adrenaline infusion was ceased and his endotracheal tube was removed at approximately 7.50pm, after which he was administered morphine to alleviate discomfort. Mr Wills was subsequently pronounced deceased at 7.58pm.[40]

THE INVESTIGATION, THE INQUEST & CONTROVERSIES

The Investigation

35. I note at the outset that Victoria Police compiled a brief of evidence and appropriately referred the matter to the Office of Public Prosecutions (**OPP**). Following consideration of the brief, the OPP determined not to pursue criminal charges against Mr Moncrieff in respect of Mr Wills' death.

36. I further note that Mr Wills' death was not independently investigated by the Disability Services Commissioner (**DSC**) as his death occurred prior to the commencement of referrals from 27 June 2016 requested by the then Minister for Housing, Disability and Ageing.

37. The jurisdiction of the Coroners Court of Victoria is inquisitorial,[41] and as such the focus of my investigation was suitably constrained to the circumstances that gave rise to Mr Wills' death and identifying any opportunities for prevention arising from his death.

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[38] Statement of Dr Karen Winter dated 7 April 2016.
[39] Statement of Maureen Marshall dated 9 August 2014.
[40] Statement of Dr Karen Winter dated 7 April 2016.
[41] *Coroners Act 2008* (Vic) s 89(4).

Mr Wills' feeding regime

38. Alfrieda Street staff on duty at mealtimes prepared meals for residents based on a set menu, but would also ask residents of their meal preferences.[42]

39. Prior to the amendments in April 2014 as outlined below, Mr Wills' care plan indicated that he was not to be provided food that was dry or difficult to swallow and his food was cut into small pieces, often with gravy to make it easier for him to swallow. Any fluids provided to Mr Wills were thickened.[43]

40. In March 2013, Mr Wills underwent a Videofluoroscopic Swallowing Study (**VFSS**) at Calvary Health Care Bethlehem,[44] the results of which indicated moderate to severe dysphagia (delayed and uncoordinated swallowing) with a high risk of aspiration. Mr Wills was previously provided high larger tablet medications in whole in yoghurt or soft food; however, following the VFSS results his tablets were crushed before being placed in yoghurt.[45]

41. Ms Parsons, who accompanied Mr Wills to his VFSS, recalled watching the procedure and observing Mr Wills' swallowing difficulties. She recalled that Mr Wills took "*two to three swallows to get food down*" and when the clinician gave him a piece of muffin, "*it did not move*".[46]

42. Towards the end of 2013, Ms Miliankos purchased a stick blender to be used for mixing the thickener into Mr Wills' fluids. In her statement to police, Ms Miliankos recalled frequently discussing Mr Wills' positioning during meal times with staff and ensuring that he did not eat or drink in bed and was fed when he was in an upright position (90 degrees).[47]

43. On 6 January 2014, Ms Miliankos made an internal request to Yooralla's speech pathologist, Laura McElhinney, to conduct an assessment of Mr Wills.[48]

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[42] Statement of Preet Kiran dated 22 August 2014.
[43] Statement of Preet Kiran dated 22 August 2014.
[44] Mr Wills' neurological treatment was managed by Calvary Health Care.
[45] Statement of Bonnie Miliankos dated 19 August 2014.
[46] Statement of Linda Parsons dated 17 September 2014.
[47] Statement of Bonnie Miliankos dated 19 August 2014.
[48] Statement of Bonnie Miliankos dated 19 August 2014.

44. From Ms McElhinney's observations of Mr Wills on 26 and 31 March 2014, he experienced "*significant coughing*" and clear indicators of aspiration when provided minced/moist foods and moderately thick fluid. When Mr Wills was provided with puree consistency/mildly thick fluids, Mr Wills finished his meal within an appropriate timeframe and did not exhibit any signs of aspiration.[49]

45. On 1 April 2014, Ms McElhinney emailed Ms Miliankos to advise she had spoken with another speech pathologist at Calvary Health Care Bethlehem and discussed Mr Wills' feeding regime and observations and recommendations from his long-term treating team. In the email, Ms McElhinney advised that she disagreed with the Calvary recommendation that Mr Wills' food be "*minced/moist consistency*" and should instead be "*pureed rather than simply minced*".[50]

46. On 9 April 2014, Ms McElhinney provided to Alfrieda Street staff an updated version of Mr Wills' "*How I Eat and Drink Profile*" (**the Profile**), which recommended that all food provided to Mr Wills be minced, moist and blended.[51] In accordance with the Profile, Sandra Capito, the Yooralla nurse educator and a qualified Division 1 nurse, developed Mr Wills' Health Support Plan.[52]

47. Ms Miliankos ceased her role as service manager at Alfrieda Street on 4 April 2014.[53] According to Ms Kiran, who took over as acting service manager following Ms Miliankos' departure, staff were notified of the changes in April 2014 whereby she placed copies of Ms McElhinney's memorandum on the staff room table and noticeboard. Ms Kiran recalled that she also wrote a note upon the staff room whiteboard and within the shift report and handover books to advise staff of the changes. In her role as the acting service manager, Ms Kiran personally spoke with all casual and agency staff to ensure they were following the guidelines and observed staff adhering to the Profile.[54]

48. On 1 May 2014, Ms McElhinney met with Alfrieda Street staff members to discuss Mr Wills' feeding regime. According to Ms Kiran, all staff present indicated they had read Mr Wills' updated Profile and indicated they understood it. Ms McElhinney reiterated that

[49] Statement of Bonnie Miliankos dated 19 August 2014.
[50] Statement of Bonnie Miliankos dated 19 August 2014.
[51] Statement of Bonnie Miliankos dated 19 August 2014; Statement of Preet Kiran dated 22 August 2014.
[52] Statement of Joanne Hine dated 26 May 2014; Statement of Preet Kiran dated 22 August 2014.
[53] Statement of Joanne Hine dated 26 May 2014; Statement of Preet Kiran dated 22 August 2014.
[54] Statement of Preet Kiran dated 22 August 2014.

the requirement for vitamising Mr Wills' food was due to his issues with chewing and swallowing and reiterated the need for Mr Wills to be positioned at 90 degrees for meals.

49. Ms McElhinney also explained to staff that Mr Wills' fluids were to be "*mildly thick*" only so as to avoid issues.[55] In her statement to police, Ms Kiran indicated that Mr Moncrieff was present and took the minutes for this meeting.[56]

50. According to the then Chief Executive of Yooralla, Dr Sherene Devanesen, the minutes reportedly taken by Mr Moncrieff of the 1 May 2014 meeting have not since been located. The responsibility for taking the minutes generally lay with the Service Manager, however they are able to delegate this task to a staff member. It is also the Service Manager's responsibility to ensure that the minutes are placed in the staff communications folder following the meeting.[57]

51. In her statement to police, Joanne Hine, group manager at Yooralla, recalled that at the time of Mr Wills' death, his Profile was referenced and available within his Health and Client Support Plans and a visual plan was located on the staff noticeboard.[58] A form was placed alongside the visual plan on the noticeboard on which staff were directed to sign and date after reading Mr Wills' Profile. Mr Moncrieff is recorded as having signed and dated the form on 13 May 2014.[59]

Mr Moncrieff's training and experience

52. At the time of Mr Wills' death, Mr Moncrieff was undertaking his Certificate IV in Disability through Independence Australia.[60] He received his theoretical training from Independence Australia and his practical component and supervision was overseen by Yooralla.

53. Mr Moncrieff commenced his traineeship at the Alfrieda Street facility on 18 February 2013 and he was supported in shadow shifts and mentored over a six-month period. Mr Moncrieff's workplace mentor at Alfrieda Street was Linda Parsons, a Disability Support

[55] Care Note Report completed by Laura McElhinney dated 1 May 2014.
[56] Statement of Preet Kiran dated 22 August 2014.
[57] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[58] Statement of Joanne Hine dated 26 May 2014.
[59] Coronial brief, 'Stuart Wills - How I eat and drink profile' acknowledgement form, p.59.
[60] Statement of Preet Kiran dated 22 August 2014.

Worker Level 5.[61] Mr Moncrieff's initial training involved a site induction and introduction to the residents, including having been shown their respective care requirements and their "*How I Eat and Drink*" profiles.[62]

54. Documents were provided to the Court by Independence Australia in relation to its arrangement with Yooralla for the placement of trainees. In particular, the Group Training Hire Agreement indicates at clause 6.2 that Yooralla is to provide trainees with "*guidance and supervision*" and are to assume "*full responsibility for the performance and conduct of any Trainees…as if they were a direct employee*". In accordance with clause 6.3 of the Agreement, Yooralla provided "*workplace training and instruction*" to assist Mr Moncrieff in attaining his qualification.[63]

55. Throughout his initial shifts, Mr Moncrieff demonstrated his ability to perform several feeding related tasks under the guidance and supervision of the supervising staff member, including the preparation and administration of foods of varying consistencies and in accordance with each resident's feeding requirements.[64]

56. In her statement to police, Ms Parsons praised Mr Moncrieff's "*person centred approach*" to caring for the residents. She recalled that throughout his initial shifts, Mr Moncrieff was "*open to correction*" and "*willing to learn*". Ms Parsons provided guidance to Mr Moncrieff in relation to manual handling to ensure resident comfort and safety, the need for such guidance was not unusual for inexperienced staff members. Ms Parsons advised that she would also offer similar advice and corrections to permanent staff members.[65]

57. On 22 July 2013, a decision was made by Alfrieda Street management and Independence Australia that Mr Moncrieff could commence active night duty. On 23 August 2013, Mr Moncrieff completed an active night duty shift with Ms Kiran, after which he was able to work alone or with non-permanent staff members throughout overnight shifts.[66]

58. By December 2013, Mr Moncrieff had completed a total of 199 day shifts and 16 night shifts. By this stage, Mr Moncrieff had accompanied Mr Wills to several speech pathology

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[61] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[62] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[63] Group Training Hire Agreement between Independence Australia and Yooralla 2013.
[64] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[65] Statement of Linda Parsons dated 17 September 2014.
[66] Statement of Bonnie Miliankos dated 19 August 2014.

appointments at Calvary Health Care Bethlehem and on family visits for Christmas. Ms McElhinney's care notes completed for Mr Wills indicate that Mr Moncrieff variously reported during appointments in May 2014 that Mr Wills "*currently had no issues eating and drinking*" and that he "*personally has observed less gurgly sounds in chest*".[67]

59. According to Dr Devanesen, Mr Moncrieff was deemed "*competent…in the tasks required of a Disability Support Worker*". Dr Devanesen asserted that the responsibility for assessment of Mr Moncrieff's competence in respect of obtaining his Certificate IV lay with Independence Australia.[68]

60. During his time at Alfrieda Street, Mr Moncrieff was the subject of several minor complaints in relation to behaviour support and the use of restraint. As a result, Mr Moncrieff attended further Yooralla induction training and a further training session in relation to supporting behaviours. According to Ms Miliankos, Mr Moncrieff responded well to feedback and supplementary training.[69]

61. According to Dr Devanesen, at the time of Mr Wills' death, Mr Moncrieff did not require supervision when carrying out daily tasks, including the preparation and feeding of residents, as he had previously demonstrated competence in these tasks over an extended period.[70]

Family concerns

62. In her statement to police, Ms Marshall, was not critical of Yooralla staff for the meal assistance provided to her son and was understanding of the difficulties associated with his ability to swallow. Mrs Marshall raised concerns in relation to staffing levels and their ability to manage clients with high level care needs, but appreciated that staff levels were complicated by the level of funding the facility received.[71]

63. I note that in the time following Mr Wills' death, his family have not subsequently raised any concerns with the Court in relation to the care he received from Yooralla, but have expressed concerns in respect of the duration of the coronial investigation.

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[67] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[68] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[69] Statement of Bonnie Miliankos dated 19 August 2014.
[70] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[71] Statement of Maureen Marshall dated 9 August 2014.

Independent documentation practice review

64. Following Mr Wills' death, a review of Yooralla practices and documentation was conducted by Adjunct Professor Jeffrey Chan, the Yooralla Chief Practitioner Quality, Innovation and Safeguards. In conducting the review, Dr Chan had regard to several documents contained within Mr Wills' resident file, including his Client and Health Support plans, his "*How I Eat and Drink*" profile, and various medical records, including his hospital discharge notes, speech pathology care notes and email correspondence.[72]

65. In his report dated 21 June 2014, Dr Chan noted that all relevant documentation within Mr Wills' resident file was up-to-date and reflected the receipt of "*good quality of care and support*". Dr Chan considered that Mr Wills' Profile in particular was kept up-to-date and Ms McElhinney provided regular and ongoing support to Yooralla in terms of Mr Wills' feeding regime in the context of his deteriorating health.[73]

66. Dr Chan identified a discrepancy between Mr Wills' Client Support Plan and his "*How I Eat and Drink*" profile in terms of the documented consistency of fluids. Within the Client Support Plan, there is a direction that "*liquids to be thickened to a nectar consistency*" unless trained in the provision of thin fluids to Mr Wills "*by a permanent/regular staff member*". Dr Chan further noted Ms McElhinney's comment in her statement in relation to difficulties associated with implementing changes to a feeding regime, but Dr Chan was satisfied that Yooralla staff had signed Mr Wills' profile to indicate they had read and understood the changes.[74]

67. In concluding his report, Dr Chan identified areas for process improvement in respect of supervision and training mealtime assistance. Dr Chan recommended that for individuals experiencing a deterioration in their condition and increased swallowing difficulties, staff members are observed and trained in mealtime assistance for several sessions to be assessed as sufficiently competent in providing mealtime assistance. Dr Chan further recommended that the supervision and training be formally documented and authorised by the relevant speech pathologist, whereby only staff members assessed and deemed competent are permitted to assist in mealtime assistance.[75]

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[72] Practice Review Report completed by Adjunct Professor Jeffrey Chan dated 21 June 2014.
[73] Practice Review Report completed by Adjunct Professor Jeffrey Chan dated 21 June 2014.
[74] Practice Review Report completed by Adjunct Professor Jeffrey Chan dated 21 June 2014.
[75] Practice Review Report completed by Adjunct Professor Jeffrey Chan dated 21 June 2014.

68. At the request of the Court, Dr Devanesen responded to Dr Chan's recommendation and advised that Yooralla has introduced increased training in mealtime assistance and dysphagia awareness since 2015. The training was directed for Yooralla staff who directly engaged with residents with identified dysphagia and swallowing issues. From July 2018, Yooralla incorporated this strengthened training regime into the staff induction training program for new staff.[76]

69. According to Dr Devanesen, the competency-based assessments recommended by Dr Chan were identified as "*very resource intensive* [and] *was not sustainable under the funding model*". Notwithstanding that Yooralla has not introduced competency-based staff training and assessments, Dr Devanesen supported the increased upskilling of staff in respect of mealtime assistance and advised that staff are encouraged to seek assistance if they are uncertain of an individual resident's feeding requirements.[77]

70. Dr Devanesen further noted that a checklist has been introduced for assessments of a resident's swallowing ability and provides prompts for staff "*to consider what changes are occurring, for example, increased coughing*". When staff identify changes, they are encouraged to seek further assessment. Dr Devanesen noted that Yooralla has worked with Speech Pathology Australia in support of additional funding from the National Disability Insurance Scheme (**NDIS**) for residents with swallowing difficulties to undergo further assessment and therapy supports.[78]

71. In respect of the circumstances immediately prior to Mr Wills' death, Dr Devanesen emphasised that Mr Moncrieff's behaviour on 20 May 2014 was contrary to his awareness of Mr Wills' feeding regime and contrary to his previously demonstrated competency in safely and correctly feeding Mr Wills. According to Dr Devanesen, Mr Moncrieff was prior to the incident considered "*most adept at managing Stuart Wills' needs including managing his food and drink regime*".[79]

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[76] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[77] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[78] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.
[79] Letter from Dr Sherene Devanesen, Chief Executive of Yooralla, to Coroners Court of Victoria dated 29 October 2018.

The Inquest and Controversies

72. The Court was advised by a representative for the Department of Health and Human Services that the Department did not consider that Mr Wills' death met the criteria for a death 'in care' pursuant to section 4(2)(c) of the *Coroners Act 2008* (Vic).

73. While Mr Wills' may not have been strictly 'a person under the control, care or custody of the Secretary to the Department' as defined in section 3 of the Act and as interpreted by the Department of Health and Human Services, I consider that his reduced functional capacity and requisite high-level care met the criteria for which oversight in respect of his care was required under the *Disability Act 2006* (Vic). Further, it is not clear to me that the interposition of Yooralla as the direct provider of care between the Department of Health and Human Services and Mr Wills means that Mr Wills was not 'in care' for the purpose of section 4(2)(c).

74. People 'in care' are vulnerable and their wellbeing needs to be carefully audited. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory. If a death occurs otherwise than as from natural causes, such as was Mr Wills' death an inquest is mandatory.

75. Representatives for Yooralla and Independence Australia were directed to provide written submissions in advance of the hearing. In his written submissions, Mr Harper for Yooralla reiterated his client's position that Mr Moncrieff's conduct on 20 May 2014 departed from his training in how to provide food safely and correctly to Mr Wills. Mr Harper emphasised that Mr Moncrieff had previously complied with Mr Wills' feeding regime prior to 1 May 2014 whereby his food was to be prepared to a "*minced/moist consistency*".

76. Mr Harper highlighted that Mr Wills' updated profile was formalised on 1 May 2014 and Mr Moncrieff attended the staff meeting on the same day in relation to those changes, after which Mr Moncrieff completed seven shifts up until the date he indicated by way of signature that he had read and understood the updated profile. According to Mr Harper, Yooralla understood that Mr Moncrieff assisted Mr Wills with meals during this timeframe in accordance with Mr Wills' updated profile.[80]

77. Each of Yooralla and Independence Australia denied responsibility for Mr Moncrieff's failure to abide by Mr Wills' feeding profile. In her written submissions, Ms Ellis for

[80] Submissions on behalf of Yooralla dated 3 July 2020.

Independence Australia emphasised Clause 6.2 of the Group Training Hire Agreement between Independence Australia and Yooralla, in which Yooralla is said to take "*full responsibility for the performance and conduct of any trainee*".[81]

78. Ms Ellis went on to highlight inconsistencies in Mr Wills' food intake forms throughout 2013 that raised the possibility of "*a degree of discretion as to the type and consistency of food*" provided to Mr Wills. Following an choking incident on 31 October 2013, Mr Wills' Client Support Plan was updated on 29 November 2013 and directed a "*mince-mashed soft food diet*". Despite this update, Mr Wills continued to receive Weet-Bix of an unspecified consistency until 5 January 2014. Ms Ellis also asserted that Mr Wills was provided with food items throughout November 2013 that were unlikely to have been minced, including cheese snacks, cheese burgers and baked food bars, as well as pizza on 21 February 2014.

79. Ms Ellis submitted that it was unlikely that Mr Moncrieff was advised that this discretionary practice was no longer applicable in the context of Mr Wills' updated feeding profile. Ms Ellis emphasised the importance of explicitly communicating the revocation of such a practice to staff in the context of a changed meal plan. Ms Ellis appropriately conceded that there was no indication in documentation and statements later provided by Yooralla that the discretionary practice existed or that Ms McElhinney was aware of such a practice when updating Mr Wills' feeding profile.[82]

80. In respect of Dr Chan's recommendations as outlined above, Ms Ellis indicated that Independence Australia and Mr Moncrieff were supportive of the recommendation for staff supervision and training in mealtime assistance, as well as an assessment of competency. Ms Ellis highlighted that the competency-based assessment proposed by Dr Chan was "*a more meaningful and safe process to engage in*" as compared to trainees signing a document to indicate they had read and understood a resident's feeding profile. Ms Ellis indicated that Independence Australia were otherwise supportive of Yooralla's comprehensive 'Mealtime Assistance (Dysphagia) Training' delivered since 2015.[83]

81. In submissions to the Court on the day of hearing, Ms Ellis for Independence Australia appropriately conceded that Mr Moncrieff provided food to Mr Wills on 20 May 2014 that was not pureed, contrary to the direction in his Profile. While Mr Moncrieff did not deny

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[81] Submissions on behalf of Independence Australia dated 3 July 2020.
[82] Submissions on behalf of Independence Australia dated 3 July 2020.
[83] Submissions on behalf of Independence Australia dated 3 July 2020.

signing the document on 13 May 2014, he did not have an independent recollection of attending the meeting on that day.[84]

82. In addressing her written submissions, Ms Ellis reiterated the existence of a discretionary practice, with which Mr Moncrieff reportedly agreed, and submitted that the discretionary practice sat alongside any documented feeding regime. Ms Ellis drew the Court's attention to Ms Hine's recollection of events, that Mr Moncrieff said words to the effect following the incident, "*Technically Jo, I know I have done the wrong thing. I should have minced his food.*" Ms Ellis submitted that the use of the word "*technically*" in this instance raises a "*technicality which…allows room for the discretion*".[85] Ms Ellis again conceded that there was no explicit reference in Yooralla documentation to a discretionary practice.[86]

83. Ms Ellis further submitted that a lack of clarity existed between mandated checks for food and its relationship risk, citing Ms Marshall's statement contained within the coronial brief, in which she referred to staff providing pureed food to Mr Wills that sometimes contained "*small, solid pieces that could easily get caught in Stu's throat*".[87]

84. Mr Harper on behalf of Yooralla disputed that there was such a discretion, and submitted that despite Ms Ellis' assertion in her written submissions that several "*seemingly inappropriate foods*" were provided to Mr Wills between 2013 and 2014, these foods were "*always reduced to a form which is compliant with the feeding plan*".[88] Mr Harper further submitted that Mr Wills was not provided with only one form of pureed food, but provided a range of foods reduced to a safe form.[89]

85. In any event, Mr Harper submitted, that any discretionary that existed was not exercised after 1 May 2014 in the context of Mr Wills' updating feeding profile, and drew the Court's attention to Mr Relf's recollection of events in which Mr Moncrieff said words to the effect, "*I knew I was meant to vitamise the food*".[90] Mr Harper emphasised that discretionary practices aside, Mr Moncrieff inexplicably provided food to Mr Wills on 20 May 2014 in "*solid pieces*" and there was no evidence that it was minced.[91] A photograph contained

[84] Transcript p.28, lines 5-15
[85] Transcript p.66, lines 21-31.
[86] Transcript p.43, lines 18-22.
[87] Transcript p.37, lines 23-31.
[88] Transcript p.51, lines 29-31.
[89] Transcript p.52, lines 14-16.
[90] Transcript p.48, lines 10-12.
[91] Transcript p.46, lines 4-9.

within the coronial brief appears to confirm this consistency and, as was accepted by the parties on the day of hearing, that the meal included a tomato sauce.[92]

86. Calvin Wills, Mr Wills' brother through his representative at hearing, Ms Pilipasidis, also disputed the existence of a discretionary practice. Ms Pilipasidis reiterated that if any such discretion existed, it was prior to 2 April 2014 when Mr Wills' deteriorating condition prompted a change in his feeding profile.[93]

87. Mr Harper submitted on behalf of Yooralla that Mr Moncrieff's conduct on 20 May 2014 in failing to adhere to Mr Wills' feeding profile was unrelated to any failure of Yooralla to provide adequate training to Mr Moncrieff.[94] While Ms Ellis on behalf of Mr Moncrieff and Independence Australia urged the Court to consider the recommendations suggested by Dr Chan,[95] Mr Harper submitted that the training and supervision provided to Mr Moncrieff and the protocols in place at Yooralla at the time of the incident were cursory issues.[96]

CONCLUSIONS AND FINDINGS

Conclusions

88. Having considered the available evidence, I find the most plausible explanation that gave rise to the incident of 20 May 2014 is that Mr Moncrieff suffered a lapse in judgment deviated from Mr Wills' feeding regime and provided food that was more solid thant it ought to have been, albeit combined with sauce. I note submissions on behalf of Independence Australia about the existence of a discretionary practice in terms of the required consistency of Mr Wills' foods; however, I am satisfied that such a discretionary practice, if indeed it existed, was superseded by Mr Wills' updated "*How I Eat and Drink*" profile from 1 May 2014.

89. There is nothing in the evidence to suggest this was an intentional act or that Mr Moncrieff acted in disregard of Mr Wills' feeding regime. I am satisfied, based on the review conducted of Yooralla practices and training, that this was an isolated incident and did not arise in the setting of uncertainty surrounding a disability support worker's competence. As such, I accept the submissions on behalf of Yooralla that Mr Moncrieff was sufficiently

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[92] Coronial brief, photograph of food provided to Mr Wills on 20 May 2014, p.57.
[93] Transcript p.56, lines 24-28.
[94] Transcript, p.53, lines 5-9.
[95] Transcript, p.42, lines 28-31.
[96] Transcript, p.55, lines 8-10.

trained and assessed as competent in mealtime assistance over an extended period of time and do not propose to make the recommendations suggested by Dr Chan in respect of competency-based assessments.

90. Having reviewed the material from Yooralla in relation to their subsequent review of practices and training, I consider that the care otherwise provided to Mr Wills immediately prior to his death was reasonable and appropriate. I have not subsequently identified any opportunities for prevention in connection with Mr Wills' death.

91. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[97] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

Findings

92. Having investigated the death of Stuart Anthony Wills and having held an Inquest in relation to his death on 15 July 2020, at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Stuart Anthony Wills, born 23 March 1969;

[97] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

(b) that Mr Wills died on 20 May 2014, at Footscray Hospital, Western Health, Gordon Street, Footscray, Victoria, from 1(a) Aspiration of food bolus and 1(b) Cerebral palsy; and

(c) that the death occurred in the circumstances set out above.

Pursuant to section 73(1B) 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:

Maureen Marshall, Senior Next of Kin

Calvin Wills, c/o Dimi Ioannou, Maurice Blackburn

Independence Australia Services, c/o K&L Gates

Jim Pearson, Department of Health and Human Services

Mario Bernardi, Department of Health and Human Services

Dr Narelle Watson, Western Health

Jayr Teng, Western Health

Yooralla, c/o Samantha Downes, Landers & Rogers Lawyers

Sergeant Christopher Morrison, Coroner's Investigator, Victoria Police

Signature:

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Date: 1 October 2021