IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2017 001781**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*

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

*Amended pursuant to section 76(a) of the Coroners Act 2008 (Vic), as at 1 August 2022*[1]

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| Findings of: | Coroner Audrey Jamieson |
| Deceased: | Phillip Charles Hodges |
| Date of birth: | 24 February 1945 |
| Date of death: | 16 April 2017 |
| Cause of death: | 1(a) CHOKING ON A FOOD BOLUS |
| Place of death: | Moran Roxburgh Park, 3 Wedgewood Road, Roxburgh Park, Victoria, 3064 |
| Keywords: | Choking, Aged Care, Lack of Training |

[1] Amendments:
i. Second line of paragraph 31 of the **Comments**: the word "imitative" is amended to read "initiative"; and
ii. Distribution list: "Donna Markham" is replaced by "Briana Bass" who is the current Chief Allied Health Officer at Safer Care Victoria.

## INTRODUCTION

1. On 16 April 2017, Phillip Charles Hodges was 72 years old when he died after he choked while he was being fed by a nurse at the aged care facility where he lived.

2. At the time of his death, Mr Hodges lived at the Moran Residential Aged Care (Moran) facility in Roxburgh Park.

Background circumstances

3. Mr Hodges' Aged Care Client Record indicates he had a history of ill health and was diagnosed with mixed dementia and speech impairment having suffered a stroke in 2007. The evidence indicates that at this stage, he was living by himself in Summerhill Village, Reservoir.[2]

4. In May 2009, Mr Hodges suffered another stroke and approximately two years later, he developed Alzheimer's Disease. In 2012, having suffered yet another stroke, Mr Hodges was placed into residential aged care at Moran after his health deteriorated even further.[3]

Medical history

5. In addition to his recurring strokes and his Alzheimer's Disease diagnosis, Mr Hodges had other significant health issues. His medical records reflect a history of the following conditions, amongst others:

   i. Aphasia;[4]
   ii. Mixed Vascular Dementia;[5]
   iii. Epilepsy;[6]
   iv. Hypertension;[7]
   v. Atrial fibrillation;[8] and
   vi. Transurethral resection of prostate and bladder tumour.[9]

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[2] Coronial Brief of Evidence [CB], Aged Care Client Record dated 15 August 2012.
[3] Coronial File [CF], Moran records indicate that Mr Hodges was admitted to their facility on 17 December 2012.
[4] Occurring suddenly after a stroke, Aphasia is a language disorder that affects a person's ability to communicate. The main treatment for the condition is speech therapy.
[5] Dementia caused by the reduced or compromised supply of blood throughout the brain.
[6] A disorder in which the nerve cell activity of the brain is disturbed, causing seizures.
[7] High blood pressure
[8] An irregular, often rapid heart rate that commonly causes poor blood flow.
[9] A urological surgical procedure to treat a prostatic or bladder tumour whether benign or malignant.

6. The evidence indicates that the combined effect of all these conditions left Mr Hodges disabled to the extent that he was non-verbal, non- ambulant and required assisted feeding with a texture-modified diet.

7. The evidence indicates further that, as a consequence of his significant health issues and history of strokes, Mr Hodges had difficulty with chewing and swallowing his food and was diagnosed with dysphagia.[10]

**THE CORONIAL INVESTIGATION**

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

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Hodges' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Phillip Charles Hodges 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

[10] CF, Moran Care Plan for Phillip Hodges dated 20 May 2016.
  i. This plan indicates that Mr Hodges had consulted a speech pathologist on 30 July 2014.
  ii. Dysphagia is the difficulty of swallowing foods or liquids. It is not always caused by underlying disease but affects the vast majority of acute stroke patients. If not managed appropriately, Dysphagia can lead to the aspiration of food or drink.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[11]

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

### Circumstances in which the death occurred

Family Visit

13. On 16 April 2017, in honouring the Easter tradition, Mr Hodges' daughter, Tarish (Trish) Remoska and two other family members visited him to share their Easter Sunday luncheon meal with him.[12]

14. Arriving at Moran at approximately 3.30 pm, Ms Remoska found her father sitting in the loungeroom 'watching TV'. There, after greeting Mr Hodges, she proceeded to feed her father some of the Easter Sunday lunch which the family had enjoyed earlier that day and was joined by her daughter and niece in doing so. Ms Remoska took all precautions to explain to them how their grandfather had to be fed—small portions of the mashed potato and vegetables so that he could 'keep up with his swallowing'. They also gave Mr Hodges some Coke and some Tiramisu. He did not finish the food or the Coke, but managed to finish all the Tiramisu, however.[13]

15. At approximately 4.26 pm, a nurse came to give Mr Hodges his medication. According to Ms Remoska, the 'medication was in a crushed form' and administered with a 'small white plastic spoon'.[14]

16. When she told the nurse that her father did not eat 'much of the potatoes', the nurse reassured her that all was 'okay' and that they will 'give him a sustagen meal replacement drink'. At approximately 4.30 pm, the nurse fed Mr Hodges the meal replacement drink which Ms

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[11] 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.

[12] CB, statement of Tarish Remoska. Ms Remoska was accompanied by her daughter, Mary Mendez and her niece, Avalon Teboneras.

[13] Ibid. The evidence indicates that Mr Hodges' appetite was not affected by his medical conditions. According to Ms Remoska, her father had 'a sweet tooth'.

[14] CB, statement of Resmy Thomas, Registered Nurse, who identifies herself as the staff member who administered the medication. The evidence indicates that Nurse Thomas gave Mr Hodges the 'sustagen' meal replacement drink as well.

Remoska observed to be 'in a clear cup with a straw'. According to Ms Remoska, her father drank the 'entire thing in 30 seconds'.

17. After Mr Hodges had eaten his meal and after he had drunk the 'sustagen' meal replacement offered to him by the nurse, his daughter and granddaughters 'spent some more quality time' with him. They then left at approximately 5 pm.[15]

Choking event

18. At approximately 6 pm, while Ms Remoska was still in the process of driving home, she received a phone call. When her daughter answered the call, she put the call on speaker because her mother was driving. According to Ms Remoska, as the call was answered, she 'heard yelling' and then she heard someone asking "Do we resuscitate, do we resuscitate?" and further "Your father's choking! He's dying, do we resuscitate?". After she responded with the word "Yes!", the 'woman yelled' out telling Ms Remoska to "Get back here". She immediately made her way back to Moran, arriving there at approximately 6.10 pm.

19. Upon her arrival back at Moran, Ms Remoska made her way to where she had left her father in the loungeroom. When she walked into the room, she found him lying on the floor, covered with a white sheet.

20. According to Registered Nurse (RN) Resmy Thomas, she 'attended on Mr Hodges to assist him with his evening meal' while he was sitting in a reclining chair, after his family left. The meal consisted of puréed meat and soft-boiled vegetables. After feeding Mr Hodges the meat portion, RN Thomas proceeded to feed him the vegetables when he 'started gagging' and appeared to be 'choking on the vegetables'.[16]

Emergency procedures

21. After she realised that Mr Hodges was choking on the vegetables, RN Thomas 'pulled' him 'forward in the recliner chair' and 'gave him a few back blows in an attempt to expel the food'. According to RN Thomas, she was unsuccessful. She then activated the emergency buzzer and after she did this she was joined by the 'nurse in charge', RN Luzviminda Cruz and a

[15] CB, statement of Tarish Remoska. The evidence indicates that, after leaving the Moran, Ms Remoska drove her niece to her car before making her own way home.

[16] CB, statement of Resmy Thomas

i. RN Thomas had been employed at the Moran since April 2012.
ii. It is not clear on the available evidence whether the chair was reclined or in the upright position at the time when RN Thomas fed Mr Hodges his evening meal.

personal care assistant (PCA), Amira Adam. With RN Cruz and PCA Adam in attendance, she left Mr Hodges and 'ran to get suction'.

22. When RN Thomas returned with the suctioning equipment, she 'attempted to clear the mouth and pharynx', after which, with the assistance of the additional staff, Mr Hodges was lowered to 'the floor in the recovery position'. Further attempts were then made to dislodge the food bolus by 'back blows and suction'. Realising that their attempts were unsuccessful, one of the 'RNs contacted 000 and shortly afterwards' RN Thomas and her colleagues 'commenced CPR in accordance with basic life support procedures'. While administering CPR, Mr Hodges 'expelled what appeared to be undigested food of about 30mL in volume' and when RN Thomas 'did some further suction', she 'suctioned out a further 20mL of food'.[17]

23. At approximately 5.30 pm, while RN Thomas and her colleagues continued to administer CPR, the Ambulance Victoria (AV) paramedics arrived and took over the CPR procedures. Their resuscitation attempts were unsuccessful, however.

24. At 6.10 pm, the AV paramedics pronounced Mr Hodges deceased.[18]

## Identity of the deceased

25. On 16 April 2017, Phillip Charles Hodges, born 24 February 1945, was visually identified by his daughter, Tarish Remoska, who signed a formal Statement of Identification.

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

## Medical cause of death

27. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 19 April 2017 and provided a written report of his findings dated 20 April 2017.[19]

28. The post-mortem examination revealed multiple bruises on the backs of the forearms and hands and needle puncture marks were observed on the antecubital fossa, the anterior aspect of the elbow. On the history given, Dr Young did not find any '*unexpected* signs of trauma'

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[17] CB, statement of Resmy Thomas who, with her colleagues, administered Cardiopulmonary Resuscitation (CPR) to Mr Hodges.

[18] Coronial File [CF], Ambulance Victoria Verification of Death Form

[19] Coronial File [CF], Medical Examiner's Report of Dr Gregory Young. In performing his duties, Dr Young perused the Victoria Police Report of Death, Form 83, the medical notes held on Mr Hodges' file at Moran and the post-mortem computed tomography (CT) scan.

and the post-mortem CT scan did not identify any 'residual obstruction in the airways". The post-mortem CT scan did, however, identify 'Coronary artery calcification' and 'Dilated ventricles in the brain'.[20]

29. Toxicological analysis of post-mortem samples identified the presence of:[21]

    i. Lamotrigine ~ 3.1 mg/L;[22]
    ii. Valproic Acid ~ 32 mg/L;[23]
    iii. Paracetamol ~ 12 mg/L;[24] and
    iv. Dipyridamole.[25]

30. Toxicological analysis did not identify the presence of any alcohol or any other common drugs or poisons.

31. Dr Young provided an opinion that the medical cause of death was CHOKING ON A FOOD BOLUS.

**THE FAMILY'S CONCERNS**

32. On 26 April 2017, Ms Remoska communicated her concerns with the Court. These concerns related to the standard of care provided to Mr Hodges at Moran. According to Ms Remoska, she believed that her father 'was mistreated at the time of his death' as she 'personally witnessed fast and forced feeding by staff members' at Moran, 'simply to move them along'.[26]

33. In summary, Ms Remoska's concerns were as follows:

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[20] Ibid.

[21] CF, VIFM Toxicology Report of Suwan Yap, Forensic Toxicologist dated 22 May 2017. All drugs indicated were detected at therapeutic concentrations.

[22] Indicated for the treatment of epilepsy and seizures.

[23] An anticonvulsant indicated for the treatment of epilepsy and bipolar mood disorder. Useful in preventing migraine headaches and seizures.

[24] Analgaesic medication indicated for mild to moderate pain.

[25] Anticoagulant medication indicated to inhibit the formation of blood clots. The concentration of this substance was not quantified.

[26] CB,

i. Email to the Court from Trish Remoska.
ii. Ms Remoska sent a second email dated 16 October 2018 to the Court with further concerns. According to Ms Remoska, in the weeks after her father's passing, she discussed the events that led to her father's death with other Moran staff members when she met them in passing.

i. Did the 'force feeding' by staff at Moran contribute to the choking episode?;

ii. Were staff at Moran able to use the 'sucker' machine during the choking emergency?;

iii. The Moran staff conveyed to Ms Remoska that the choking episode occurred whilst the family members were feeding Mr Hodges, not when the staff were feeding him;

iv. The medical record provided to the Victoria Police erroneously referred to Mr Hodges as 'having cancer'; and

v. The final statement of account reflecting the family's outstanding bill to Moran after Mr Hodges' death, bore an incorrect first name.

34. To investigate the family's concerns, I considered the evidence available to me at this juncture which included the Police Report of Death, Form 83 and the Medical Examiner's Report. Having perused these sources of evidence, I determined that I did not have enough information before me at that stage to place the family's concerns in context.

35. Consequently, on 30 May 2017, I directed my Coroner's Investigator, Senior Constable (SC) Rohan Wills, to investigate the death and to compile a Directed Brief. SC Wills was expressly requested to include the following:[27]

i. A statement from the family about feeding procedures for the deceased including specific details about the incident; and

ii. Statements from the medical clinicians and staff at Moran about the incident.

36. On 7 December 2017, SC Wills delivered the Coronial Brief of Evidence which, in addition to the statements which I expressly sought, included Closed Circuit Television (CCTV) footage of the incident, depicting the events as they unfolded, for my perusal and further consideration.

37. My initial review of the Coronial Brief of Evidence revealed that the choking episode occurred while a staff member was feeding Mr Hodges. As articulated in Ms Remoska's letter to the Court, her concern that the choking episode occurred while the family was feeding Mr Hodges arose by way of her meeting another staff member in passing some time after the death. However, even a cursory review of the CCTV footage does not depict the presence of family

[27] CF, Letter from the Court, dated 6 June 2017, to the Officer in Charge, Broadmeadows Police Station.

members as the events unfolded. While I acknowledge the distress that this information caused Ms Remoska, there is no evidence to support her concerns in this regard. Accordingly, I have determined that this concern raised by Ms Remoska is not connected to the circumstances in which the death occurred and does not require further investigation.

38. In relation to Ms Remoska's concerns that her father was reported to have had 'cancer' which, according to her was incorrect, my review of Mr Hodges' medical records indicated that he underwent a surgical procedure in the past. This surgical procedure, a 'Transurethral resection of prostrate and bladder tumour', appears to have been misinterpreted as 'cancer' by virtue of its appellation or the naming convention of the procedure as indicated by the inclusion of the word "tumour". While there is no evidence to indicate whether the "tumour" was malignant or benign, this misinterpretation of the word 'tumour" to mean "cancer', can be considered as reasonable in the circumstances. Ultimately, whether Mr Hodges had cancer or not, is unrelated to the circumstances in which the death occurred. Accordingly, I have determined that Ms Remoska's concern in this regard is not connected to the death and does not require further investigation.

39. Similarly, the incorrect reference to Mr Hodges' first name on the final bill of account, by virtue of the nature of the concern raised, is not connected to the death and does not require further investigation. I do, however, acknowledge Ms Remoska's distress caused by the lack of clerical accuracy, particularly in light of the fact that the bill was issued within a relatively short period of time after her father's death.

40. The evidence contained in the Coronial Brief including the CCTV footage of the incident indicates, however, that Ms Remoska's first and second concerns are related to the death. To summarise, the first concern related to choking risks in aged care residents, predisposed to such risk by a diagnosis of stroke, dysphagia or otherwise. Secondly, the clinical skills of the staff employed in aged care facilities to effectively deal with these risks. That is, whether the staff, both RNs and PCAs, were appropriately qualified or adequately trained to deal with choking hazards. Consequently, I determined that by investigating these aspects, I would advance my own investigation into Mr Hodges' death.

**INVESTIGATIONS**

41. Having reviewed the Coronial Brief of Evidence and the CCTV footage which depicted that the staff member commenced feeding Mr Hodges at approximately 5.25 pm. The CCTV

footage indicated further that the staff member stopped feeding Mr Hodges at approximately 5.31 pm when he started to choke, showing signs of discomfort.

42. Further review of the evidence as contained in the CCTV footage revealed the following:

  i. In response to the choking incident, Mr Hodges was lowered to the floor and placed on his right side;[28]
  ii. It appeared that there was an issue with the suction equipment—either a technical or mechanical issue with the apparatus itself or in the operation of the apparatus by the Moran staff;
  iii. CPR procedures were only commenced at approximately 5.44 pm, a delay of around 13 minutes after Mr Hodges started to choke;
  iv. It appeared that CPR procedures were abandoned until the emergency services call operator instructed the Moran staff to continue their attempts to administer CPR;[29]
  v. The CCTV footage did not depict the arrival of AV paramedics.

43. In order to clarify these glaring discrepancies, as indicated by the evidence, on 29 January 2018, I Directed that the AV records and the medical records held by Moran on Mr Hodges' file be obtained. In particular, I wanted to ascertain when the emergency call was initiated, what information was provided to the emergency services call-taker, what time the paramedics were dispatched to Moran and when they arrived there.

44. Having considered the available evidence at this stage of my investigation against the background of the family's concerns, obtaining these records, in my view, could potentially provide clarity or certainty as to what transpired. In addition, because the circumstances of this death involved health care workers in the setting of an Aged Care Facility, I determined that a review of the evidence and, particularly a review of the circumstances in which the death occurred, by the Health and Medical Investigation Team (HMIT) of the Coroner's Prevention Unit (CPU) to be appropriate and would advance my investigation.[30]

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[28] According to RN Thomas, he was placed in the 'recovery position'.

[29] It is not clear for how long the interruption in providing CPR endured.

[30] The Coroners Prevention Unit (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 is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

**FURTHER INVESTIGATIONS**

45. On 25 May 2018, I convened a meeting with the appropriate members of the HMIT to discuss the matter. More importantly, mindful of my prevention role as a Coroner, I defined the parameters of my investigation, highlighting my aim to identify any opportunities for the improvement of the management and care afforded to Mr Hodges proximate to his death. In my view, in the circumstances in which the death occurred, by choking on a bolus of food while being fed by a staff member in a registered aged care facility, Mr Hodges' death was preventable.

46. Against this background and, recognising that contributing factors in choking-related deaths may have been identified by Aged Care Sector related sources previously, I requested the HMIT to review the circumstances in which the death occurred taking into account any existing protocols and procedures, legislative or otherwise, relevant to the Aged Care Sector. More specifically, I sought to obtain a statement from Moran's Director of Nursing, responding to the family's concerns and my own observations in the CCTV footage and the discrepancies which I identified in that evidence. As focal point of my investigation, in reviewing Mr Hodges' death, the HMIT was to consider the response from the Director of Nursing at Moran against any relevant literature produced by the Australian Aged Care Quality Agency (AACQA), Safer Care Victoria (SCV) or any other agency or government institution of that ilk.[31]

47. On 8 August 2018, in an electronic mail message to the Court, Briege Eva of SVC responded to my query for relevant information. In summary, the SVC informed me that the Public Sector Residential Aged Care Services Division of the Department of Health and Human Services (DHHS), as it was then known, was better placed to provide the information I sought.[32]

48. On the same day, Brett Morris of DHHS referred to me the Victorian Government's research and guidelines relating to the standardised care process in aged care choking hazards which included a reference to other DHHS resources. In particular, I was referred to a DHHS

[31] Under the aegis of the Department of Health and Ageing, Residential Aged Care Services (RACS) is funded by the Federal Government. In Australia, accreditation standards of all RACS are determined by the AACQA. By my Direction, statements and/or information was sought from the individuals and/or agencies identified to advance my investigation.

[32] CF, Email correspondence from SVC's Senior Project Officer, Briege Eva to the Court. According to Ms Eva, as far as she knew, the appropriate authority within SVC to answer my questions would be the SVC's Care of the Older Person Clinical Network (COPCN). However, Ms Eva was not aware at that stage whether SVC's COPCN had produced any topical literature relevant to my investigation.

document, available on the Department's website, titled "*Resident and Family Health Resource on Swallowing*" and further, to a seminal work, a research paper published in the Medical Journal of Australia, 2017, by Professor Joseph Ibrahim of Monash University, titled "*Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services*.[33]

49. I have perused these documents and I have considered their import in the context of my investigation into Mr Hodges' death, particularly Chapter 3, *Choking*, of Professor Ibrahim's Report which deals extensively with pre- choking incident recommendations to health care workers, during-choking incident recommendations to health care workers and post-choking recommendations to health care workers. In my view, the depth and quality of Professor Ibrahim's research paper is exemplary, and it adequately addresses the issues identified by me for further investigation into Mr Hodges death. Accordingly, I determined that the documents were relevant to my investigation and Directed the HMIT to consider the content of the documents in their review of Mr Hodges' care and treatment and in the management of his choking episode which resulted in his death.

50. Furthermore, I considered the nature of the information contained in these documents and determined that if the documents were made available to Moran and the AACQA, they would be better placed to respond to my queries. In my view, because Professor Ibrahim's Report and the DHHS documents fell squarely within the context of my investigation into Mr Hodges' death, it would assist both Moran and the AACQA in responding to my queries. Accordingly, Moran and AACQA were advised to consider the relevance, or otherwise, of these documents to their responses to my questions.

51. On 21 September 2018, Denise Lowe-Carlus of the AACQA provided a statement to the Court. Having perused her statement, I was satisfied that, in the context of the parameters of my investigation as defined by myself, the content sufficed to inform the HMIT's review of the circumstances in which the death occurred.

[33] CF, Email from Brett Morris.

i. Brett Morris is a Manager, Health and Wellbeing Division at DHHS.
ii. Since 1 February 2021, DHHS has become known as the Department of Families, Fairness and Housing (DFFH)
iii. Professor Ibrahim was attached to the Health Law and Ageing Research Unit, Department of Forensic Medicine at Monash University. His research in the field and his Report was co-funded by the Commonwealth Department of Social Services, DHHS (Vic), Department of Forensic Medicine, Monash University and the VIFM.

52. On 17 December 2018, Adrian Sheridan, the Performance and Risk Manager at the Moran Group, provided a statement to the Court. Similarly, having perused his statement, I was satisfied that the content adequately addressed the discrepancies I identified in the CCTV footage and, in this way, it would advance my investigation.[34]

53. Consequently, having considered all the sources of evidence, to facilitate their review, the HMIT was provided with the following:

    i. The Victoria Police Report of Death, *Form 83*;
    ii. Medical Examiner's Report of Dr Gregory Young of the VIFM;
    iii. E-Medical Deposition Form;
    iv. The Coronial Brief of Evidence;
    v. Moran medical records held on Mr Hodges' file, including the CCTV footage of the choking incident;
    vi. AV records relating to the incident;
    vii. Medical records from the Epping Medical Centre held on Mr Hodges' file;
    viii. Statement of Adrian Sheridan, Performance and Risk Manager at Moran;
    ix. Statement of Denise Lowe-Carlus, Director—Regulatory Policy, AACQA;
    x. Ms Remoska's letters outlining her concerns (emails); and
    xi. Email from Safer Care Victoria.

## CPU REVIEW

54. By my Direction, the CPU focused their review of the circumstances in which Mr Hodges' death occurred on the two issues which I identified—the choking risk to aged care residents predisposed to choking and the clinical skills of the staff to effectively deal with the risk of choking.

55. In their review of the circumstances in which the death occurred, the CPU identified from my investigation thus far that:[35]

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[34] CB, statement of Adrian Sheridan. To facilitate making this statement, I formulated certain questions relevant to my investigation. My questions were sent to Mr Sheridan and he was expressly directed to respond in the form of a written statement. The questions related to the family's concerns, the discrepancies I observed in the CCTV footage and glaring inefficiency of the emergency procedures during the fatal event.

[35] CB, CPU reviewed the statements, requested as part of my further investigation, of:
i. Adrian Sheridan of Moran; and
ii. Denise Lowe-Carlus of the AACQA

i. At the time of Mr Hodges' death, the staff at Moran were not appropriately trained to deal with the choking risks in residents.; and further that:

ii. At the time of Mr Hodges' death, the AACQA did not specify what 'staff training' was 'required for accreditation of aged care facilities'.

<u>Adrian Sheridan's response to my questions</u>

56. According to Mr Sheridan, aligned with AACQA requirements, Moran did not provide any formal resuscitation training 'to its care delivering or other staff' (sic) because basic life support training 'is not part of the aged care mandatory training requirements'. While RNs have basic life support and first aid training in their academic modules as students, the Australian Health Practitioner Regulation Agency (AHPRA) does not require ongoing training to satisfy registration imperatives. Similarly, PCAs were not required to be trained in basic life support procedures.

57. Mr Sheridan stated further that 'staff training in safe feeding and dysphagia was not provided to carers' at Moran 'until after Mr Hodges' death.

58. Attached to his statement, Mr Sheridan provided a copy of the last speech pathology assessment conducted on Mr Hodges in the year 2014. The clinical notes of this assessment indicated that although Mr Hodges tolerated his diet well and had 'no choking episodes', he required nutritional supplements due to his ongoing weight loss.

59. The evidence indicates that Moran had the appropriate systems in place to identify and communicate to their staff that Mr Hodges required a texture modified diet and that his medication was to be administered in a 'crushed' form, mixed with his puréed food. This information was contained in Mr Hodges' 'Nutrition and Hydration Care Plan" which was devised by Moran for him. In terms of this plan, Mr Hodges was identified as a resident who experienced 'difficulty with chewing', is one who 'gets tired' and one who 'requires position in bed or chair' (sic). The plan also indicated that Mr Hodges required 'one on one physical assistance'.

60. Mr Sheridan's response indicated further that Moran 'stocked' an oxygen cylinder, suction apparatus and a 'bag valve mask and airways' and attached the record indicating that the equipment was checked on a daily basis. He did not, however, indicate whether or not the staff were trained how to use the equipment.

Australian Aged Care Quality Agency's response to my questions[36]

61. By and large, the response received from the AACQA was consistent with Moran's response in relation to training standards and requirements of staff employed in residential aged care services.

62. According to Ms Lowe-Carlus, the AACQA Accreditation Standards at the time of Mr Hodges' death were not prescriptive and did not delineate any expected outcomes to be met by aged care service providers. This omission in their Accreditation Standards related to both the care and management of the residents and the equipment required to deliver quality care to the residents.

63. Commenting on Professor Ibrahim's recommendations on choking hazards in aged care facilities and on whether the AACQA considered those recommendations in formulating their revised aged care standards, Ms Lowe-Carlus stated that *The Aged Care (Single Quality Framework) Reform Bill 2018* (The Bill) introduced new Quality Standards. At the time of providing her response. Ms Lowe-Carlus noted that The Bill was passed by both Houses of Parliament and would come into effect on 1 July 2019.[37]

64. With this new regime in place, Ms Lowe- Carlus stated further as follows:[38]

    i. Under the new Quality Standards, the Quality Agency expects organisations to identify and address areas of risk that are prevalent in the sector and specific to the organisation and its consumers (the resident in my investigation);
    ii. The new Quality Standards consider effective management of high-impact or high-prevalence risks associated with the care of each consumer, the resident. To meet required standards, individual organisations need to do as much as possible to manage risks associated with the care of each resident by following best practice guidelines and using control measures to ensure that the risk is as low as possible. In turn, to

[36] CB, statement of Denise Lowe-Carlus.
[37] *Aged Care (Single Quality Framework) Reform Act 2018* (Commonwealth)—No. 102, 2018
  i. The provisions of this Act came into effect on 1 July 2019.
  ii. This Act amends the Aged *Care Act 1997* (Aged Care Act) and the *Australian Aged Care Quality Agency Act 2013* (Quality Agency Act).
  i. Sections 54-2 to 54-5 effectively repeals the authorisation in the Aged Care Act to set out Accreditation Standards, Home Care Standards and Flexible Care Standards in the Quality of Care Principles and authorises standards to be known as the Aged Care Quality Standards to be set out in the Quality of Care Principles
[38] For the purpose of my Finding, I have summarised the salient points of Denise Lowe-Carlus' statement, relevant to my investigation into Mr Hodges' death.

implement any changes, individual organisations are required to review their current care practices and apply new methods to respond appropriately and timeously to a resident's changing needs and evolving risks;

iii. For high-impact and highly prevalent risks associated with the care of each resident, organisations are to conduct risk assessments, in consultation with the resident, in their quest to reduce these risks by providing staff training and education on managing the risks and on the use of medical or other equipment to abate the effects of the risk involved and to deliver appropriate care safely. Ultimately, it remained the responsibility of the organisation, as the service provider, to develop strategies to minimise the effect and number.

iv. Risk management processes should be aligned with each resident's presentation so that the service provided is suited to each resident's specific needs.[39]

CPU opinion

65. On 1 February 2019, the HMIT submitted their report for my consideration.

66. Having considered the responses of Moran and the AACQA in conjunction with sources of evidence which I made available to them, particularly the CCTV footage, the HMIT formed the view that despite Ms Remoska's concerns about her father 'being force-fed', the CCTV footage revealed that he was 'correctly upright' and was being fed food of 'appropriate consistency', one spoon at a time. Furthermore, Mr Hodges did not appear to be distressed until he started to choke.

67. However, from the CCTV footage, the HMIT was unable to discern whether Mr Hodges had swallowed what he was being fed before another spoon of food was offered to him. With his known medical conditions, limited mobility and being non-verbal, it was likely that Mr Hodges would not have been able to communicate that he did not want his meal and his raising his arm, as was visible on the CCTV footage, 'could be interpreted as minor resistiveness to being fed'. (sic)

68. In the likelihood that Mr Hodges was not hungry after his family had shared their Easter Sunday meal with him and after he had drunk the 'sustagen' meal replacement, the possibility

[39] That is, a subjective approach must be adopted to the needs of each resident. In Mr Hodges' case, Moran's risk management processes had to be aligned to his specific needs given his history of strokes and Dysphagia.

existed that RN Thomas, who lacked necessary training to recognise this possibility, was not aware that he 'was pooling his meal in his mouth' and continued to feed him.

69. Furthermore, after the choking episode became apparent to RN Thomas, the CCTV footage depicted a delay of minutes in finding and connecting the 'sucker machine'. According to the HMIT, this delay may not have altered the outcome for Mr Hodges as the suction equipment, being more suited to liquid consistencies, may have become blocked by Mr Hodges' texture-modified diet of puréed food. It is unclear on the CCTV footage, however, if this is, in fact, what had occurred.

70. Despite this delay, the emergency procedures undertaken by Moran's staff 'was in keeping with the flow chart developed' by DHHS. As such, their response to the choking episode 'represents an expected standard of response for staff without formal training'.[40]

71. In Mr Hodges' circumstances, noting his physical disabilities, his medical history and particularly, his diagnosis with Dysphagia and the inability to discern from the CCTV footage whether Mr Hodges had been 'pooling his food', the HMIT suggested that I obtain an expert opinion from a speech pathologist to make this determination.

72. On 8 March 2019, I convened another meeting with the HMIT to discuss the content of their report. This report, in conjunction with the available evidence indicated that the lack of training of the Moran staff and the technique adopted in feeding Mr Hodges, a man predisposed to choking, was unavoidably linked to the events that led to his death. Similarly, the evidence supported a conclusion that the inability of the staff to operate the suction equipment and the failed resuscitation attempts was an opportunity lost for Mr Hodges.

73. Mindful that the available evidence would inevitably lead me to make adverse comments about Moran's staff training regime and the feeding technique and because the determination of unsafe feeding practices was beyond the expertise of the CPU, I formed the view that the suggested expert opinion on the effects of 'food pooling' in patients diagnosed with Dysphagia, would enhance the probative value of the available evidence and therefore advance my investigation.

74. Having taken the view that the conduct of the staff at Moran was unavoidably linked to the events that led to Mr Hodges' death, I determined that I would refer this matter to an Inquest.

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[40] "Standardised Care Process" developed by the DHHS for the Victorian residential aged care services in the public sector.

In my purview, if Moran was not prepared to concede that the conduct of their staff, acting in the course and scope of their employment, contributed to the death and, having determined previously that, in discharging my duties under the Act, I would make adverse comments and recommendations connected with the death, the correct forum to deal with this matter would be at a public hearing.

75. Consequently, to advance my investigation into Mr Hodges' death to a public hearing, I decided to list the matter for a Directions Hearing to give the interested parties an opportunity to be heard on my proposed adverse comments and recommendations. To facilitate the process further and to enhance the probative value of the available evidence, I endorsed the suggestion of the HMIT to obtain an expert opinion from a Speech Pathologist.

76. On 10 April 2019, the Court commissioned Ms Michelle O'Rourke, Head of Speech Pathology at Monash Health as the expert in my investigation into Mr Hodges' death.

Speech Pathologist's opinion

77. By way of background information, Ms O'Rourke was provided with the following:

    i. The Victoria Police Report of Death, Form 83;
    ii. The VIFM Medical Examiner's Report of Dr Gregory Young;
    iii. The Coronial Brief of Evidence;
    iv. Moran Aged Care, Roxburgh Park Records including the CCTV footage of the choking incident;[41] and
    v. Statement of Adrian Sheridan, Performance and Risk Manager, Moran Group.

78. On 29 May 2019, Ms O'Rourke submitted her expert opinion for my consideration.

79. In summary, Ms O'Rourke opined that the speed at which Mr Hodges was fed was appropriate in the circumstances. She could not, however, determine from the CCTV footage whether Mr Hodges was 'pooling food' in his mouth.

80. Noting that the last time that Mr Hodges was assessed by a Speech Pathologist was on 13 August 2014, Ms O'Rourke expressed her concerns in this regard. According to Ms O'Rourke, given Mr Hodges' medical diagnosis of vascular dementia and his history of chest infections

[41] CB, Expert Opinion of Michelle O'Rourke dated 29 May 2019. The CCTV footage was captured from distance of approximately five metres. The footage is visual only and does include audio functionality. The viewer is therefore not enabled to hear the communication between the staff members as the events were unfolding.

and his ongoing weight loss, he should have been assessed by a speech pathologist in the period leading to his death. That is, in the period between the last speech pathology assessment and the date of his death. On the sources of information available to her, Ms O'Rourke formed the opinion that it was possible that Mr Hodges' 'vascular dementia' led to the development of 'pharyngeal stage swallowing impairment' (PSSI) which remained 'undetected' because he was not assessed by a Speech Pathologist more regularly.[42]

81. Ms O'Rourke stated further that Mr Hodges' history of chest infections supported her conclusion that he was suffering from PSSI and his 'chest concerns' were indicative of his 'potential for silent aspiration'. By conjecture, Ms O'Rourke concluded that if Mr Hodges' condition was reviewed by a Speech Pathologist, given his 'chest concerns', he may have been considered for 'a referral for instrumental assessment and he may have been placed on a different diet consistency'.[43]

82. I have scrutinised Ms O'Rourke's expert opinion and I have considered its probative value in the context of my investigation into Mr Hodges' death and the body of available evidence. In my view, in the circumstances in which the death occurred, in an aged care facility, death by choking is preventable and the failure to provide regular speech pathology assessments represented an opportunity lost for Mr Hodges.

83. Having considered the contribution of Ms O'Rourke's expert opinion to the body of evidence yielded during my investigation, including the statement from Mr Sheridan of Moran, conceding that the staff was inadequately trained to deal with choking emergencies and further that RN Thomas' conduct in feeding Mr Hodges, acting in the course and scope of her employment, was unavoidably linked to the death, I took the view that I had enough evidence to finalise this matter by way of an In-Chambers Finding, without referring the matter to oral evidence at a public hearing.

84. Consequently, in complying with the procedural fairness imperatives under the Act, I resolved to list the matter for a Mentions Hearing to afford the interested parties an opportunity to be heard in anticipation of the adverse comments and recommendations previously identified.[44]

[42] Ibid.
[43] Ibid
[44] CF, Direction of 20 August 2019.

Mentions Hearing[45]

85. At the Mentions Hearing on 18 December 2019, Leading Senior Constable (LSC) King Taylor of the Police Coronial Support Unit (PCSU) appeared to assist me.

86. Neither the family nor Moran were legally represented. However, both Ms Remoska, the Senior Next of Kin and Mr Sheridan, on behalf of Moran, were present in Court. As the interested parties were not legally represented, I took the opportunity to explain to them the function and purpose of the coronial jurisdiction and my role as the Coroner in investigating reportable deaths.

87. At this Mentions Hearing I informed Mr Sheridan of the probability that adverse comments and recommendations about Moran in relation to the conduct of the staff may arise from my investigation into Mr Hodges' death. In this regard, I pointed out that his statement contained information which was tantamount to concessions by Moran, specifically in relation to the lack of adequate staff training initiatives in feeding techniques and resuscitation procedures.

88. I informed Mr Sheridan further that I had obtained the expert opinion from the Speech Pathlogist which indicated that Moran's failure to conduct regular speech pathology assessments represented an opportunity lost for Mr Hodges.

89. Mr Sheridan did not make any submissions at the Mentions Hearing.

90. I then informed the interested parties that I had considered all the evidence, including the concessions made by Moran which obviated the need to adduce oral evidence at a public hearing. As such, the available evidence now enabled me to finalise the matter on the papers by means of an In-Chambers Finding.

91. After Ms Remoska raised a few questions to clarify the process, she agreed with my proposal to finalise the matter without an Inquest.

[45] Transcript of Proceedings dated 18 December 2019. The title page erroneously reflects the Mentions Hearing as a Directions Hearing. This appears to be a *bona fide* error on the part of the Victorian Government Reporting Service.

**COMMENTS**

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Management of choking-related risks

1. The available evidence indicates, incontrovertibly, that Mr Hodges' death by choking was preventable. In the circumstances of this matter, Mr Hodges, a man whose health was compromised by strokes and vascular dementia, died in an aged care facility after his upper airway was obstructed by a bolus of food while being fed by a registered nurse.

2. Mr Sheridan conceded that the Moran Aged Care Facility did not provide training to its staff 'in safe feeding' of residents diagnosed with dysphagia.

3. Similarly, Ms Lowe-Carlus stated that the AACQA did not prescribe or 'identify specifics of staff training that were required for accreditation of aged care facilities.

4. I have viewed the CCTV footage which depicts a team working under distressing conditions with an unexpected acute medical emergency in a pre-arrest situation for which the staff did not have any formal training.

5. Although the CPU review in this matter identified that the emergency procedures undertaken by Moran's staff 'was in keeping with the flow chart developed' by DHHS and their response to the choking episode 'represents an expected standard of response for staff without formal training', my investigation into Mr Hodges' death did, however, identify a number of shortcomings in the management of his choking episode.

6. In this regard, Mr Sheridan's concession that the staff at Moran lacked adequate training has left me particularly concerned and I would be remiss in my duty as a Coroner if I did not apply my mind to public policy considerations in this regard which require staff in aged care facilities to have the same or similar clinical skills and knowledge as those in an acute hospital environment. Unfortunately, this community expectation has not been met.

7. I acknowledge and accept that a system of training 'arrest teams' to manage medical emergencies as deployed in a hospital setting may not be feasible in a residential aged care facility. I am not satisfied, however, that aged care facilities should be completely devoid of

any training initiatives to effectively manage medical emergencies, given their function and the services they aim to provide to the community. By and large, residents in aged care facilities are at high risk of developing life-threatening complications for various reasons including, but not limited to, advanced age, co-morbidities or other conditions which render them prone to medical emergency. In Mr Hodges' case, his history of vascular dementia and stroke placed him in this high-risk category. The evidence indicates that choking is a common occurrence in aged care facilities, most especially in residents, like Mr Hodges, affected by neurological conditions such as stroke and dementia.

8. Against this background, I deem it unacceptable that clinical staff employed in the aged care sector are not required by legislative mandate to undergo any form of training to effectively manage medical emergencies as they arise in an aged care setting.

9. Accordingly, my first Recommendation is appropriate in the circumstances.

<u>Lack of staff training</u>

10. In the past, staff-related training concerns in the aged care sector have been the focal point of other coronial investigations. As recently as August 2019, in my *Finding into the Death with Inquest of John Frederick Reimers (Reimers)*, I noted my concerns in this regard.[46]

11. In that matter, concerned by the lack of mandatory qualifications required by PCAs and their ongoing training in the aged care sector, as well as the lack of a regulatory framework for staff to patient ratios, I made pertinent recommendations to both the Federal and State Government Health Departments to address these issues.

12. On 12 November 2019, The Secretary of the DHHS, acknowledging my concerns and Recommendations, responded favourably. According to the DHHS, my concerns have already been recognised and addressed by the promulgation of the *Safe Patient (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (Vic). In addition to hospital settings, the provisions of this Act were applicable to aged care facilities as well and the first phase of the implementation process was approved by Parliamentary sanction to begin in February 2019. I acknowledge and commend this positive response.[47]

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[46] COR 2016.5983, *Inquest into the Death with Inquest of John Frederick Reimers*, delivered on 23 August 2019 and published on the *Coroners Court of Victoria* website.

[47] COR 2016. 5983, *Reimers*, Coronial File, Letter from Kym Peake to the Court dated 12 November 2019.

13. Similarly, the DHHS acknowledged my concerns and Recommendations in respect of staff training and agreed that a national regulatory approach for the 'personal care workforce' would provide a level of assurance to safeguard aged care consumers.[48]

14. With the assurance that these concerns and Recommendations to the Federal and State Governments have been addressed in the *Reimers* matter, I do not consider it appropriate to repeat those Recommendations in the current matter, my investigation into Mr Hodges' death.

<u>Restorative and preventative measures adopted by Moran after Mr Hodges' death</u>

15. According to Mr Sheridan, Moran had implemented several improvements to the service provided to residents at the facility in the period following Mr Hodges' death, including:

    i. Providing education and training modules to 'Care delivering staff' (sic) on Dysphagia and respiratory illnesses;

    ii. Adopting a policy and/or developing a further protocol in relation to ambulance transfer of residents where emergency services are deployed. This improvement in the ambulance transfer protocol required staff to meet the ambulance personnel at the entrance to the facility to usher them to the exact location of the medical emergency;

    iii. The resident admission process had been adapted to include 'swallowing screening' which is now to be conducted within the first two hours after admission, unless the resident was attended to and assessed by a speech pathologist prior to admission and there was a 'modified and fluid orders diet already in place'; and

    iv. Moran had conducted and completed a review of the assessment and care planning process across all their facilities and following this review, they had implemented changes to their policies and procedures. These changes included the 'timing and frequencies of assessments, family conferences and care plan reviews'. According to Mr Sheridan, Moran adopted these measures 'in an attempt to identify and close any gaps in care required'. (sic)

[48] Ibid. It is noted, however, that this response related to the proposed regulation of mandatory staff qualifications and training of unregistered aged care service providers. In response to this loophole, the Victorian Government promulgated the *Health Complaints Act* 2016 (Vic) incorporating a Code of Conduct for unregistered providers of healthcare which covers aged care workers not registered with the Australian Health Practitioners Regulation Agency (AHPRA).

16. I acknowledge and commend the action taken by Moran in implementing the restorative and preventative measures as outlined by Mr Sheridan. However, in considering the body of evidence available to me including the research by Professor Ibrahim into choking risks in the aged care sector, I am of the view that more specific training regimens are required, either by operation of legislative intervention or by any other regulatory process.

17. Professor Ibrahim specifically identified the importance of including annual choking hazard drills and feeding assistance in the ordinary course of staff training in the aged care sector.

18. Having considered the factual matrix of this matter and the overwhelming literature on the shortcomings of staff training in the aged care sector, the weight of the available evidence supports the inclusion of Professor Ibrahim's suggestions for reform in the aged care sector and I adopt his suggested recommendations.

19. Accordingly, my second and third Recommendations are appropriate in the circumstances.

Governmental Agency and/or other initiatives

20. Recognising that all the shortcomings in the residential aged care industry are beyond the scope of my Finding into Mr Hodges' death, I considered the circumstances of his death against the background of governmental or other aged care sector-related initiatives. Focusing on my prevention role as a Coroner in this matter, I specifically sought to discharge my duty under the Act by taking into account current aged care sector regulatory initiatives in order to highlight existing preventative and restorative measures.

21. In this regard, I have considered and noted the Findings and Recommendations in the Final Report (FR) of the Royal Commission into Aged Care Quality and Safety (RC) which was published on 26 February 2021.[49]

22. Established by the Governor-General of the Commonwealth of Australia on 8 October 2018, the object of the RC's inquiry was to investigate the quality of aged care services and whether those services were meeting the needs of the Australian community.[50]

[49] The Royal Commission Report was tabled in Parliament on 1 March 2021.
[50] The Governor-General appointed the Honourable Mr Tony Pagone QC and Ms Lynelle Briggs AO as Royal Commissioners with the former holding the Chair.

23. On 31 October 2019, the RC delivered their Interim Report (IR) to the Governor-General which was tabled in Parliament on the same day. The IR identified that the current aged care system failed to meet the needs of the ageing population in the delivery of safe and quality care and that the system required a fundamental overhaul.

24. In their FR, having interrogated the deficiencies in the aged care system identified in the IR further, the RC held that 'the extent of substandard care in Australia's aged care system reflects both poor quality on the part of some aged care providers and fundamental systemic flaws with the way the Australian aged care system is designed and governed. People receiving aged care deserve better'.

25. Relevant to my investigation into Mr Hodges' death, the RC identified, in their FR, that many people living in aged care have complex care needs that extend beyond assistance with day-to-day self-care. Defining 'complex care', the RC noted that such needs arise when people require support that is less predictable or requires more skilful care. In this regard, their investigation identified further, that areas of substandard complex care of people living with conditions like dementia, amongst others, was commonplace.[51]

26. Most notably, the RC commented that the process of ageing naturally leads to the need for routine care and assistance with the activities of daily living like feeding and that routine daily care should be predictable and reliable because it should enhance the person's health and wellbeing and avoid reasonably preventable harm. The FR specifically articulated that routine care relating to matters critical to the health of older people like diet and nutrition, particularly in residential aged care, did not meet these community expectations.

27. In an attempt to improve living conditions for people living in aged care facilities, the RC made pertinent recommendations to Parliament. The RC recommended the establishment of a new Australian Aged Care Commission to manage the performance of aged care service providers amongst other things. It was envisaged that this new entity should develop the aged care workforce by setting up and refining the requirements for minimum staffing levels and qualifications.[52]

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[51] CF, Royal Commission Summary of Final Report.
[52] CF, Royal Commission Summary of Final Report, page 170.

28. I have considered the Royal Commission Final Report and this specific recommendation, and I consider its import relevant to the circumstances of Mr Hodges' death. I acknowledge and commend the work done by the RC and the initiatives taken by the Australian Government after accepting the RC recommendations to improve the lives of people living in aged care facilities.

29. The strides taken by the Government, while the RC inquiry was pending and after its conclusion, to improve living conditions for residents in aged care are particularly commendable. In this regard, I have noted that the Department of Health and Ageing had reviewed the functions of the Australian Aged Care Quality Agency and the functions of the Aged Care Complaints Commissioner. This review culminated in the amalgamation of these two agencies to form the National Commission of Aged Care Quality and Safety. In addition, the Department of Health and Ageing appointed a Chief Clinical Advisor whose role was created, in collaboration with the National Commission of Aged Care Quality and Safety, to support clinical care of older persons in residential aged care facilities by developing specific clinical standards for common clinical risks. I acknowledge this initiative by the Department of Health and Ageing in their quest to deliver positive outcomes for aged care residents and I commend the strides taken to implement restorative and preventative measures in the aged care sector.

30. More specifically related to Mr Hodges' death, Safer Care Victoria has identified the need for guidance in managing choking risks in healthcare facilities. Although focused on public hospitals, Safer Care Victoria has recognised that this need for guidance should be extended into the disability care and aged care domains.

31. According to Donna Markham, the Chief Allied Health Officer at Safer Care Victoria, their initiative in this regard was well underway and they have 'commenced with a multidisciplinary expert reference group to consider key components that would need to be included in any guidance material' produced by Safer Care Victoria. Ms Markham informed me further that Safer Care Victoria, amidst growing concerns in the community, envisaged that they would consider extending the scope of the need for guidance to the aged care sector,

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i. Recommendation 5
ii. On 30 November 2020 the Australian Government tabled its response to the recommendations in Parliament and accepted all the recommendations.

but whether the scope would be extended across the different sectors, is yet to be determined, however.[53]

32. The action taken by these authorities represents an awareness of the need for regulatory reform or legislative intervention in the aged care sector to address the shortcomings in aged care in relation to staff training needs to abate the risks associated with medical emergencies like choking. These strident initiatives by the Department of Health and Ageing and Safer Care Victoria to restore public confidence in the aged care sector and to prevent fatalities following medical emergencies are commendable in my view.

33. Accordingly, given their standing initiatives and processes, I am satisfied that Recommendations to the Department of Health and Ageing and Safer Care Victoria are not appropriate in the circumstances.

**RECOMMENDATIONS**

Pursuant to section 72(2) of the Act, I make the following recommendations connected with the death:

1. In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments create a legislative mandate requiring annual drills for residential aged care staff to enable the staff to develop the necessary skills to abate the medical emergency risks presented by choking incidents.

2. In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments include a training module to cover emergency procedures in choking incidents as part of any standing First Aid Response training in residential aged care.

3. In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments devise or develop a training module for staff employed in residential aged care to be trained to safely provide feeding assistance at all times to residents with modified texture diets.

[53] CF, Email correspondence from Donna Markham to the Court.

**FINDINGS AND CONCLUSION**

1. 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 explication.[54] 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.

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

   a. the identity of the deceased was Phillip Charles Hodges, born 24 February 1945;

   b. the death occurred on 16 April 2017 at Moran Roxburgh Park, 3 Wedgewood Road, Roxburgh Park, Victoria, 3064; and

   c. I accept and adopt the medical cause of death as ascribed by Dr Young and I find that Phillip Charles Hodges died by choking on a food bolus.

3. I find that Moran Residential Aged Care, Roxburgh Park, failed to ensure that staff had the necessary induction, skills, competencies and training to effectively manage the critical choking incident which resulted in the death of Phillip Charles Hodges.

4. I find that this failure to ensure that the staff was adequately trained to effectively manage the critical choking incident was causally connected with Phillip Charles Hodges' death.

5. I find that in the circumstances in which his death occurred there is cogent evidence that Phillip Charles Hodges' death was preventable. The weight of the available evidence indicates that by reason of a lack of skill and training, there was a failure to recognise timeously that Phillip Charles Hodges was unable to swallow the food while being fed by the staff member which led to his fatal choking incident and further, the available evidence indicates that when the staff member realised that Phillip Charles Hodges was choking and in

[54] *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…'.

distress, she was unable to effectively manage the situation to abate the risks associated with choking.

6. I find that Moran Residential Aged Care, Roxburgh Park, failed to provide regular speech pathology assessments to Phillip Charles Hodges and I find further that the failure to provide regular speech pathology assessments represented an opportunity lost to alter the outcome for Phillip Charles Hodges.

7. AND, having considered all the circumstances, the weight of the available evidence supports a conclusion that the conduct of the attending staff, by virtue of their lack of skill and training in the management of the choking episode, contributed to Phillip Charles Hodges' death.

8. AND FURTHER, I am satisfied that the interested parties in this matter have been given reasonable notice of the content and scope of my adverse comments and Findings and they were afforded a reasonable opportunity to respond timeously to mitigate my adverse comments and Findings.

I convey my sincere condolences to Mr Hodges' family for their loss.

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:

Tarish (Trish) Remoska

Adrian Sheridan, Performance and Risk Manager, Moran Group

Denise Lowe-Carlus, Director—Regulatory Policy, Australian Aged Care Quality Agency

Professor Joseph Ibrahim, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University

Briana Bass, Chief Allied Health Officer, Safer Care Victoria

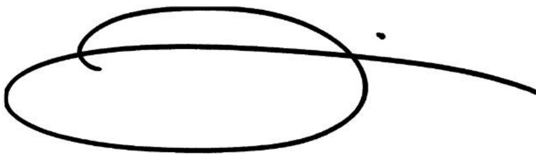
Chief Clinical Advisor, National Commission of Aged Care Quality and Safety

Victorian Government Minister for Health and Minister for Ambulance Services, the Honourable Mary-Anne Thomas, MP

Australian Government Minister for Health, the Honourable Mark Butler, MP

Senior Constable Rohan Wills, Coroner's Investigator

Signature:



**AUDREY JAMIESON**

**CORONER**

Date: 1 August 2022

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.