IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6518

FINDING INTO DEATH WITHOUT INQUEST

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

Inquest into the death of DEVA FRIJLINK

Delivered On:	28 March 2022
Delivered at:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK, VICTORIA
Hearing Date:	9 NOVEMBER 2021
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MS RACHEL QUINN, CORONER'S SOLICITOR
Villa Maria Catholic Homes:	Ms Natalina Velardi

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6518

FINDING INTO DEATH WITHOUT INQUEST

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

I, PHILLIP BYRNE, Coroner having investigated the death of DEVA FRIJLINK

AND having held an inquest in relation to this death on 9 November 2021 at Southbank, in the State of Victoria:

find that the identity of the deceased was DEVA FRIJLINK

born on 27 October 1976

and the death occurred on 28 December 2018

at Belgrave-Gembrook Road, Belgrave, Victoria, 3160

from:

1 (a) CHOKING ON A FOOD BOLUS

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

Background

1. Deva Frijlink, aged 42 years at the time of her death, lived at shared supported accommodation at 48 Chappel Drive, Wantirna South, Victoria. Deva had resided at the accommodation, run by Villa Maria Catholic Homes (VMCH) since approximately 2000. Deva had diagnoses of intellectual disability, and schizoaffective disorder.
2. Deva is survived by her parent's Joanna and Hugo Frijlink, brother Swen and nephew Brandon. In 2005, Deva's sister Elka passed away. This had a profound effect on Deva.
3. VMCH had a detailed Lifestyle Plan personalised to Deva that was reviewed in 2018. The plan included a meal support plan, prepared by a speech pathologist from Yooralla Community Learning & Living Service in December 2017.
4. Deva was a long-term attendee of a day program through Melba Support Services, attending the program five times weekly.

5. For the purposes of my coronial investigation, I determined that Deva "was a person placed in custody or care" within the definition of the *Coroners Act 2008*. As Deva's death was not due to natural causes, I am mandated to hold an Inquest into Deva's death.

Circumstances of the death

6. On 28 December 2018, Deva attended an excursion to Mount Dandenong with five other shared supported accommodation residents under the care of VMCH Residential Support Worker, Ms Emma Hill. Ms Hill had known Deva for approximately five years and was familiar with her care needs.

7. They left the facility around 11.30am. At approximately midday Ms Hill parked the bus at the carpark of the Puffing Billy trestle bridge, so that Deva and the other residents could watch the train go past as they ate their lunch. According to Ms Hill she had previously prepared a sandwich for Deva earlier in the day and that it was cut into small pieces.

8. Ms Hill stated that she gave food to those who were able to feed themselves and stood in the middle of the bus. She noted that she was two arm lengths from Deva to supervise Deva's eating, giving her one piece of the sandwich at a time. Ms Hill stated that she gave Deva her first piece of sandwich. Before giving Deva the second piece of sandwich Ms Hill observed that Deva still had a mouth full of stodgy partially chewed food.

9. According to Ms Hill she told Deva that she needed to swallow the food or spit it out and began to imitate a spitting motion in the hope that Deva would copy her. However, Ms Hill observed that Deva appeared to be in distress, and immediately got her off the bus. Upon leaving the bus Deva's lips had turned blue, and she collapsed.

10. Ms Hill stated that she lowered Deva to the ground and attempted to remove the food. Deva remained conscious at the time and was making gurgling noises.

11. Ms Hill contacted emergency services at 12.17pm and began administering cardiopulmonary resuscitation **(CPR)** until the arrival of Ambulance Victoria paramedics at 12.31pm.

12. Despite treatment by paramedics including continued CPR and attempts to clear Deva's airway, they were unable to resuscitate her, and Deva was formally declared deceased at the scene.

Report to Coroner

13. The matter was appropriately reported to the Coroner. Having regard to the circumstances, and having conferred with a forensic pathologist, I directed an external

only post mortem examination and routine toxicological testing. A post mortem examination was performed by Dr Joanne Glengarry, Forensic Pathologist, at the Victorian Institute of Forensic Medicine.

14. Dr Glengarry advised that the immediate cause of Deva's death was:

    I (a) Choking on a food bolus

15. Toxicological analysis of post-mortem specimens detected benzodiazepines, diazepam, nordiazepam, temazepam and oxazepam. Quetiapine, an anti-psychotic agent was also detected as well as sertraline.

16. In a supplementary report Dr Glengarry commented that:

    Prediction of the precise clinical effects of the medications detected is problematic, however in general it may be noted that benzodiazepine medications and anti-psychotic medications may cause central nervous system depression or impairment of coordination.

Further investigation

17. In January 2019 at my request my then registrar sought a Coronial Brief of evidence from Coroner's Investigator, Senior Constable Grant Harrison of Victoria Police. Senior Constable Harrison submitted the brief of evidence in May 2019. The coronial brief included a statement from Ms Hill, and Senior Constable Harrison as well as photographs from the scene, VMCH's Lifestyle Plan, Individual Profile and Mealtime Support needs for Deva. I was also provided with two VACIS Electronic Patient Care Records from Ambulance Victoria. However, I note that one of the VACIS Electronic Patient Care Records only came to my attention on 5 November 2021, due to some confusion with the transfer of this report from the Victorian Institute of Forensic Medicine and the Court's computer systems. I will speak further to the Ambulance Victoria records later within my finding.

18. Deva's meal support plan provided detailed information outlining her support needs. This included the following instructions for staff caring for Deva:

    "*No specialised seating is required, however supervision is essential.*

    For safest and most comfortable eating and drinking it is recommended that all eating and drinking needs to be while seated upright in the appropriate chair.

    Avoid distractions or provoking laughter whilst eating and drinking, as this could increase risk of aspiration.

Deva needs supervision and prompting with eating and drinking. Supervision and prompting is required to ensure food and drink is not ingested too rapidly, which may result in choking or aspiration…

Prompting may be required to slow down, take smaller bites/spoonfuls, and generally engage in the eating process.

Make sure food that poses a choking risk is cut into easily managed pieces.

Watch for fatigue when eating, which increases choking and aspiration risk.

Avoid food with mixed textures that may be difficult to swallow safely such as chunks in liquid.

If food pieces are cut up to smaller than 1cm. they will present less of a choking risk….

19. I was advised that the Disability Services Commissioner (DSC) was investigating the provision of disability services to Deva to VMCH prior to her death.

20. Pursuant to section 7(a) of the *Coroners Act 2008* (Vic), I decided to leave further investigation of Deva's death in abeyance to avoid unnecessary duplications of inquiries and investigations.

21. In April 2020, I received a copy of the DSC's investigation report into disability services provided to Deva by VMCH.

22. The DSC's investigation canvassed matters beyond those which I have examined in the course of my investigation given that I am limited to investigating matters that can reasonably be seen as causal or contributing factors to the death under investigation.

23. In contrast to the DSC, the sole focus of my investigation was whether the care/management of Deva, including mealtime management, was appropriate at the Puffing Billy excursion on 28 December 2018 and whether there was any act or omission which could reasonably be seen as a causal or contributing factor in Deva's untimely death.

24. The DSC's report made a number of findings against VMCH, including "Finding 1: Inadequate management of choking risk by VMCH".

25. The DSC concluded there were three bases if mismanagement of the risk:

"*…despite Deva having an identified choking risk, VMCH did not provide adequate supervision to Deva during the mealtime that led to her death*"

"…the food provided to Deva did not consistently accord with her recommended modified diet"

"…direct care staff were inadequately trained in mealtime management, choking and dysphagia risk, placing Deva at significant risk of choking".

26. In May 2020 after careful examination of the content of the DSC's report, the Court wrote to VMCH, then Legal Counsel Ms Stephanie Collins advising that it was my tentative view to finalise my investigation "on the papers"; in effect to "*ride on the coattails of the DSC investigation*". However, as a matter of natural justice/procedural fairness, that I did not propose to proceed on that basis until VMCH had an opportunity to consider my tentative position and if inclined, oppose/challenge/counter that process.

27. On 4 June 2020, the Court received correspondence under the hand of Ms Natalina Velardi Company Secretary and General Counsel, General Manager Governance at VMCH advising of VMCH's intention to make submissions and requesting the opportunity to review any unseen material and, if relevant, make submissions on the material.

28. On 16 June 2020, the Court wrote to Ms Velardi advising that my tentative view was to adopt the conclusions reached by the DSC set out in the Court's letter dated 7 May 2020 and advising that a copy of the coronial brief was forwarded to VMCH on 22 November 2019.

29. On 30 June 2020, the coronial brief was again provided to VMCH.

30. On 6 August 2020, the Court received detailed submissions from VMCH dated the same, written under the hand of Jack Tracey of Counsel for VMCH. In submission, Mr Tracey submitted that it would be entirely inappropriate for me to proceed to finalisation for a number of reasons. Broadly VMCH submitted that:

    a. *Ms Hill and VMCH did not cause, or by any act or omission on their part cause, or contribute to Ms Frijlink's [Deva's] death (Coroners Act, sub 1(b));*

    b. *the cause of death (Coroners Act, sub 1(b)) was choking, although the evidence is equivocal as to whether the reason for the choking or airway obstruction was the presence of 1. "copious amounts of vomit," 2. The presence of a food bolus, or 3. A combination of each of these (with the extent to which vomit on one hand, or a food bolus on the other, contributed to the choking unable to be determined on the evidence…;*

    c. *the (sufficiently proximate) circumstances in which the death by choking occurred (Coroners Act, subs 1(c)) were as described by the only witnesses who can, and do give direct evidence to those circumstances, most notably Ms Hill,…and also the unknown person who prepared the Ambulance report…*";

d. the Report of the Commissioner [DSC], *and its conclusions in relation to the circumstances of Ms Frijlink's* [Deva's] *death, cannot safely be relied upon by the Coroner…*

31. On 1 October 2020 the Court wrote to Ms Natalie Velardi, Company Secretary and General Counsel of VMCH to advise that after having reviewed their submissions, I had abandoned my tentative proposal to finalise my investigation by adopting conclusions reached by the DSC.

32. On 19 February 2021, the Court wrote to Deva's parents, Mr and Mrs Frijlink advising that it was my tentative view to finalise my investigation by way of a Summary inquest on the basis of the accumulated written material. The Court advised that Mr and Mrs Frijlink that I would hold my investigation in abeyance for a one-month period to enable them to respond to my proposal, should they wish to do so. To my knowledge Mr and Mrs Frijlink did not provide a response to this correspondence.

33. At my direction on 15 April 2021, the Court wrote to Ms Velardi informing VMCH that I having abandoned my proposal to adopt the conclusions reached by the DSC, I proposed to list the matter for summary inquest and that I did not intend to make any adverse findings against Ms Hill. VMCH were agreeable to this course of action.

34. As referenced above, in paragraph 18 it came to my attention several days prior to the summary inquest that there was a second Electronic Patient Care Records from Ambulance Victoria paramedics who attended the scene. It is important to note that in relation to treatment undertaken of Deva by paramedics, this record outlined that at 12.27pm on 28 December 2018paramedics took the following action regarding her treatment, "*laryngoscope with magill's forceps required. Large pieces of food in airway. Pt airway anatomy was poor, difficult to effectively visualise. Multiple pieces of bread/food removed from airway. Unable to determine if there is more in the lower airway*". The first Electronic Patient Care Record completed by attending MICA paramedics noted that at 12.33pm "*copious amounts of chunky vomit continued to enter the oropharynx throughout job. Difficulty with the suction catheter getting blocked due to the size of the chunks*".

35. Ms Hill was the only witness to the choking incident and has provided a sworn statement. Ms Hill stated that she had previously prepared Deva's sandwich ensuring the "*the pieces were very small*" and gave Deva "*a piece at a time*" of the sandwich, while supervising her eating on the bus. Ms Hill was also familiar with the requirements of Deva's mealtime management having been known to Deva for approximately 5 years.

36. This dichotomy between the Ambulance Victoria records and Ms Hill's sworn statement was recognised and addressed by Mr Tracey in his submission as referenced in paragraph 31(b) of this finding.

37. On the basis of this dilemma, I sought advice from the senior pathologists at the Victorian Institute of Forensic Medicine prior to the summary inquest. They advised that it would be an extremely difficult issue to resolve, as to whether it was: A) the bolus; B) the regurgitation and then that material going into the airway or C) a combination of both. On the basis of that advice, I concluded I would be unable to come to a definitive conclusion as to this issue

38. The summary inquest proceeded on 9 November at which Deva's brother Sven engaged by way of video link. Rather than me seeking to encapsulate the dialogue with the solicitor for VMCH and Sven, so that nothing lost or misconstrued in the translation, I propose to annex to the finding a transcript of the hearing.

39. Following the formal summary inquest hearing the court was provided with further material by VMCH in relation to staff training, a copy of which was recently provided to Sven Frijlink.

40. I now proceed to finalise my investigation by way of a Finding with Inquest. I am satisfied, having considered all of the evidence before me, that no further investigation is required.

Finding

41. I find that Deva Frijlink died on 28 December 2018 at Belgrave-Gembrook Road, Belgrave, Victoria, as the result of choking on a food bolus.

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

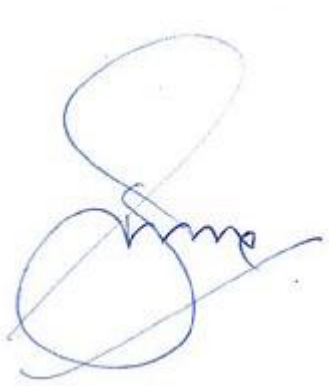
43. I direct that a copy of this finding be provided to the following:

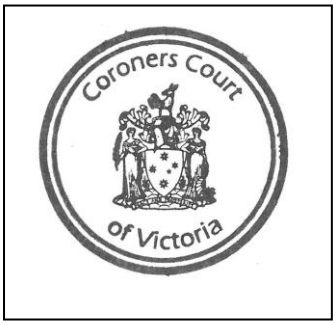
    Mr Sven Frijlink on behalf of Mr Hugo and Mrs Joanne Frijlink, Senior Next of Kin; and

    Ms Natalina Velardi, Company Secretary & General Counsel, Villa Maria Catholic Homes; and

    Senior Constable Grant Harrison, Coroner's Investigator, Victoria Police.

Signature:





_____

PHILLIP BYRNE
CORONER

Date: 28 March 2022