IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4527

FINDING INTO DEATH WITHOUT INQUEST

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

I, JOHN OLLE, Coroner having investigated the death of MARJORIE HALL
without holding an inquest:
find that the identity of the deceased was MARJORIE HALL
born on 5 June 1938
and that the death occurred on 7 October 2013
at BUPA Aged Care, 256-260 Station Street, Edithvale VIC 3196
from:

1(a) ASPIRATION OF FOOD IN A WOMAN WITH DEMENTIA

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

1. Marjorie Hall was born on 5 June 1938 and was 75 years old at the time of her death. Mrs Hall was admitted to BUPA Aged Care Edithvale, on 18 July 2011, in the context of onset of dementia and short-term memory impairment.

2. Mrs Hall had a documented medical history of dementia, short term memory loss, osteoporosis, gastroesophageal reflux disease (GORD), hypertension and urinary incontinence.

3. On 16 January 2013 Mrs Hall was placed on a diet consisting of vitamised food[1] and thickened fluids.[2] This was due to her having problems with chewing and swallowing solid food and aspirating thin fluids when drinking, combined with her worsening dementia. An

[1] Food must be smooth in texture, but not runny; texture consistent for all items; served with a thick sauce or gravy for moisture.
[2] Often used for people with dysphagia, a disorder of swallowing functions. The thicker consistency makes it less likely that an individual will aspirate while they are drinking. Individuals with difficulty swallowing may find liquids cause coughing, spluttering or even choking and thickening drinks enables them to swallow safely.

entry in her medical progress notes states that Mrs Hall needed "full assistance/encouragement to eat, reminders to swallow spoonful then have another".

4. On 6 April 2013, Mrs Hall was moved to the secure dementia-specific unit of the facility for staff to monitor her at all times, as she was at a higher risk of absconding and her behaviour towards staff and other residents was occasionally resistive and aggressive.

5. On 22 June 2013, Mrs Hall was reviewed by the speech pathologist who recorded that she should continue on the vitamised diet and thickened fluids. The speech pathologist wrote in Mrs Hall's Plan of Care, "staff to ensure to always supervise me as pick wrong (sic) food from other residents and at risk of choking. Staff to ensure not to leave me unattended in the dining area while other residents have food". On 2 October 2013, there were further notes to increase monitoring of Mrs Hall's food intake, as she continued to take food from other residents and the meal trolley. It appears that staff were all aware of this issue and were vigilant and reactive to it.

6. On 7 October 2013 at approximately 5.35pm Mrs Hall was observed by staff member Karen Garwood to be walking the corridors of the unit eating a slice of bread. Knowing Mrs Hall to be restricted to a vitamised diet she took the bread from Mrs Hall and advised one of the personal care assistants, Gift Kachi. She also handed Mr Kachi what was left of the slice of bread. Mrs Hall did not appear to be choking when Ms Garwood left her.

7. Mr Kachi found Mrs Hall staggering in the corridor returning to her room. Mr Kachi followed her into her room and heard her gasping for breath and saw her in the bathroom drinking and trying to remove something from her mouth with her fingers. Mrs Hall then walked towards her bed and collapsed on the floor.

8. Mr Kachi went for help and returned with registered nurse Vicky Pelayo. On entering the room Ms Pelayo was advised that Mrs Hall was possibly choking on food. She asked Mr Kachi to advise the nurse-in-charge of the incident and to get the suction machine. Ms Pelayo attempted to dislodge the food by performing abdominal thrusts and back slaps which did not appear to have an effect. Mrs Hall resisted Ms Pelayo's ongoing attempts to assist her, by flailing her arms around and pushing Mr Pelayo's hands away. After a short period of time Mrs Hall went limp and became semi-conscious. When the suction machine arrived Ms Pelayo attempted to use it, however Mrs Hall continued to resist Ms Pelayo by biting down, stopping Ms Pelayo from putting the tube down her throat. After a short time Mrs Hall

became completely limp and unconscious and Ms Pelayo was able to suction, however was only able to get a very small amount of food from Mrs Hall's throat. The unit manager and Ms Pelayo checked Mrs Hall's vital signs, and noticed that she had no pulse or obvious breathing and had no reaction to painful stimuli. The nursing staff were aware that a 'not for resuscitation' order was in place, in the event of sudden health crisis. Consequently, no resuscitation was initiated and an ambulance was not requested. Dr Bob Hoskins attended shortly thereafter and confirmed that Mrs Hall had passed away at 5.50pm.

POST-MORTEM INSPECTION AND REPORT

9. A post-mortem inspection and report was undertaken by Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Bouwer reported that the external examination was consistent with the reported circumstances. There was some partially chewed food present in the mouth and nostrils.

10. The post-mortem CT scan showed a large food bolus in the back of the throat/pharynx and upper airway. There were increased lung markings and brain atrophy.

11. Toxicological analysis of post-mortem blood specimens detected risperidone, hydroxyrisperidone and paracetamol at levels within therapeutic range.

12. Dr Bouwer reported that the cause of death is aspiration of food in a woman with dementia.

FURTHER INVESTIGATION

13. At my request, the Coroners Prevention Unit[3] reviewed the medical care and management and of Mrs Hall. I have used this information to assist my finding.

14. Rosalyn Andrew, manager at BUPA Edithvale Aged Care Facility, provided a comprehensive statement and enclosed a copy of the following BUPA Aged Care Facility documents: 'Policy: Incident Management', 'Procedure: Incident Management', 'Procedure: Assisting residents at

[3] A specialist service for coroners created to strengthen their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'. The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the brief of evidence, medical records, the autopsy report and any particular concerns which have been raised.

meal times', 'Clinical fact sheet on choking and dysphagia', 'Dysphagia and choking education program' and 'CPR training for all registered division 1 and 2 nurses'.

15. Ms Andrew stated that following a speech pathologist review in June 2013, Mrs Hall's 'Plan of Care' was updated to note that she required full assistance with meals. As such, a staff member was required to be with Mrs Hall throughout her entire meal. This appears to have happened, however somehow after finishing her meal Mrs Hall appears to have wandered off and taken at least a piece of bread from another resident's plate or the meal trolley.

16. As a result of this incident BUPA Edithvale provided emergency response training, including cardiopulmonary resuscitation (CPR), to relevant staff at the facility. This training was completed in 2014. Further, BUPA conducted an internal review which was completed by Ms Andrew and Ms Maureen Berry, Clinical Service Improvement Director at BUPA. As a result of this review, there have been numerous measures indentified and changes made to reduce the risk of a similar incident occurring in the future. These include:

    a) Emergency response training for staff on 31 July 2014 and 14 August 2014;
    b) Training in relation to dysphagia and choking in the elderly on 6 August 2014;
    c) A door has been installed in the dementia unit to restrict residents' from accessing the kitchen area, reducing their risk of being able to access food and fluids;
    d) Modified meal trolleys have been purchased for use in the dementia unit. The trolleys have special zipped covers, preventing residents from accessing the food trays whilst they are being transported on the trolleys;
    e) An audit of the nutrition and hydration arrangements for the residents in the dementia unit has been carried out, and a handover tool prepared for staff to highlight residents at risk of choking;
    f) Staff meetings have been held in relation to upcoming emergency training, updating Plans of Care and the door and trolleys in the dementia unit; and
    g) In April 2014 BUPA's resident admission process was updated to ensure the Admission Data Base Assessment records a residents risk of dysphagia and choking.

17. In February 2014 BUPA's Critical Incident Policy (which covers all BUPA facilities across Australia) was revised to include an 'Incident Severity Rating' (ISR) matrix. The ISR matrix rates all incidents from 1-5, with 5 being the most severe or serious. Incidents that rate either 4-5 must be subjected to a Root Cause Analysis (RCA) investigation, that is carried out by a party external to the facility where the incident occurred.

FINDING

18. I am satisfied that no further investigation is required.

19. The facility records and statement of clinical course produced by BUPA Aged Care Edithvale satisfy me that Mrs Hall's care and management at the nursing home was reasonable and appropriate generally. However, I find that there were shortcomings in the care provided to Mrs Hall in relation to supervising that she did not obtain food from other sources outside of meals provided to her. I acknowledge and commend the improvements made by BUPA Aged Care Edithvale to the delivery of health care services, in response to such shortcomings.

20. I find that Marjorie Hall died on 7 October 2013 and that the cause of her death is aspiration of food in a woman with dementia.

RECOMMENDATIONS

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

1. With the aim of minimising risk and preventing like deaths, I recommend that the emergency response training, including cardiopulmonary resuscitation training, that BUPA provided as a result of this incident, is undertaken annually by all BUPA Aged Care Facilities.

2. With the aim of minimising risk and preventing like deaths, I recommend that all changes made by the BUPA Aged Care Edithvale dementia unit, as a result of this incident, be implemented at all other BUPA Aged Care dementia units.

3. With the aim of minimising risk and preventing like deaths, I recommend that BUPA Aged Care review the process for adding or updating information to the 'Plan of Care' document. Currently it is hand written by the reviewing practitioner. Care directions are confusing and not written chronologically with a legible name and date from the practitioner. This is an important care document and I recommend that it should be reprinted each time it is altered by a practitioner, with the new plans of care dated and set out chronologically.

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

The family of Marjorie Hall;

Investigating Member, Victoria Police; and

Interested parties

Signature:

JOHN OLLE
CORONER
21 September 2015