IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005138

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Keith Walter Fisher
Date of birth:	14 August 1934
Date of death:	6 September 2022
Cause of death:	1(a) Complications of a choking incident in the setting of ischaemic heart disease
Place of death:	Holmwood Aged Care, 17-19 Lalors Road, Healesville, Victoria, 3777
Keywords:	Aged care facility; choking; supervision; distant supervision; Safer Care Victoria; clinical guidelines; speech pathology

INTRODUCTION

1. Keith Walter Fisher was 88 years old when he died on 6 September 2022. At the time of his death, Mr Fisher was a resident of Holmwood Aged Care, at 17-19 Lalors Road, Healesville, Victoria.

2. Mr Fisher was admitted to Holmwood Aged Care (**HAC**) on 6 July 2022 for respite care. Mr Fisher's medical history included rheumatoid arthritis, bilateral total hip replacements, recent lower respiratory tract infection, shoulder pain, neuropathic pain, depression, gout, gastro-oesophageal reflux disease, chronic lower back pain with L4-5 lateral fusion, skin infections, and osteoporosis.

3. While at HAC, Mr Fisher was under the care of General Practitioner Dr Peter Trigg, until 12 August 2022. He was then transferred back to his regular General Practitioner, Dr Sivendran Somasundaram. Dr Somasundaram reviewed Mr Fisher on 29 August 2022 and 5 September 2022 for wound and pain management.

4. Mr Fisher's weight remained stable throughout his two-month stay at HAC, but staff raised some concerns about his swallowing due to observed difficulty eating vegetables. Mr Fisher had no dentition but preferred not to wear dentures. He stated he was able to chew and bite meat which was cut up. HAC also suggested Mr Fisher eat his meals in the dining room with other residents and closer to the nurses' station, however, Mr Fisher advised that he preferred to eat his meals in bed due to back pain.

5. Mr Fisher was referred to a speech pathologist on 12 August 2022 for a swallowing assessment. Speech pathologist Emma McLauchlan assessed Mr Fisher on 15 August 2022. Ms McLauchlan was aware that he preferred not to wear dentures and his diet was modified to suit his ability to eat without dentures. Mr Fisher was approved by Ms McLauchlan for normal food that was easy to chew and thin fluids.

6. Ms McLauchlan also made recommendations as follows:

> 1. REGULAR EASY TO CHEW DIET (IDDSI Level 7)
>
> - Please assist resident to cut-up, as required
>
> - Extra sauce/gravy/cream to moisten
>
> - Meats to be TENDER with extra sauce/gravy
>
> - Bread/toast suitable with ample spread

2. THIN FLUIDS (IDDSI Level 0)

3. Distant supervision during oral intake

4. Ensure oral cavity clear between mouthfuls

5. Medications as tolerated

6. Fully alert and upright for all oral intake. Please encourage resident to remain upright for >30 minutes following meals.

7. Please continue to monitor for choking risk and overt signs of aspiration (eg. coughing, choking, throat clearing, voice changes post swallow, ongoing chest health) and diet tolerance (eg. fatigue, prolonged/effortful mastication).

8. Resident would benefit from increased lifestyle support given reduced emotional state.

9. Contact Speech Pathologist if deterioration occurs.

7. Ms McLauchlan reviewed Mr Fisher one week later. He presented with a functional swallow.[1] There were no overt signs of aspiration or choking episodes reported. Mr Fisher was happy with the diet modification and, importantly, able to eat the meals. The instructions and recommendations remained unchanged from the assessment on 15 August 2022.

THE CORONIAL INVESTIGATION

8. Mr Fisher'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.

9. 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.

10. 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

[1] No dysphagia or difficulty swallowing. Dysphagia in older patients is often mild for long periods of time. This is due to age-related changes in laryngeal and pharyngeal sensations as well as very mild discoordination between oral and pharyngeal phases of swallowing that allows the food to safely pass the vocal cords on the way to the stomach. Because these are often mild, they go undiagnosed until a larger medical problem arises and then the swallowing problems may be exacerbated due to weakness or deconditioning.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. This finding draws on the totality of the coronial investigation into the death of Keith Walter Fisher 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.[2]

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

Circumstances in which the death occurred

12. On 6 September 2022 at 12:05 pm, Mr Fisher was given his lunch in bed. It consisted of easy to chew foods and thin fluid. Mr Fisher was sitting upright, with his meal cut up in front of him when the personal care attendant (**PCA**) left the room.

13. Mr Fisher's roommate and a visitor were also present in the room but left at about 12:15 pm. At some point over the next 5 to 10 minutes, the same PCA walked past Mr Fisher's room and observed him to be grey in colour and not breathing. A nurse attended and could not find a heart rate.

14. Three registered nurses and the facility manager attended and assisted with resuscitation. An airway check showed undigested food obstructing Mr Fisher's mouth. The airway was cleared of food by staff, and cardiac compressions commenced. When emergency medical equipment was brought to the room, oxygen was provided and a Guedel airway was inserted. The rescue breaths were ineffective and Mr Fisher's mouth was suctioned, but there was no change in the air entry noted as the chest was still not inflating.

15. Ambulance Victoria paramedics attended at 12:34 pm. By that stage, Mr Fisher was apnoeic, cyanotic, with an unrecordable pulse, and dilated and non-reactive pupils. His airway was again cleared of food by the paramedics, but he remained in asystole despite CPR and administration of adrenaline.

[2] 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.

16. Mr Fisher's family arrived at about 12:58 pm and asked for resuscitation to be ceased, at which time Mr Fisher was declared deceased.

Identity of the deceased

17. On 6 September 2022, Keith Walter Fisher, born 14 August 1934, was visually identified by his wife, Kerry Fisher, who signed a formal statement of identification to that effect.

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

Medical cause of death

19. On 14 September 2022, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an autopsy. Dr Francis reviewed the Victoria Police Report of Death Form 83, post-mortem computed tomography (**CT**) scan, Ambulance Victoria report, concerns raised by the senior next of kin, and medical records from Holmwood Aged Care and Yarra Valley Clinic. Dr Francis provided a written report of her findings dated 7 August 2023.

20. The post-mortem examination revealed chewed food packed throughout the oesophagus and some chewed food within the trachea and main bronchi. Dr Francis noted that Ambulance Victoria officers had also described the airway as obstructed by undigested food.

21. The heart showed cardiomegaly with single vessel coronary artery atherosclerosis and myocardial fibrosis. Coronary artery atherosclerosis occurs when there is a build-up of cholesterol and other material in the blood vessels that supply oxygen and other nutrients to the heart. When the narrowing of the vessel becomes significant, this can cause the supplied area of heart muscle to die (myocardial infarction) or it may cause arrhythmias (disturbance in the nervous system regulating the heartbeat). Both conditions can result in sudden death. Dr Francis noted that if there is a short time interval between the onset of an arrhythmia and death, then ischaemic changes may not be identifiable at autopsy.

22. Risk factors for coronary atherosclerosis include increasing age, smoking, hypertension, family history, diabetes mellitus, obesity, gender (male) and other factors such as hyperlipidaemia (high cholesterol).

23. There were anterior rib and sternal body fractures, consistent with CPR having been performed.

24. Dr Francis provided an opinion that the medical cause of death was "1 (a) Complications of a choking incident in the setting of ischaemic heart disease."

25. I accept the opinion of Dr Francis.

FAMILY CONCERNS

26. Mr Fisher's family contacted the Court regarding concerns about the level of supervision provided to Mr Fisher and the choking incident. They also raised concerns that the response from nursing and care staff was too slow, and that this may have been due to a staff shortage.

FURTHER INVESTIGATIONS

CPU review

27. Following receipt of the family's concerns, I requested that the Coroner's Prevention Unit (**CPU**) conduct a review of the case. Specifically, I asked for a review of the circumstances of Mr Fisher's death, including whether his residential aged care home (**RACH**) met industry standards for "distant supervision during oral intake" when he was served lunch and left unattended in his room for between 10 and 15 minutes.

28. The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the Coroner. The CPU comprises health professionals with training in a range of areas including medicine, nursing, public health, and mental health.

29. To facilitate the CPU review, further information and statements were obtained including statements on behalf of HAC and from Mr Fisher's speech pathologist Ms McLauchlan. The statements addressed the issue of what was required for "distant supervision" of meals.

Evidence regarding the understanding of "distant supervision"

30. Neville Watson, Operations Manager at HAC, stated that HAC understood Ms McLauchlan's recommendations to mean that Mr Fisher needed both "distant supervision" during meals, and to ensure his oral cavity was clear between mouthfuls. Mr Watson stated that these requirements had established meanings. HAC understood that the "distant supervision" did not necessitate the presence of a carer in the room at all times. Rather, it required only occasional checks and monitoring of the person during mealtimes. HAC also understood that

the need to ensure there was no build-up of food residue in the oral cavity was directed to Mr Fisher and he was able to do this. Mr Watson explained the HAC position as follows:

> Because it was not part of the recommendations, Mr Fisher was not provided with 1:1 care or direct monitoring for the entire duration of his meal.
>
> […]
>
> As specified above, the PCA delivered Mr Fisher's meal and then observed him occasionally – by way of 'distant supervision' – while he ate his meal.
>
> Staff did not ensure Mr Fisher cleared his oral cavity between mouthfuls, because that was believed to be under Mr Fisher's control.
>
> Their understanding was that Mr Fisher had no cognitive impairment, he had spoken to [the speech pathologist] and he understood that that specific Recommendation was guidance to him; not a direction to Holmwood staff.

31. Mr Watson also noted that if both recommendations were to be interpreted as requiring action by HAC staff, they were inconsistent, as distant supervision required only occasional check-ins, whereas care staff ensuring that the oral cavity was clear between mouthfuls would require "'1:1' or 'close' supervision throughout the course of the meal".

32. Mr Watson also noted that at HAC, a more intense level of specified supervision or continual monitoring would generally only be provided to residents with limited cognitive abilities, severe cognitive impairment, or in the event of severe oral dysphagia – none of which applied to Mr Fisher.

33. In contrast to the understanding of HAC, Ms McLauchlan stated that her recommendation of "distant supervision" required HAC staff to maintain visual contact with the resident at all times, although they were not required to be within arm's reach. Ms McLauchlan's expectation was that if Mr Fisher was eating in his room, a staff member was either in the room or standing at the door, maintaining visual contact. Ms McLauchlan advised that a carer could then periodically check Mr Fisher's oral cavity to ensure it remained clear. This could be done by approaching him during pauses in his eating or visually assessing the cavity from a distance, paying attention to auditory signals such as coughing and grunting. Ms McLauchlan regarded such measures as being sufficient to ensure Mr Fisher's oral cavity remained clear.

34. The statements of Mr Watson and Ms McLauchlan were both provided to the CPU for review.

CPU advice regarding management of choking risk and the choking incident

35. The CPU advised that the management of the choking incident by HAC, being the attempts to remove the food obstruction and commencement of CPR, was in line with accepted care standards for choking in residential aged care. The CPU also advised that at the time of Mr Fisher's incident, there was a total of nine care/nursing staff rostered on the Townsend Unit at HAC, and all three registered nurses attended Mr Fisher within minutes of being advised of his condition. The CPU therefore concluded "that HAC was not understaffed and the response to the emergency was appropriate".

36. The CPU did not identify any issues with HAC's initial assessment of Mr Fisher's difficulties with chewing and swallowing, which appropriately led to a referral for specialist review by a speech pathologist. The review was attended to within three days and the specialist's recommendations for meal modification were enacted by HAC. Mr Fisher had a review one week later by the same specialist, and it was documented that he was happy and managing well with his new diet. The CPU noted that Ms McLauchlan stated she left clear documentation on both occasions of her visits and verbally communicated with staff members at HAC about the recommendations.

37. Regarding the management of the choking risk, the CPU noted the difference in understanding between HAC and Ms McLauchlan of what the recommendations required. The CPU advised that Ms McLauchlan's understanding of "distant supervision" aligned with Safer Care Victoria's (**SCV**) best practice guidance, *Communicating safe eating and drinking* (**the SCV guidance**), which states that "supervision is the constant visual observation of the person for the specified time for the specified task".[3] The CPU advised that the HAC approach to "distant supervision" did not align with the SCV guidance, or with the recommendation to "continue to monitor for choking risk and overt signs of aspiration".

38. The CPU further noted that Mr Fisher's choking incident was not witnessed and opined that if he had been observed having difficulties with his oral intake and choking at the time it occurred, interventions could have been attempted, such as initially encouraging coughing or five back blows and/or five chest thrusts alternating. If these were unsuccessful, CPR would be commenced. The CPU advised that immediate first aid for choking may have prevented

[3] www.safercare.vic.gov.au/sites/default/files/202006/GUIDANCE%20%20Communicating%20safe%20eating%20and%20drinking.pdf Accessed on 8 May 2024.

Mr Fisher's death, and hence the interpretation and operationalisation of the term "distant supervision" was an issue in Mr Fisher's case.

The SCV guidance

39. As part of the coronial investigation, further information was requested from SCV regarding the SCV guidance. SCV advised that the SCV guidance was published and implemented in June 2020. The communications strategy involved an announcement on SCV's Twitter, Instagram, and LinkedIn accounts, an announcement sent to SCV email contacts for further distribution, and an email announcement sent to interested stakeholders and parties. SCV also advised that as a public healthcare agency, they work closely with public health services, however, to date the remit of SCV and scope of work has not included the active engagement of residential aged care facilities in clinical practice. It was also noted by SCV that the guidance is not mandated and should not replace the clinical judgements of healthcare teams.

The HAC response

40. As a result of the CPU review, HAC were provided an opportunity to respond to proposed findings and recommendations.

41. In response, legal representatives acting on behalf of HAC submitted that the evidence did not support findings to the effect that HAC should have been aware of and followed the SCV guidance. They noted that the SCV guidance was never published to HAC specifically, or generally to the non-hospital sector of aged care in Victoria, and that the guidance provided by SCV was inconsistent with the requirements of the industry regulator, the Aged Care Quality and Safety Commission (**ACQSC**). They further noted that the SCV guidance document expressly states that parties "Who should use this guide" are "Public health services including emergency departments, acute and subacute services and aged care wards", and that non-hospital aged care providers such as HAC are not referenced.

42. In response to any implication that HAC staff should have followed the SCV guidance regardless of the speech pathologist's express directions (as they understood them), HAC submitted that to do so would have been contrary to requirements imposed by the ACQSC, and noted that the SCV guidance expressly states that its general guidance is subject to the results of a professional swallowing assessment in any given case. They submitted that in Mr Fisher's case, HAC staff received express directions from the speech pathologist following

two swallowing assessments, but that those directions were not consistent with the SCV guidance.

43. In relation to the phrase "distant supervision", HAC submitted that any finding that HAC had misunderstood the term depended entirely on which of many definitions was accepted. They reiterated that HAC contracted preparation of its primary policies, including those relating to supervision, to industry experts, and noted that there are myriad government and aged care industry guidelines and policies applicable to managing choking risks and dysphagia, but that no other is expressed in the same terms as the SCV guidance. The SCV guidance was not referenced in the formulation of these policies. HAC advised they were not aware of the reasons for this but suggested it may be because the SCV guidance was not known to the contractors or was not considered relevant.

44. Finally, HAC acknowledged that Mr Fisher's death appeared to reveal an inconsistent level of expectation, if not a divergence of opinion, about aged care supervision - an issue that they regarded as industry-wide and not specific to HAC. They submitted that a recommendation for standardised supervision principles to be developed and published throughout the aged care industry would be reasonable.

Further CPU review

45. As a result of the response received by HAC, I requested further advice from the CPU.

46. The CPU confirmed that the SCV guidance was not directed to the residential aged care facilities sector, whose regulation is federal. The CPU also noted that the interaction between the national standards referred to by HAC and the SCV guidance was confusing.

47. The CPU explained that at the time of Mr Fisher's passing, ACQSC guidance for nutritional supervision sat within Standard 4 of the *Aged Care Quality Standards*,[4] "Services and supports for daily living", and links with Standards 1, 2, 7 and 8.

48. The ACQSC provides general advice that "the food and dining experience offered by your aged care provider should be safe, enjoyable, respectful and based on what you like".[5] It also provides advice in relation to choking risk, including that:

[4] This version of Aged Care Quality Standards was in effect between 1 July 2019 and 31 October 2025. See: https://www.agedcarequality.gov.au/providers/quality-standards/previous-aged-care-quality-standards & https://www.agedcarequality.gov.au/sites/default/files/media/Standard%204.pdf

[5] https://www.agedcarequality.gov.au/older-australians/health-wellbeing/food-and-nutrition#swallowing.

- there is a higher risk of choking in people who have various types of dysphagia or swallowing dysfunction;
- a speech pathologist can help assess swallowing risk and advise on strategies to minimise this risk, including feeding, timing and posture strategies and texture modification of foods;
- A multidisciplinary team assessment and discussion including the older person in the process, can identify risk mitigation strategies, and ensure the team is knowledgeable regarding support required for safer eating, drinking, and swallowing.
- any discussions between a resident, speech pathologist and staff member about swallowing issues needs to be consumer-focused, individualised and well documented;
- residents can decide to what extent they take the advice and accept known risks.[6]

49. In summary, the ACQSC requires that aged care homes recognise that their residents with swallowing dysfunction are at higher risk of choking. The ACQSC also advises aged care homes to provide nutrition in accordance with speech pathologists' recommendations. Of note, the ACQSC does not define nutritional supervision in distinct categories, such as "distant supervision" or "close supervision".

50. By comparison, SCV's *Communicating safe eating and drinking* guidance defines "supervision" as "the constant visual observation of the person for the specified time for the specified task", removing ambiguous descriptors such as *full, close, distant* or *direct* supervision that are commonly used in the industry. The guidance additionally states that "Communicating every aspect of supervision helps ensure nothing about providing the supervision is misunderstood" and recommends that supervision is communicated by describing the following six elements of supervision:

    1) Why is supervision being requested?
    2) Who can provide the supervision?
    3) When and how often is supervision required?
    4) What supervision is needed?
    5) How long is the supervision required?

[6] https://www.agedcarequality.gov.au/news-publications/clinical-alerts-and-advice/ensuring-first-aid-capabilities-manage-choking-risk-residential-aged-care

6) What needs to happen if supervision cannot be provided or is unavailable?[7]

51. The CPU opined that the SCV guidance provides a more detailed description of how supervision during meals can be provided to ensure patient safety, removes ambiguous terminology, and would ideally be implemented in all residential aged care homes.

52. In Mr Fisher's case, the CPU was satisfied that HAC staff complied with the industry standard by promptly arranging an assessment by a speech pathologist, but did not ultimately follow the speech pathologist's advice as was intended by the speech pathologist due to different understandings of the term "distant supervision".

53. The CPU noted that if HAC was unclear about what was required by the speech pathologist's recommendations, or if HAC regarded one recommendation as being inconsistent with other recommendations, clarification should have been sought by HAC. Furthermore, the CPU thought a "patient centric" approach to Mr Fisher should have involved documented education given to Mr Fisher and putting a safety plan in place. This related to the HAC belief that the recommendation regarding clearing of the oral cavity of food residue was directed to Mr Fisher, and his desire to eat independently. The CPU view was that if Mr Fisher was regarded as independent and self-monitoring in relation to this risk, this should have been documented. The CPU still questioned whether HAC had followed the speech pathologist's recommendations, noting that "distant supervision" appeared to be qualified in the sentence below that recommendation indicating that each mouthful was to be cleared.

54. However, the CPU also concluded it was unclear whether it was communicated by the speech pathologist that the recommendation regarding mouth clearing was directed to HAC staff, and not Mr Fisher, and the language in the notes by Ms McLauchlan which recorded the recommendations was ambiguous regarding whose responsibility this was.

55. The CPU observed that the issue in Mr Fisher's case was ambiguous terminology. It was observed that the federal standards for a RACF were broad, and industry experts determine what "distant supervision" requires. The CPU advised that more guidance was needed on what 'supervision' required, and that Speech Pathology Australia may be best placed to provide such guidance.

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7 https://www.safercare.vic.gov.au/sites/default/files/202006/Guidance%20_%20Communicating%20safe%20eating%20and%20drinking.pdf.

PROPOSED RECOMMENDATIONS

56. Speech Pathology Australia and the ACQSC were both contacted as part of the coronial investigation to seek their input in relation to recommendations that might best address the apparent inconsistency in understandings about supervision in the aged care sector.

Speech Pathology Australia

57. As the national peak and regulatory body for speech pathologists in Australia, I invited Speech Pathology Australia to respond to the following proposed recommendations:

> That Speech Pathology Australia
>
> 1. Advise their members to discontinue categorical descriptors of supervision such as 'distant' or 'close' supervision of persons identified at risk of choking due to swallowing problems and/or unsafe eating and drinking behaviours;
>
> 2. Endorse individualised plans that align with the six elements described in the Safer Care Victoria 'Communicating safe eating and drinking: Best practice guideline' or develop a similar guideline; and
>
> 3. Collaborate with the aged care sector and other stakeholders to support education and documentation for RACH staff in relation to care planning for residents identified at risk of choking (due to swallowing problems and/or unsafe eating and drinking behaviours), to align with the Safer Care Victoria 'Communicating safe eating and drinking: Best practice guideline' or develop a similar guideline.

58. In correspondence dated 18 September 2025, Speech Pathology Australia supported these recommendations and indicated an intention to:

a) amend content within the *S*peech Pathology Australia *Dysphagia Practice Guideline* (2025) to highlight and promote the SCV guidance as best practice.

b) promote the SCV guidance as best practice across aged care and relevant sectors, which may include disability accommodation, university speech pathology programs and health settings; and

c) continue collaboration and advocacy with the aged care sector and other stakeholders to support education and documentation for residential and aged care staff in relation to care planning for residents identified at risk of choking to align with the SCV guidance.

ACQSC

59. As the industry regulator of aged care providers, I invited the ACQSC to respond to the following proposed recommendations:

> That the ACQSC:
>
> a) Consider adopting the SCV guidance as part of its Quality Standards; and
>
> b) Consider including in the Quality Standards a requirement that aged care providers make specific enquiries with speech pathologists to ensure care staff understand the terminology used in speech pathologists' recommendations regarding safe nutrition for residents with choking risk.

60. By letter of 17 October 2025, the ACQSC, in consultation with the Department of Health, Disability and Ageing (**the Department**), advised that the Aged Care Quality Standards had recently undergone review in response to recommendations made by the Royal Commission into Aged Care Quality and Safety. As a result, strengthened Quality Standards were then developed which provide stronger requirements for clinical care, and food and nutrition. The strengthened Quality Standards came into effect on 1 November 2025.

61. The ACQSC advised that the strengthened Quality Standards highlight the need for effective communication, staff skills and competencies, and management of clinical risks such as choking. Of note, the introduction of a dedicated Standard for food and nutrition (Standard 6) recognises that food and nutrition are important aspects of an older person's care and can have a significant impact on a person's health, wellbeing and quality of life. Standard 6 requires providers to support older people to eat and drink. In addition, the new dedicated clinical care standard (Standard 5) outlines requirements to manage clinical risks. This includes identifying, monitoring and managing high impact and high prevalence risks in the delivery of clinical care, including choking and swallowing. To demonstrate meeting this outcome, providers can implement processes to support safe chewing and swallowing when an older person is eating, drinking, taking oral medicines and during oral care (Action 5.5.2).

62. In relation to the proposed recommendations, the ACQSC advised that although there may be opportunity to consider the subject of the proposed recommendations further, incorporating the SCV guidance into the Quality Standards would not generally align with the design and structure of the Quality Standards. They explained that the Quality Standards provide broad guidance on the community's expectations of aged care providers when delivering aged and

clinical care, but do not develop clinical guidelines. Instead, the ACQSC expects aged care providers to source relevant guidelines from reputable and translatable sources to develop organisational policies for use by their staff in the Australian aged care context.

63. The ACQSC also referred to the range of industry education materials published through the ACQSC's *Food, nutrition & dining: resources for providers* website[8] with a particular focus on the need for providers to understand and effectively implement speech pathology recommendations in aged care settings.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Keith Walter Fisher, born 14 August 1934;

    b) the death occurred on 6 September 2022 at Holmwood Aged Care, 17-19 Lalors Road, Healesville, Victoria, 3777, from complications of a choking incident in the setting of ischaemic heart disease; and

    c) the death occurred in the circumstances described above.

65. Having considered all the circumstances, I am satisfied that HAC staff met industry standards of care by promptly arranging an assessment by a speech pathologist for Mr Fisher. However, HAC did not implement the advice as it was intended by the speech pathologist.

66. I accept that this due to a misunderstanding, which was primarily a result of industry-wide variation in understandings of the term "supervision" and inconsistent use of descriptors such as *full*, *close*, *distant* or *direct* supervision. This was compounded by ambiguity in how the recommendation made by the speech pathologist was recorded, and an absence of recoded education and discussion with Mr Fisher about the recommendations and how they would be implemented. In my view, such misunderstandings could be avoided in the future with more clarity provided to aged care providers about what is required.

67. Having regard to all the available evidence, it cannot be known if Mr Fisher's choking incident would have been averted with closer supervision, but I am satisfied that the risk would have decreased if the speech pathologist's recommendations had been implemented as intended.

[8] See: https://www.agedcarequality.gov.au/providers/food-nutrition-dining/food-nutrition-dining-resources-providers#swallowing

Namely – that supervision of mouth clearing be attended to by HAC staff and that there be staff supervision of Mr Fisher's mealtimes within his room.

68. However, whilst the occurrence of the choking incident could potentially have been prevented, it is not possible to determine whether this would have averted Mr Fisher's death. It remains possible that the choking incident was caused by a medical event, having regard to the evidence of ischemic heart disease documented in the report by Dr Francis and her opinion regarding the cause of death. Mr Fisher's level of heart disease was such that he may have experienced a myocardial infarction or a fatal arrhythmia which would have been sufficient to have caused death, but this cannot be established by an autopsy. It is therefore not possible to determine the degree to which Mr Fisher's death was caused or contributed to by a cardiac event, and it is not possible to find that his death would have been averted if the choking incident had not occurred or been rectified with immediate intervention. It is also remains possible that the resuscitation measures which occurred in response to the choking event were ultimately not successful due to an underlying cardiac event which had occurred.

RECOMMENDATIONS

69. Pursuant to section 72(2) of the Act, I make the following recommendations:

That Speech Pathology Australia:

(i) advise their members to discontinue categorical descriptors of supervision such as "distant" or "close" supervision of persons identified at risk of choking due to swallowing problems and/or unsafe eating and drinking behaviours;

(ii) endorse individualised plans that align with the six elements described in the Safer Care Victoria *Communicating safe eating and drinking: Best practice guideline* or develop a similar guideline; and

(iii) collaborate with the residential aged care sector and other stakeholders to support education and documentation for residential aged care staff in relation to care planning for residents identified at risk of choking (due to swallowing problems and/or unsafe eating and drinking behaviours), to align with the Safer Care Victoria *Communicating safe eating and drinking: Best practice guideline* or develop a similar guideline.

I convey my sincere condolences to Mr Fisher'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:

Kerry Fisher, Senior Next of Kin

Holmwood Aged Care Healesville

Emma McLauchlan, Beyond Speech Pathology

Speech Pathology Australia

Safer Care Victoria

Aged Care Quality and Safety Commission

Signature:

Coroner Catherine Fitzgerald

Date : 18 February 2026

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.