IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 / 5187

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JACQUI HAWKINS, Coroner having investigated the death of Katrina Mary West

without holding an inquest:
find that the identity of the deceased was Katrina Mary West
born on 27 June 1958
and the death occurred on 4 October 2014
at Monash Medical Centre, 246 Clayton Road, Victoria, 3168
from:

1 (a) HYPOXIC ISCHAEMIC BRAIN INJURY
1 (b) UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS
1 (c) INTELLECTUAL DISABILITY

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

1. Katrina Mary West, also known as Katie was 56 years old at the time of her death. She was intellectually disabled after suffering an acquired brain injured shortly after birth.

2. Katie lived with her parents until 2009, when they moved to an aged care facility. Katie's mother had dementia and passed away in 2011 and her father passed away in October 2012. Katie has three older loving sisters who had regular contact with her and cared for her overall health and wellbeing.

3. Katie attended a day placement at Melba Adult Training and Support Services five days per week. Katie was very social and communicated well with her other residents and disability workers. Katie enjoyed craft, particularly knitting.

4. At the time of her death, Katie was living in supported accommodation at a Scope facility at Kidgell Street in Lilydale funded by the Department of Health and Human Services. The

facility contained two units with five clients and ten Scope staff. Katie lived with five other residents who all have significant physical disabilities and required significant support and assistance with all aspects of their daily lives. There were two clients living in Unit 1 and three clients living in Unit 2. Located between the two units is the staff office and access to the units could be gained from the office with a security pass.

5. On Saturday 4 October 2014, Disability Support Workers Phil How and Kelly Johnson were preparing dinner for all five clients. The meal was roast pork with vegetables and it was being cooked in Unit 1. At dinner time, Mr How realised the pork was undercooked, so he cut the meat into pieces and placed it back into the oven to ensure it was properly cooked.

6. When a roast is cooked for the residents, dinner it is normally eaten with all clients together but on this occasion a client in Unit 1 was being disruptive therefore it was decided that the meals would be served in each separate unit.

7. At approximately 6.20pm, Mr How prepared the meals for the clients in Unit 2. The meals were taken to Unit 2 and placed on the kitchen table. According to Mr How, each client, including Katie eats independently. Once the meals were placed on the table, Mr How returned to Unit 1 to help Ms Johnson prepare the meals for the residents in Unit 1.

8. At approximately 6.23pm, Ms Johnson heard the doorbell from the staff office. One of the clients from Unit 2 was at the door. The client had walked around the rear of the unit to the staff door as there was no access for residents through the staff door that leads directly to the office. The internal staff door was locked and required a security pass allocated only to staff.

9. Ms Johnson called Mr How for assistance and they both went to Unit 2 and found Katie on the floor. Ms Johnson observed Katie was not breathing and could not locate a pulse. Ms Johnson commenced cardiopulmonary resuscitation (CPR). Mr How went to the foyer of the office and rang emergency services.

10. Katie was turned onto her side by Mr How as instructed by the operator. Mr How checked her mouth but could not find any obstruction. Ms Johnson was on the phone to the emergency operator and provided instructions to Mr How. He placed Katie onto her back and began chest compressions until the ambulance arrived.

11. According to the ambulance notes, they were notified at 6.29pm and arrived at 6.41pm. Paramedics removed the piece of meat from Katie's airway by forceps and continued CPR. Spontaneous circulation was achieved approximately 25 minutes after the arrival of the ambulance.

12. Katie was taken by ambulance to the Monash Medical Centre and admitted to the Intensive Care Unit. Dr Timothy Crozier, Intensive Care Specialist treated Katie with therapeutic hypothermia, for presumed aspiration pneumonia. Discussions were held with Katie's sister in relation to the possibility of a poor neurological outcome.

13. Katie was witnessed to have myoclonic seizure activity. Levatiracepem was commenced as an anticonvulsant agent and an EEG was performed. This resulted in the presence of bilateral, lateralised epileptiform discharges. Supportive care was given over subsequent days with ongoing anticonvulsant therapy, with no evidence of any neurological recovery.

14. On 7 October 2014, a CT scan of the brain revealed a loss of normal grey-white matter differentiation, diffuse density affecting the bilateral basal ganglia and sulcal effacement, which indicated diffuse hypoxic ischaemic brain injury.

15. A neurological review on 9 October 2014, revealed ongoing status myoclonus and a Glascow Coma Scale of 3. There was absence of most brainstem reflexes, namely corneal reflex, gag cough and dolls eye reflexes. Katie's family were advised of her dire condition and agreed for Katie to be placed in palliative care. Withdrawal of life treatment occurred on 10 October 2014 and Katie died at 11am. Katie's family consented to organ donation.

16. On 12 October 2014, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an external examination on Katie and provided an opinion that her medical cause of death was:

    1 (a) HYPOXIC ISCHAEMIC BRAIN INJURY
    1 (b) UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS
    1 (c) INTELLECTUAL DISABILITY

Victoria Police investigation

17. Victoria police commenced an investigation into the circumstances of Katie's death and took statements from relevant witnesses and her treating physician at Monash Medical Centre and prepared a coronial brief.

Family concerns

18. Katie's sisters Sherie Kerr, Wendy Lange and Robyn Stewart wrote to the Coroners Court in November 2014 with concerns relating to their sister's death. Specifically, they felt that Katie should have been supervised during her meal and that there should have been a carer present, as the incident required one of the residents to go and seek help and was not in a position to

assist Katie. They felt that if a Scope worker was present to administer immediate first aid, there may have been a different outcome.

19. The sisters noted "*it was our assumption that in this form of supported accommodation style living, a degree of 'duty of care' was standard practice and that clients would always be supervised during mealtimes, not only for physical and safety reasons, but for socialisation purposes as well.*" Consequently, Katie's sisters believed that Scope employees were not adequately staffed or trained.

Scope's response to coronial enquiries

20. Ms Charlotte Stockwell, General Manager of Scope East Region wrote to the Coroners Court on 16 February 2016 in response to my further request for information. Ms Stockwell advised that no root cause analysis was conducted by Scope in relation to Katie's death, however two incident reports were prepared and she provided those incident reports.

21. Ms Stockwell advised that staff are required to have a current First Aid, Level 1 Certificate in addition to CPR certification, and training is provided annually. During the pre-employment phase, staff are re-trained and assessed on their meal assistance skills. In addition, staff may be required to undertake meal assistance training in relation to an individual client's needs. Staff must also participate in Duty of Care, Food Handling, Manual Handling and other training during their employment with Scope.

22. Mr How and Ms Johnson were on duty on 4 October 2014 and their training records were provided to the Coroners Court. Both staff received training in meal assistance as part of their induction and had current First Aid and CPR qualifications at the time of Katie's death.

23. According to Ms Stockwell, Katie required no supervision at meal times and was able to eat independently. She had no known swallowing difficulties requiring supervision. Katie preferred to eat cereal in the morning and would usually take a sandwich, fruit and yoghurt for lunch. Katie often went out for lunch and dinner with friends and family where she ate without supervision or assistance. Further, her medical assessments did not disclose any problems associated with swallowing or any prior episodes of choking.

24. Ms Stockwell noted that food consumption is monitored on an individual basis depending on a client's needs and consequently, Scope has not made any changes to their food consumption practice or policy.

Scope Records

25. I have extensively reviewed the Scope records in relation to notes or comments regarding food or meal assistance for Katie and found the following relevant documents as part of my investigation:

    a. *Dietary Recommendations for Katie West* - "Keep all food out of sight to make it easier to manage" and the document suggests "I need tough meat cut up".

    b. *Support Plan* document under the heading Meal Assistance, notes "I eat independently with a knife and fork" and "I need you to cut up my meat in to small pieces".

    c. *Client Care Profile* document notes that under the comment section of Meal Assistance Katie is "independent".

26. In summary, there is no notation in her Scope file that Katie needed direct supervision.

Further family concerns

27. Katie's sisters were provided a copy of Ms Stockwell's letter and were surprised that no follow up actions have taken place at Scope.

28. The sisters were also surprised that Ms Stockwell noted that Katie often ate with her family without supervision. The sisters firmly dispute this and reported that

> *Katrina never ate alone when with family. We were all aware of the importance of mealtime being a social time with family and that Katrina needed continual reminding not to rush her meals, not to put too much in her mouth at once and to chew her food properly before taking the next mouthful, even an employee from Katrina's unit commented on how she needed constant reminding of these facts. She had quite often gagged at mealtimes and on one occasion we had to thump her on the back in a restaurant to dislodge a piece of meat.*

29. Katie's sisters made a number of suggested improvements that Scope could implement including:

    a. Is level 1 first aid qualification sufficient training for carers who are working with people with such high needs?

    b. Clients should never be left without supervision, particularly during mealtimes.

    c. Could clients access a simplified means of gaining staff attention when they are in the office or in the other unit? eg: an alarm

    d. Could surveillance cameras and/or two way mirrors be installed so that staff do have visual access to clients when they are in the office or the other unit.

e. Could time for paperwork be arranged so that the clients are not left on their own for extended periods of time?

30. I have considered these suggestions and do propose to make a recommendation in relation to item 29(c) above.

Findings

31. I find that Katrina Mary West also known as Katie died on 10 October 2014 from:

1 (a) HYPOXIC ISCHAEMIC BRAIN INJURY
1 (b) UPPER AIRWAY OBSTRUCTION BY FOOD BOLUS
1 (c) INTELLECTUAL DISABILITY

32. I find that Katie was eating her dinner with other Scope residents in Unit 2 on 4 October 2014, when a piece of meat became lodged in Katie's throat and she was unable to remove it. I further find that the disability workers Mr How and Ms Johnson were unavailable to immediately assist as they were preparing food in Unit 1 for the other residents and were notified that Katie was choking by a resident from Unit 2. I acknowledge that this was distressing and a huge responsibility for a resident with a physical and intellectual disability.

33. I find that as soon as Mr How and Ms Johnson became aware of Katie's predicament, they immediately went to her assistance, called emergency services and commenced CPR. I am unable to determine whether the circumstances would have resulted in a different outcome, had Mr How or Ms Johnson been present in the Unit at the time of the incident.

34. I acknowledge that Scope consider the two staff members were adequately trained and that none of Katie's Scope or medical records referred to any potential risk of choking or need for supervision whilst eating. I accept this is in dispute with Katie's sisters' understanding of her need for supervision during meal times.

35. I acknowledge the devastation of Katie's loss on her three sisters and their extended families. The tenacity and strength by the sisters in advocating for Katie during the coronial investigation is to be admired. It is evident to me that they dearly loved their little sister.

36. I offer my sincere condolences to the West family for the unexpected death of Katie.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

37. I recommend that Scope East Regional Office install an alarm in the kitchen in each unit located at 26 Kidgell Street, Lilydale Scope facility, to ensure that residents can readily alert the disability workers to an adverse or dangerous event.

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

- Ms Wendy Lange
- Ms Charlotte Stockwell, General Manager, Scope East Regional Office

Signature:

JACQUI HAWKINS
Coroner
Date: 23 May 2016