QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Davis**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Maroochydore
FILE NO(s):	2018/1612
DELIVERED ON:	17 April 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 January 2019 (Brisbane), 26-28 February 2019 (Maroochydore)
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Death in Care, intellectual and physical disability, choking on food, adequacy of resuscitation provided by carer and ambulance services, Public Advocate report.

REPRESENTATION:

Counsel Assisting:	Ms A Tarrago
Counsel for Queensland Ambulance Service:	Mr M Hickey i/b QAS
Counsel for Dr E Scott:	Ms J Fitzgerald i/b Avant Law
Counsel for Multicap:	Mr A Herbert i/b McCullough & Robertson
Public Advocate as intervener:	Ms M Burgess, Public Advocate

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Introduction

1. John Davis died on 10 April 2018 at the Sunshine Coast University Hospital (SCUH) following his admission on 8 April 2018. Mr Davis was 50 years of age at the time of his death. He had a past medical history including an acquired brain injury from birth resulting in intellectual impairment and epilepsy, severe obstructive sleep apnoea, gastro-oesophageal reflux disease and osteoporosis.

2. Mr Davis had been admitted to the SCUH after choking on a food bolus on 8 April 2018 at a Multicap Ltd supported accommodation residence located at 64 Atkinson Road, Bli Bli, Queensland.

3. At approximately 11:00am on 8 April 2018, Mr Davis and the three other residents at the facility were given lunch by their daily carer, Mr Joseph Oderinde, at a dining table near the kitchen. At some point Mr Davis was the only person left at the table and Mr Oderinde was in the kitchen when Mr Davis was heard to collapse to the floor. Mr Oderinde found Mr Davis unresponsive. Mr Oderinde called 000 and monitored Mr Davis' response with the assistance of the Emergency Medical Dispatcher (EMD). When it became apparent Mr Davis was not breathing he was instructed to perform cardiopulmonary resuscitation, which he did until the first paramedics arrived.

4. A total of three Queensland Ambulance Service (QAS) crews were eventually dispatched to the residence as Mr Davis deteriorated. When paramedics first arrived they found Mr Davis with a Glasgow Coma Scale (GCS) of 3 and in pulseless electrical activity (PEA). Mr Davis had no cardiac output and was noted to be difficult to ventilate. After initial difficulty with a faulty laryngoscope and the attendance of a Critical Care Paramedic, a large piece of meat was cleared from the airway using a different laryngoscope. Mr Davis was subsequently easier to ventilate and returned to spontaneous cardiac activity.

5. Mr Davis could not be intubated at the scene and was successfully ventilated using a laryngeal mask airway. Apart from the difficulties in clearing the airway due to instrumental issues, there were some issues relating to proper documentation of the event on the Electronic Ambulance Report Form (eARF). These issues were investigated separately by QAS and a report was provided to me.

6. Mr Davis was transferred to the SCUH and was noted to be spontaneously breathing and easy to ventilate with the laryngeal mask airway. He remained at a GCS 3 and was intubated.

7. A CT scan revealed changes consistent with significant brain injury due to the period without blood and oxygen supply, known as hypoxic-ischaemic encephalopathy. The CT scan also revealed that changes related to his previous brain injury, which was reported as being stable in comparison with

scans taken in January 2014 (over 4 years earlier).

8. Mr Davis made no significant recovery and died at 00:50am on 10 April 2018.

The issues for Inquest

9. Given Mr Davis' residential and disability issues, his death is a reportable death in care and as such an inquest must be held in circumstances that raise issues about the care, as they do here. There were a number of issues requiring further ventilation following information gathered during the coronial investigation.

10. At a pre-inquest hearing held on 16 January 2019 the issues for inquest were determined as follows:
    i. The findings required by section 45(2) of the *Coroners Act 2003* namely the identity of the deceased, how he died, when he died, where he died and what caused his death.
    ii. Whether the health, disability and supported accommodation services provided to the deceased were adequate and appropriate.
    iii. Whether first aid and disability services carer training of the supported accommodation carers were adequate and appropriate.
    iv. Whether the resuscitation performed by the Queensland Ambulance Service was adequate and appropriate.
    v. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

    The witnesses heard at the inquest were:
    i. Dr Ian Home, Clinical Forensic Medicine Unit (CFMU);
    ii. Joseph Oderinde, Multicap;
    iii. Cleopatra Emeshie, Multicap;
    iv. Joanne Jessop, Multicap;
    v. Officer Christopher Lahood, QAS;
    vi. Officer David Nightingale, QAS;
    vii. Officer Darren Sweedman, QAS;
    viii. Dr Stephen Rashford, QAS;
    ix. Dr Edward Scott, General Practitioner;

Autopsy results

11. On 16 April 2018 an external and partial internal examination of the abdomen, chest, neck and airways was performed by senior forensic pathologist, Dr Nathan Milne. The autopsy report was dated 3 August 2018.

12. The senior forensic pathologist concluded firstly, that the cause of death to be hypoxic-ischaemic encephalopathy resulting from the arrest, which was due to choking on food, which was reported to be a large piece of steak.

Secondly, it was the underlying acquired brain injury that was considered to be the most likely underlying cause of the choking.

The Public Advocate

13. The Public Advocate was granted leave pursuant to s 36(2) and (3) of the *Coroners Act 2003* (the Act) to make submissions on any recommendations that might be considered under s 46(1) of the Act. This leave was granted in recognition of the Public Advocate's independent role for helping to ensure the safety and wellbeing of persons in care with a disability, and to assist the court to consider what recommendations may be appropriate and responsive to the circumstances of Mr Davis' death, as a public interest intervener. It should be noted section 36(2) and (3) effectively limits the Public Advocate's submissions to matters about which a coroner may make recommendations pursuant to section 46, and not to matters about which a coroner is required to make findings of fact pursuant to section 45.[1]

14. By way of background, the Office of the Public Advocate (Qld) undertook a review of the deaths of 73 people with disability who died in care in Queensland between 2009 and 2014[2]. Choking on food/food asphyxia was identified as one of the leading causes of death, with the review noting that swallowing and eating difficulties are common in people with certain types of disability, which in turn places them at a high risk of choking as well as aspiration.

15. The findings of that review, which were published in February 2016, identified that whilst swallowing assessments had been conducted and mealtime management plans developed for three of the five people who died from choking on food or food asphyxia in the sample of deaths reviewed, these assessments and plans were not sufficient to prevent those deaths, due in large part to an apparent lack of compliance by support staff with the plans and periods of non-supervision.

16. With regards to this non-compliance, the review acknowledged multiple contributing factors including staff turnover, lack of training and skills, poor staff to client ratios, and possibly a feeling amongst support staff that mealtime management plans are potentially inconsistent with service philosophy around maximising a person's choice and control over what they eat and how they eat.

17. In the review, the Public Advocate made the following comments/recommendations for consideration by Government to help to prevent deaths from choking on food and food asphyxia in the future:

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[1] The Public Advocate was also invited to intervene in the Inquest into the death of Paul Milward, 2018, another choking death and provided helpful submissions

[2] The Office of the Public Advocate (Old) *Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland,* 2016

i. Service organisations and support staff must be alert to risks that indicate the need for further investigation of eating, drinking, swallowing and/or breathing difficulties.
ii. Support staff must work closely with health practitioners to ensure that risks are appropriately assessed, and that mealtime management plans are developed, the resultant plans strictly complied with, and regular reviews undertaken. Factors such as resourcing and rostering must be considered and addressed in developing plans.
iii. There is a clear need for increased understanding and training in relation to the preparation of food; physical positioning, prompting and pacing during meals; maintaining close supervision; and in administering emergency care
iv. The potential for legal liability should diagnosed conditions or identified issues not be appropriately managed is an important matter for organisations and staff alike.

18. The Public Advocate reviewed the brief of evidence as it was relevant to her submissions but did not participate in the inquest and as such, I had the benefit of hearing the evidence of witnesses, which did provide a more nuanced version of events over and above the documentary record.

19. In reviewing the material in this case the Public Advocate submitted the issues identified in the matter were relevant to people in disability care in general.

20. In considering the material it was acknowledged the care and treatment provided to Mr Davis was generally thorough and demonstrated a high degree of care.

21. The Public Advocate considered there was some information contained in the material relating to Mr Davis' swallowing difficulties that could have been acted upon more proactively and may have reduced the likelihood of the choking incident.

22. The Public Advocate noted the two presentations to hospital on 20 February 2014 and 5 July 2016 and was concerned that the information provided did not appear to result in any change in the care provided by the service providers nor was the information acted upon by his regular GP.

23. The Public Advocate noted the multiple *Comprehensive Health Assessment Program (CHAP)* reports completed by the GP did not record any issue with swallowing despite the directions of the speech pathologist in the context of his frequent and prolonged bouts of pneumonia, that were described on the clinical file.

24. The Public Advocate noted the hospital speech pathologist report in 2014 suggested relatively minimal intervention but the Public Advocate considered that some level of intervention in care was still recommended. As well it

appears that the service provider, Multicap was unaware of any swallowing issues Mr Davis may have had.

25. It was considered this case demonstrated that the issues with swallowing, however minor, still impose a significant on-going threat to a person's life and health and it is extremely important that all providers of care to people with disability and dysphagia issues, are aware of the life threatening potential of these orders and treat any indication of the presence of these conditions as a serious health issue that requires active management.

26. It was submitted that specific recommendations should be made in the context of this case regarding the actions that should be taken by all those involved in the care of people with swallowing issues when they are identified.

27. Subsequent to the completion of the evidence the Public Advocate was provided with a copy of the additional statement from Ms Jessop, the Chief Executive Officer (CEO) of Multicap and the Nutrition and Swallowing Checklist now being utilised by Multicap. The Public Advocate stated the checklist certainly looks comprehensive and should assist to identify future residents who may have swallowing/choking risks.

28. I will therefore be recommending that similar checklists be considered generally for use by care providers who are providing disability care services to those who would be considered in a risk category for swallowing difficulties.

Background Medical and Personal History

29. Whilst Mr Davis was independently mobile, he required supervision and assistance with a range of daily activities and personal care, due to his intellectual disability and other diagnosed conditions which included:
    - Acquired brain injury from birth, which appeared to have resulted from an arteriovenous malformation and was associated with intellectual impairment, epilepsy and hydrocephalus. He was later treated with a shunt;
    - Obstructive sleep apnoea;
    - Osteoporosis; and
    - Iron deficiency anaemia.

30. Mr Davis also utilised a continuous positive airway pressure (CPAP) machine at night time due to sleep apnoea.

31. Ms Rennie-Sia, the niece and next of kin of Mr Davis, attended on day one of the inquest. She explained that her uncle came into the family at eight weeks old and was not supposed to live past 10 years of age. She described him as a quiet person who was slow to anger. He was also a religious man who had strong beliefs. She said he was a family man and loved to be a part of the family. Ms Rennie-Sia described how important her uncle was to her family including her triplets. She said that he loved life and enjoyed drama and horse riding when he could still ride.

32. Ms Rennie-Sia said that Mr Davis was intelligent and cognitive in his thoughts and that his communication difficulty was due to a neural pathway that made him slow in his responses. However, if people gave him time to speak, he could have a full conversation. She explained that if people rushed him or stressed him, he would shut down.

33. Ms Rennie-Sia stated that Mr Davis never had any issues in swallowing.

34. On 14 February 2014, Mr Davis attended the Nambour General Hospital (NGH) Complex Dysphagia Clinic, where a clinical bedside examination was completed by Speech Pathologist, Meghan Gregory. Ms Gregory stated Mr Davis had been referred by his general practitioner for a swallow assessment after a barium swallow on 6 February 2014 confirmed aspiration in the setting of recurrent chest infections.

35. Ms Gregory does not have a recollection of the assessment but she did complete a comprehensive clinical record at the time. She stated a speech pathologist uses clinical examination of the patient to assess for signs of oropharyngeal dysphagia, which can cause a patient to aspirate food and/or fluids into the lungs. Part of the assessment requires the speech pathologist to identify the patient's risk of aspiration/penetration and looks at strategies to reduce this risk. Ms Gregory stated from the referral and carer report she deduced that the intake of fluids was the main concern and conducted a clinical examination, which included an oromotor assessment (assessing how the muscles/nerves of the head and neck are working in non-swallow tasks), trialling thin fluids, mildly thick fluid and extremely thick fluids.

36. At the time Mr Davis presented with mild pharyngeal dysphagia characterised by a mild incoordination of breath swallow pattern and decreased hyolaryngeal excursion, secondary to poor posture at intake and fatigue effects. There were no signs of aspiration or penetration observed at the time of the assessment.

37. Ms Gregory stated that based on Mr Davis' case history information and his current positioning at rest, safe swallowing strategies were outlined and provided to the patient and carer to reduce the potential risk of aspiration. The strategies would have been used as part of the assessment to satisfy her that Mr Davis was safe to commence thin fluids and continue a full diet.

38. Ms Gregory forwarded a letter to Mr Davis' GP and this indicates that written documentation was provided to Mr Davis and his carer outlining safe swallowing strategies. Based on her usual practice these would have been identified in her recommendations from the progress notes and GP letter including:
    - The patient should be alert for intake;
    - Sit upright for oral intake;
    - Remain upright for 30 minutes; and

- Refer to a speech pathologist if signs of aspiration occur.

39. It was recommended Mr Davis:
    - Consume a full diet and thin fluids;
    - Use straws for liquids to avoid neck extension when drinking;
    - Consume teaspoon or smaller mouthfuls with adequate breaks in between;
    - Decrease intake of mixed consistencies, to reduce the risk of aspiration prior to swallow trigger;
    - Smaller and more frequent meals; and
    - His carer monitor signs of aspiration (for example, cough, throat clear, increased temperature or decreased chest status). Further if this was present, to cease oral feeding and contact a GP or a speech pathologist.

40. In October 2016, a CHAP form was completed and indicated no difficulties in Mr Davis' swallowing.

41. There were two admissions in 2016, both through QAS and not a GP referral. The first was on 16 June 2016 to Nambour General Hospital due to a fall, possibly from a seizure two days previously and with a fracture of T12. Due to decreased mobility he acquired the early signs of pneumonia, likely due to aspiration. A speech pathologist review was conducted on 17 June 2016 where the impression was that his swallow appeared functional and there were no signs of aspiration/penetration. A full diet, thin fluids and the patient being upright and alert were recommended. He was transferred to the Sunshine Coast University Private Hospital on 17 June 2016. He was discharged on 20 June 2016 and on discharge there were no recommendations relating to swallowing or diet.

42. On 25 June 2016, Mr Davis was admitted to Nambour General Hospital with lower back pain on a background of recently recognised health-care acquired pneumonia as well as a stable T12 fracture. He was transferred to Sunshine Coast University Private Hospital on 28 June 2016. On discharge to SCUPH a speech pathology review for swallowing recommended an elevated bed for fluid/fluids and moderately thick fluids. The main presenting problem for this particular presentation was bilateral lower lobe pneumonia, which occurred in the context of hospitalisation and aspiration and not from swallowing difficulties as such.

43. On discharge from SCUPH on 5 July 2016 the discharge summary noted he had been reviewed by a speech pathologist who recommended a diet of thickened fluids and minced moist diet. The discharge plan included for him to see his GP within seven days of discharge and he was discharged to his supported accommodation home. In fact, his GP Dr Edward Scott, reviewed him on 6 July 2016 and there were no issues raised about his swallowing or choking risks. The consultation dealt specifically with the pain to his back

44. On 2 August 2017, Mr Davis was referred to an outpatient Speech Therapy clinic to improve strength and speech as he wanted to develop his

communication skills. On 3 August 2017, the Executive Director Medical at the Sunshine Coast Hospital and Health Service, Head and Neck Service declined the referral for speech therapy as Mr Davis did not meet the criteria for this particular outpatient service.

The evidence on the issues

Care provided by Dr Edward Scott

45. Dr Edward Scott of Nambour Clinic Family Medicine, was the general practitioner who treated Mr Davis during his residence at Multicap. Dr Scott developed *Comprehensive Health Assessment Programs* over the years and attended to various health issues as they arose.

46. In October 2013, Mr Davis developed issues with swallowing and aspiration. Dr Scott referred Mr Davis for a CT chest scan. The scan showed bilateral atelectasis/chest infection but no diagnosis of aspiration.

47. On 6 April 2014, a barium swallow test was performed, which noted only minor aspiration into the upper trachea, but was not causing coughing.

48. In 2017, a referral was made to the Sunshine Coast Hospital Speech Therapy Head and Neck Clinic for an outpatient appointment. In relation to the referral to the speech pathologist on 2 August 2017, Dr Scott referred Mr Davis to improve his speech and communication and that swallow concerns were not mentioned on the referral. Dr Scott stated that he was contacted by therapists from the Sunshine Coast University Hospital at the time and advised that no funding was available to patients in Mr Davis' situation and that he was not able to access therapy through the hospital.

49. It was suggested to Mr Davis by Dr Scott that he could access the future National Disability Insurance Scheme (NDIS) funding or pay privately for therapy. After discussions with Mr Davis and his care team, Dr Scott asked the care team to see if Mr Davis would be able to fund private sessions. However, referral for therapy was not discussed at future appointments.

50. Dr Scott stated the usual method of communication about Mr Davis' medical issues was provided by giving the attending carer a copy of the progress note for a particular presentation. He would not generally provide a copy of a discharge summary or other report he received from a hospital. He said there was no particular reason for this and he had never considered it.

51. Dr Scott stated the episodes of 2014 and 2016 principally related to issues of thickened fluids. If post hospital there are no reported problems then he considered it reasonable to relax any restrictions. He had no such reports. He stated he had no problem referring Mr Davis to other investigations and the record does indicate he did so routinely.

Care provided by Multicap Ltd

52. Multicap Ltd CEO, Joanne Jessop, provided information and two statements. Multicap currently supports around 1200 people with disability across Queensland and northern NSW and employs 900 staff.

53. On 31 August 2015, Multicap was asked by Disability Services Queensland (DSQ) to take over service delivery to 15 men as quickly as possible, as at the time the current service provider was in the hands of an administrator due to insolvency. Multicap did not receive a formal handover from the previous provider.

54. DSQ funding was transferred on 1 October 2015 and Multicap commenced providing services from that date. Multicap put in place a review and updating of all customer records and moved to an electronic customer management system in 2016. Some client files were obtained from the previous provider although there was poor clarity around the fees and charges the men were paying.

55. Mr Davis had two brothers, who are now deceased. It is apparent that Mr Davis had been residing at the same property since January 2000 after the death of his mother. Sometime between 2002 and 2006 the records indicated Mr Davis was living with his brother, Alan and his wife but returned to the previous service provider's care in 2006. When Multicap took over, the family contact was with a son of a deceased brother and it is evident his niece Ms Rennie-Sia was also involved.

56. Multicap supported Mr Davis for at least two years in an accommodation support arrangement in Bli Bli on the Sunshine Coast. Initially these premises housed eight people but at the time of Mr Davis' death there who were four people residing there. Ms Jessop stated the role of Disability Support Workers (DSW's) was to encourage independence of the client and to work out where they needed help and provide that help. Multicap's mandatory requirements included that DSWs must have a Bluecard, and up to date CPR and Senior First Aid training. Ms Jessop stated that in cases such as happened here where someone has collapsed the staff are not expected to make clinical decisions. Their primary role is to call 000 and follow instructions from the call taker.

57. Mr Davis resided with the other three other men in a supported arrangement staffed 24 hours per day, seven days per week, which included a sleepover shift by a DSW each night from 10:00pm to 6:00am. Communications between staff and the organisation was through a number of methods including a Communication book onsite, staff meetings, intranet and customer files including electronic files.

58. Mr Davis had an intellectual disability. He was also diagnosed with epilepsy

and used a CPAP machine at night due to sleep apnoea. Ms Jessop stated that based on Multicap's understanding, Mr Davis was in care because of his intellectual disability, not because he was physically incapable of his own care.

59. A detailed client profile was in place. This provided information regarding the range of areas were Mr Davis was independent and areas where he required assistance. Mr Davis was independently mobile but required supervision and assistance with a range of activities of daily living including full assistance with showering and personal care.

60. A *CHAP* tool was completed by Multicap staff and the GP on 15 March 2018. This did not suggest Mr Davis had any difficulty with feeding himself.

61. Mr Davis had a documented *Epilepsy Management Plan* completed by his GP on 4 May 2016.

62. He also had a *General Practitioner Management Plan,* which provided information about current medication, goals to be achieved and required treatments. This was last dated 8 March 2018. Actions noted in the plan included monitoring general health and refer as appropriate; foot care; medication review; CPAP monitoring; treatment of gastritis; control of GORD; monitoring health and bowel movements; and cardiology reviews, as required.

63. It should be noted there had been no previous occasions identified in relation to swallowing or eating issues for Mr Davis other than in 2014. Mr Davis was recognised as being slow in his physical movements, and this included a slowness in eating and talking.

64. One of the goals for Mr Davis was about further developing his communication skills. This was identified as a priority by Mr Davis and his support network. As a result, the GP made a referral for speech therapy to the Head and Neck Service on 2 August 2017. This was declined by the service as it did not meet the criteria for this particular outpatient service.

65. Ms Jessop stated all DSWs are required to have and maintain current senior first aid and CPR qualifications. Multicap also provided a number training opportunities to staff including:
    - Conflict management;
    - Manual handling;
    - Medication administration;
    - Fire warden;
    - Preventing abuse and neglect;
    - Code of conduct;
    - Effected debriefing;
    - Introduction to the NDIS;
    - Organisational communication;

- Orientation to Multicap;
- Person centre philosophy; and
- Work health and safety.

66. Ms Jessop stated that in 2018, Multicap conducted a review of all their policies in the light of three deaths (including Mr Davis) that occurred in their facilities in a six month period between January and July 2018. The review noted, consistent with the findings of the Public Advocate on swallowing and dysphagia issues in the disability sector, there was an opportunity for Multicap to further improve support for customers by improving its mealtime management practices. Ms Jessop stated this finding was independent of knowledge of the cause of death of Mr Davis as they were not aware of the cause of death as due to choking until the inquest was announced. Multicap identified the CHAP assessment was not specific on this issue. As a result they have now implemented a *Nutrition and Swallowing Risk Checklist* as a resource to help Multicap understand the nutrition and swallowing needs of customers and implement strategies and to proactively identify any nutrition and swallowing risk. The checklist is a trigger for appropriate follow-up action by the customer's general practitioner. The checklist was adapted by one already in use by the NSW Department of Ageing, Disability and Home Care.

67. Since implementation of the checklist, Multicap have identified 35 people who have been referred back to their GP for further assessment on nutrition and swallowing needs.

Care provided by Joseph Oderinde

68. Mr Oderinde provided a statement stating that he has been a DSW since 2014 and had been working at Multicap since 6 November 2017. His experience included first aid training and CPR training completed on 20 July 2017.

69. Mr Oderinde says he also received medical training in Nigeria including in community medicine and he has completed a degree in Medical Science at Sunshine Coast University Hospital. There is no suggestion Mr Oderinde was holding himself out as having clinical medical qualifications in so far as his work with Multicap.

70. Mr Oderinde stated he also received training in a number of areas provided by Multicap including:
    - Preventing and responding to abuse and neglect;
    - Autism;
    - Performance capability for supervisors;
    - Epilepsy; and
    - Midazolam training.

71. Mr Oderinde states he was aware of Mr Davis' personal care plan which

identified his co-morbidities including epilepsy, intellectual disability and sleep apnoea.

72. Mr Oderinde stated his role in CPR was to check the airways for breathing difficulties and if there is no response to call 000 immediately. He told the court that his CPR training included hitting a person firmly on the back if there were concerns there was a food blockage. On this occasion he checked the airway but he could not see anything and therefore did not apply a back slap and called 000.

73. The incident occurred around lunch time. Mr Davis and his fellow residents had been served a lunch of roast lamb and steamed vegetables. The roast was cut into smaller pieces for all the residents including, Mr Davis. Medication was given to Mr Davis at the start of the meal, which he took.

74. As Mr Davis was a slow eater, the other residents had finished their meal while he was still eating. Mr Oderinde stated Mr Davis eats quite slowly and he did not finish his meal in the same time as the other residents living there, but apart from this he has been quite good about swallowing and eating food by himself. He was not aware of any medical information that Mr Davis was having concerns with swallowing. At the time of the incident the other residents had finished their meal and had brought their plates to the kitchen and were not at the dining table.

75. Mr Oderinde says he heard a thud sound coming from where Mr Davis was sitting. He immediately attended Mr Davis and could see him lying on the floor on his back. His lunch plate was empty. The veins in his neck were noticeably dilated. He says he did not hear a cough.

76. A chronology of events provided by Multicap indicated that when Mr Oderinde heard Mr Davis collapse, he checked for a response. He saw Mr Davis with his eyes wide open with large veins on his neck, with the loss of colour on his fingertips. Mr Oderinde grabbed a pillow and phoned 000. He also expressed some frustration in his communication with the 000 operator.

77. Mr Oderinde spoke with the operator on Mr Davis' vital observations. He was initially breathing as he could see his chest move up and down. The 000 EMD twice asked for the mobile phone to be brought closer to Mr Davis so she could hear the breathing effort. The 000 call does not contain any reference by Mr Oderinde to suggest Mr Davis had been eating at the time he collapsed.

78. At about 10.5 minutes into the call it was indicated by Mr Oderinde that Mr Davis had become unconscious and had stopped breathing. Mr Oderinde was directed to start CPR, which he did until two ambulance officers arrived. Mr Oderinde then cleared from the area before the QAS officers were able to commence CPR. He was asked by QAS to continue CPR but he stopped immediately. Officer Nightingale found this unusual. It is unclear if Mr Oderinde understood what the paramedics were saying and I make no

adverse comment about this relatively minor incident. Mr Oderinde then tried to contact the Multicap '*on call'* staff to advise what had happened in accordance with the organisational policy for such adverse events.

79. The first responding paramedics stated they had not received any information that Mr Davis had been eating lunch or that he began to cough. This information is recorded in the eARF completed by Officer Nightingale and it is unclear where this information came from or at what point in time, but most likely it was from Mr Oderinde. It is probable this information was passed on later as it is evident Officer Nightingale spoke to Mr Oderinde to obtain a further history as Mr Davis was being loaded into the ambulance.

80. Mr Oderinde completed all necessary paperwork and completed his shift. He then handed over to the next DSW, Ms Cleopatra Emeshie.

81. Mr Oderinde's documentation of the incident completed after the event late in his shift around 4:00pm indicates he heard Mr Davis fall to the ground at 11:52am. Mr Oderinde remained adamant this was the time despite the 000 call being logged at 12:07pm. This suggests an almost 15 minute delay before he called emergency services. Mr Oderinde's evidence is he made the 000 call quickly after attending to Mr Davis, clearing a space and checking his responsiveness.

82. There are two possibilities. Firstly, Mr Oderinde delayed making the 000 call or secondly he is mistaken about the time of 11:52am. I find the most likely explanation is the latter in that he is mistaken about the time of 11:52am.

Queensland Ambulance Service attendance

83. A report provided by the QAS indicates that a request for service was made at 12:07pm on 8 April 2018 after a call had come through that a male patient had collapsed. A dispatch code 1 'Lights and Sirens' response was issued and Advanced Care Paramedics (ACPs) Christopher Lahood and David Nightingale were dispatched to assist.

84. At 12:19pm, further information was received that CPR was in progress. A unit of ACPs, Daniel Hirsimaki and Jason Moye were then dispatched along with Critical Care Paramedic (CCP) Darren Sweedman.

85. At 12:20pm, Officers Lahood and Nightingale arrived on scene and noted CPR was in progress through Mr Oderinde. Initial assessment revealed Mr Davis was in cardiac arrest with the electrocardiograph (ECG) showing pulseless electrical activity at a rate of 20 complexes per minute. It was suspected by the paramedics there was an airway obstruction that needed to be cleared. Officer Lahood inspected the oral cavity and noted it appeared clear. However, attempts to provide assisted ventilations via a bag-valve-mask were unsuccessful. Officer Lahood then attempted direct laryngoscopy but was not able to visualise the vocal cords or any obstruction. Both officers

then rolled Mr Davis onto his side and applied back blows in an attempt to clear his airway. Officer Lahood then attempted direct larynoscopy for a second time. Bag-valve-mask ventilation was continued but was still unsuccessful.

86. At 12:29pm, Officers Hirsimaki and Moye arrived at the residence and assisted in resuscitative efforts but had no direct involvement with airway management or other concerns relating to this incident.

87. At 12:30pm, CCP Sweedman arrived and says he received a handover and was told that Mr Davis was seen to be eating lunch, was witnessed to choke and subsequently collapsed to the floor. It is now unclear if this was the handover received then or if this information became subsequently available. CCP Sweedman stated in evidence he was not sure where he received that information but it was certainly something he was aware of.

88. Officer Lahood advised CCP Sweedman they had attempted to visualise the airway but were unable to ventilate Mr Davis. CCP Sweedman then attempted direct larynoscopy using the larynscope previously used but noted the light was not working. At 12:32pm CCP Sweedman used his own larynscope and visualised a large piece of meat obstructing Mr Davis' airway and promptly removed the obstruction using Magill forceps. Following the removal of the obstruction it was noted ventilation was now effective. He then secured Mr Davis' airway with a laryngeal mask airway. Mr Davis subsequently established a return of spontaneous circulation. During transport to a hospital he was administered chemical sedation using midazolam and morphine in order to provide sedation to maintain mechanical ventilation.

89. Shortly after arrival at hospital, CCP Sweedman was dispatched to a separate incident. Officer Nightingale completed and printed an eARF, without obtaining input or checking by officers Sweedman or Lahood. Upon returning to his home station, CCP Sweedman reviewed the completed eARF and noted relevant clinical information was not present in the detail required for such a case. He subsequently created a backup eARF, which more accurately reported the incident. Due to a technical issue, he later created a further additional eARF which documented the use of schedule 8 drugs.

90. Following the case, Officers Nightingale and Lahood did not report the incident as a clinical incident to any operational manager.

91. On 11 April 2018, CCP Sweedman discussed his concerns with clinical support officers at a clinical forum.

92. All paramedics gave evidence to the effect that the use of a laryngoscope for finding a foreign body airway obstruction was a very rare event. It was also evident that for ACPs, CPR in the context of a cardiac arrest was in itself rare and only occurred a few times a year. This evidence was confirmed by Dr

Stephen Rashford.

93. Officer Hirsmaki had eight years' experience and had only come across a foreign body obstruction on two occasions and on both of these occasions he used a laryngoscope.

94. ACP Jason Moye had 22 years' experience and stated he would have used a laryngoscope approximately a dozen times and only 2-3 times relating to a foreign body airway obstruction.

95. ACP Nightingale stated he would have had five cases in 20 years relating to a foreign body airway obstruction. ACP Nightingale stated that he did not receive any handover from the carer but prior to arrival, given the code had changed, he knew the person was in cardiac arrest. His responsibility was to focus on CPR and ACP Lahood took over responsibility for the airway. ACP Nightingale did not have any information about choking from the carer but given it was clear there was some form of airway obstruction and this led them to that suspicion and he performed three back blows.

96. ACP Nightingale prepared the initial eARF and stated it was an oversight on his part to not make reference to the difficulties with the laryngoscope. He stated it subsequently after the investigation there was extra training involving use of the laryngoscope and airway obstructions and riding of the eARF. He stated he had participated in the process and agreed there were some shortcomings which he states has been addressed through the further training he has received.

97. ACP Nightingale stated his role was to manage the airway and he used oxygen to ventilate. He stated there was no information given to him from the carer that Mr Davis had been coughing or choking nor was there any indication that he had been eating at around the time. He suspected an airway obstruction given he was difficult to ventilate. He first had a basic look into the open mouth and could not see anything. He then applied the laryngoscope to inspect and did this on two occasions. On the second attempt the light started to flicker. During the first attempt he was unable to visualise anything but the light was working.

98. Officer Nightingale then applied back blows in between the attempts with the laryngoscope. Officer Lahood had been a paramedic for 16 years and this was the first occasion he had used a laryngoscope on a patient and he had no previous experience of a foreign body airway obstruction.

99. Officer Lahood stated he knew there must be an obstruction but he could not see anything and therefore was not able to use the forceps. He stated it was possible that the food bolus had moved in the course of the back slapping but did not think so. He stated that the problem was probably due to his in experience with the use of the laryngoscope. He subsequently participated in an internal investigation and was placed on a clinical support plan and had

received very helpful training in the use of a laryngoscope and dealing with foreign body airway obstructions.

100. CCP Sweedman is a critical care paramedic of 20 years' experience. He stated that in a 15 year period he had come across a foreign body obstruction of the airways on approximately three occasions. CCP Sweedman stated it was critical that the airways be checked and if you were not able to see any obstruction and still not able to ventilate then you need to recheck. Having a laryngoscope that works is final as without that instrument you are not able to see below the oral cavity. He stated it was easy to remove the obstruction once it was able to be visualised. It was on this occasion a large piece of meat. He stated that he uses a laryngoscope two to three times a month but mainly for intubation purposes. He explained that only Critical Care Paramedics have the advanced qualifications to intubate and accordingly he uses a laryngoscope regularly but Advanced Care Paramedics would not have that regular use.

Queensland Ambulance Service Investigation

101. A QAS internal clinical investigation was conducted. The investigation found that:
    - Officers Lahood and Nightingale failed to adequately identify and manage a patient with a foreign body airway obstruction.
    - The primary patient care eARF was of significantly poor standard with major errors and admissions.
    - Officers Lahood and Nightingale failed to self-report this case as a clinical incident.

102. Additionally, significant and vital equipment failure occurred during the incident (probable flat laryngoscope batteries), with no documented pre-shift vehicle and equipment check for that day.

103. The review stated the evidence is highly suggestive that the cause of the cardiac arrest was a foreign body airway obstruction. There was a delay in removing the foreign body. At the time of the arrival of the first attending paramedics, Mr Davis was in cardiac arrest. Therefore, it is difficult to quantify the exact impact, if any, upon the outcome from the identified performance issues.

104. Officers Nightingale and Lahood were to be performance managed by the QAS to address operational deficiencies and provide professional development opportunities to improve their delivery of care.

Review by Dr Stephen Rashford

105. Dr Stephen Rashford the Medical Director for QAS also gave evidence for QAS with respect to the matter. Dr Rashford has extensive experience in

emergency medicine and has given expert evidence on such issues on many occasions. Dr Rashford provided a report which essentially dealt with two aspects of the QAS response being:

- The handling of the 000 call by the QAS Operations Centre; and
- The clinical treatment provided by the attending QAS paramedics

106. Dr Rashford stated that on this occasion he believes the accent of Mr Oderinde may have been a factor. It was clear his actions were well intentioned but his grasp of English made things difficult for the EMD, who are trained civilians with no specific clinical experience. Dr Rashford commented that whilst this was a difficult call for the EMD, on balance, it was not handled optimally nor was it entirely in accordance with QAS procedure.

107. He noted that the caller provided initial observations that Mr Davis was awake, had shallow breathing and was pale in colour. At approximately 2.5 minutes into the call information was given that Mr Davis had just eaten lunch, could not talk but was normally non-verbal. This prompted the EMD to use a breathing counter available within the software program which is used when it is difficult to establish if the patient is breathing effectively.

108. Dr Rashford stated that the breathing counter is a relatively recent upgrade to the software system. This occurred as there was a worldwide problem with bystanders interpreting agonal breathing as a sign of life, when in fact it represented the last best as use of brain activity. Agonal breathing is not effective to sustain oxygenation of the blood. On this basis, cardiac arrest is now considered to be present when a person is unconscious and ineffective breathing is established

109. At three minutes and 15 seconds into the call, the caller indicates a breathing rate of 15 breaths per minute which would not be consistent with agonal breathing.

110. At four minutes and 31 seconds it is suggested that Mr Davis is unconscious and a short time later the caller says it “is as if he is choked”. Dr Rashford stated that the phone was held close to the patient at five minutes and 46 seconds when there are noises consistent with ineffective breathing with a significant airway obstructive element. This was very concerning and indicates a pre-cardiac arrest scenario and it is highly likely Mr Davis was unconscious with precipitously low oxygen levels at that time.

111. At six minutes it was noted that Mr Davis’ eyes were open and at six minutes and 28 seconds, the breathing counter indicated a respiratory rate of 16–20 breaths per minute. It was Dr Rashford’s opinion that this updated scenario was completely inconsistent with what was actually occurring, reflecting a missed interpretation by the caller, albeit well intentioned.

112. Dr Rashford stated that human factors can potentially complicate scenarios such as this. He stated that whilst the breathing counter was introduced to

overcome mismanagement of cases due to these human factors, it is his view that in most situations if the breathing counter is considered, the victim should just immediately be considered in cardiac arrest and CPR should be commenced. CPR to someone with cardiac output is not life-threatening but delayed CPR in a cardiac arrest scenario is.

113. The caller, at one stage, mention that Mr Davis was blinking earlier during the call. This appeared to distract the EMD and a number of times she deviated from the formal software scripting, asking if Mr Davis was blinking, as if looking for a sign of life.

114. At eight minutes and 30 seconds the phone was held close to Mr Davis and there are minimal breathing sounds consistent with agonal obstructive breathing. Despite this, the caller indicates a short time later Mr Davis is awake but not blinking. Dr Rashford's opinion is that Mr Davis was in cardiac arrest or a very low output state at that time and most likely had been for some time. This conflicting pattern of information resulted in further delay of another 2.5 minutes in commencing CPR.

115. Dr Rashford stated that from listening to the call the EMD found the case very difficult due to the conflicting information being presented. These human factors at play resulted in a delay in recognising the choking episode complicated by cardiac arrest. Despite that, there was no delay to paramedics arriving on the scene.

116. It was the opinion of Dr Rashford that Mr Davis actually suffered severe hypoxia well before the initial paramedic crew attended. This hypoxia occurred in the setting of the choking episode and then the unrecognised period of cardiac arrest. He does not agree Mr Davis suffered a cardiac arrest in the minute or two before the paramedics arrived. The exact point of cardiac arrest was difficult to determine but, early in the call, there is evidence of ineffective breathing and unconsciousness.

117. Dr Rashford stated that most emergency medical services have concentrated on educating the staff, over a number of years, in an attempt to improve cardiac arrest identification and to reduce the time until CPR commences. QAS has already undertaken significant education in this area and is currently developing further education on decision-making to the effect that staff will be directed to proceed as if a cardiac arrest is present if they are considering the use of the breathing counter.

118. In relation to the actions of the paramedics Dr Rashford stated that they acted in accordance with standard practice of delineating roles for the resuscitation. The inability to visualise the airway obstruction was unsatisfactory and was a failure to perform to the standard expected but can be explained by the relative rarity of the condition and infrequent experience of real-time direct visualisation laryngoscopy by ACPs.

119. Dr Rashford further stated that ACP level paramedics provide hands on treatment to less than two cardiac arrest annually. Whilst paramedics attended a number of patients in cardiac arrest, the majority of cases do not have any resuscitative attempts undertaken, due to rapid discontinuation criteria being present.

120. Of cardiac arrests attended by ACPs, it is rare for a foreign body airway obstruction to be the primary cause. Most paramedics will never encounter this type of case, nor have the requirement to undertake laryngoscopy under these circumstances during their career.

Review by Clinical Forensic Medicine Unit

121. Dr Ian Home, Forensic Medicine Officer of the CFMU reviewed medical and carer progress notes and the resuscitation response of the carer and QAS.

122. At lunchtime on 8 April 2018, Mr Davis collapsed as a result of airway obstruction caused by a food bolus. QAS diagnosed a pulseless electrical activity arrest and had difficulty ventilating him. CCPs attended 10 minutes later and removed a large piece of meat from the upper airway. Spontaneous circulation was restored soon afterwards.

123. Despite spontaneous ventilation and normal pupillary response on arrival at the SCUH, Mr Davis had experienced a prolonged downtime. Subsequent CT scan revealed diffuse hypoxic brain injury. Following discussions with the family Mr Davis was palliated and passed away at 00:50 on 10 April 2018.

124. The cause of death was listed as:

1a)	Diffuse hypoxic brain injury	2 days
1b)	Cardiac arrest	2 days
1c)	Respiratory arrest	2 days
1d)	Airway obstruction	2 days
1e)	Food bolus	2 days

125. Dr Home noted the Multicap notes do not indicate any specific dietary or swallowing issues and a *CHAP* form completed in October 2016 indicated no difficulties swallowing. It was noted a referral to an outpatient Speech Therapy clinic was declined in August 2017. Dr Scott clarified that although concerns regarding swallowing safety were raised in October 2013 and February 2014, a barium swallow (a series of x-rays taken while swallowing a radiopaque liquid to assess coordination during swallowing) performed on 6 February 2014 showed only minor aspiration into the upper trachea that did not result in any coughing. As a result no further investigations were undertaken. The purpose of the speech therapy referral in August 2017 was not related to swallowing concerns but was not done with the aim of improving his speech and communication.

126. According to the QAS eARF documentation Dr Home noted that Mr Davis began coughing whilst eating lunch then became more and more distressed. In contrast, Dr Home noted the incident form attached at the end of the carer records indicate the person who completed the form heard a thud and came out of the kitchen to find Mr Davis lying on his back on the floor and was unresponsive. Dr Home stated it was unclear which version of events is inaccurate. Dr Home opined that if Mr Davis was found coughing following eating, the CFMU primary concern related to the provision of basic life support measures by the carer; primarily back blows (or use of the Heimlich manoeuvre) to someone who appears to be choking. It was assumed all carers should be up to date with basic life support training.

127. It was also unclear if the initial ambulance crew inspected the airway for a foreign body, which should be part of the initial A-B-C's of resuscitation. Given the prompt return of circulation once the airway was cleared, these measures may have altered the outcome in this case.

128. Dr Home stated that although choking could not have been predicted or prevented, if a food bolus was considered and attempts to remove it been made prior to arrival of the CCP crew, the outcome may have been different. Once he suffered prolonged hypoxia the outcome was inevitable.

129. Dr Home noted QAS conducted a thorough clinical investigation of the events. Dr Home noted there appears to be some inconsistencies as to the level of the information available at the time of QAS arrival. Despite basic resuscitation steps to check airways, breathing and circulation in that order, it is unclear whether or not the airway was immediately inspected for a foreign body.

130. Dr Home stated that in circumstances of coughing whilst eating, the primary consideration would be obstruction of the airway by a foreign body, such as a food bolus. Whilst it is his understanding that knowledge of basic first aid may not be a requirement of carers, these skills should be mandatory for any person responsible for the well-being of others. Ambulance courses teach that in cases of suspected airway blockage, the patient should be bent forward and five sharp blows should be applied to the back between the shoulder blades. If this fails, one hand should be placed in the middle of the back for support, whilst five chest thrusts are applied. Dr Home opined attempts at such basic manoeuvres may have dislodged the food bolus and prevented Mr Davis' further deterioration.

131. Dr Home stated the findings of the QAS clinical investigation were critical of the initial management. Whilst it is possible the various manoeuvres performed prior to arrival and inspection of the airway by CCP Sweedman may have repositioned the food bolus making it easily visible, it remains apparent that initial efforts to exclude a foreign body were substandard.

132. Given Mr Davis had already lost cardiac output by the time the first QAS crew

arrived, caution needs to be applied when considering if the additional 10 minute delay before the food bolus was removed represents a clear outcome changing event. Given CPR was commenced only a short time prior to QAS arrival and the prompt return of spontaneous breathing and circulation occurred once the food bolus was cleared, it was the opinion of Dr Home that Mr Davis may well have survived.

133. Dr Home also had the benefit of considering the audio of the 000 call. In evidence at the inquest he agreed there was some uncertainty as to the condition of Mr Davis and that at about 10.5 minutes into the call at 12:18pm it was evident he was no longer breathing.

134. Dr Home stated that if CCP Sweedman attended 10 minutes prior, and successfully removed the food bolus, the outcome may have been different.

135. Dr Home agreed that at about 8.5 minutes into the call obstructed or ineffective breathing can be heard and then breathing stops at 10.5 minutes.

136. Dr Home agreed that if Mr Davis had an epileptic seizure and blacked out for a period of time with the food in his mouth that this could have caused the obstruction or it was possible the food was aspirated.

137. Dr Home stated that basic support skills should train people to look at the airways but it was difficult to be critical of DSWs who are more at a domestic level. He stated the carer did what he was told according to the 000 call and Dr Home stated he would have liked the EMD caller to have said something more about clearing and checking the airways.

Conclusions on the issues

138. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

139. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[3] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

140. With respect to the *Briginshaw* sliding scale it has been held that it does not

[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.

141. In matters involving health care, when determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered. That is, after an event has occurred there is an inclination to see the event as predictable, particularly where the outcome is serious, despite there being few objective facts to support its prediction.

How he died

142. There is no doubt Mr Davis died after a large piece of meat became lodged in his trachea, blocking the airway such that his brain was deprived of oxygen causing significant brain damage from which he could not survive.

143. How the piece of meat became lodged is not altogether certain as the incident was unwitnessed. Mr Davis did have a history of infrequent seizures due to epilepsy and one possibility that was suggested is that he had a seizure and in the course of this may have aspirated the food bolus which became lodged in his airway. Dr Home conceded this was a possible explanation. There was no evidence Mr Davis was having a seizure when first observed by Mr Oderinde.

144. Accepting that the possibility of a seizure cannot be absolutely excluded, on balance I find it is more likely Mr Davis was completing his lunch and unfortunately swallowed a large piece of meat which found its way to his trachea. The proximity in time to Mr Davis choking and him having his lunch is one significant factor supporting such a finding.

Whether the health, disability and supported accommodation services provided to the deceased were adequate and appropriate.

145. As noted by the Public Advocate in considering the material it would seem the care and treatment provided to Mr Davis by Multicap was adequate and appropriate. The Public Advocate considered it was generally thorough and demonstrated a high degree of care.

146. In respect specifically to swallowing issues, I accept the submission of Counsel Assisting that on the balance of the evidence Mr Davis had isolated occasions of swallowing issues as identified upon review by the speech pathologist in 2014 and 2016. In hindsight, perhaps the issue could have been more routinely investigated but the evidence does not suggest there was any particular failing to escalate or investigate a particular swallowing concern around the time of the choking incident.

147. It does appear there could have been better communication of ongoing issues concerning Mr Davis' hospital attendances in 2014 and 2016 between carers and clinicians. The Public Advocate raised concerns that despite these

two particular admissions no change appeared in Mr Davis' care in relation to his diet by either his regular GP, Dr Scott or by Teralba or Multicap. Further, that there appear to be no communication between Dr Scott and Multicap in relation to the post admission care plan, as would have been required in the multiple CHAP reports that were completed.

148. I accept, it is likely that any review may not have changed the plan of management given Dr Scott stated the episodes of 2014 and 2016 principally related to issues of thickened fluids, and as post hospital there were no reported problems he considered it reasonable to relax any restrictions.

149. In any event Multicap subsequently identified a gap in the annual CHAP report relating to swallowing and has now developed a checklist to assist carers in identifying issues with swallowing. This seems to have already identified a number of such cases that required review of particular clients and the Public Advocate considers the checklist looks comprehensive and should assist to identify future residents who may have swallowing/choking risks.

Whether first aid and disability services carer training of the supported accommodation carers were adequate and appropriate.

150. It is apparent Multicap ensures all its DSWs have up to date First Aid and CPR training. Other relevant training is also provided as evidenced by the workers and Ms Jessop.

151. DSWs do not provide clinical care and could not be expected to in the circumstances. The appropriate policy in place was for DSWs to follow their training and call emergency services.

152. In this case it is evident Mr Oderinde cleared the area to make it safe for CPR, checked the airway and rang 000. Mr Oderinde did not observe any obstruction and it is fair to say neither did Officer Lahood.

153. I find on balance that Mr Oderinde was wrong about the time he called 000 and it was much closer to 12:07pm than 11:52am. It may have been whatever time piece he used that showed this timing was incorrect. I accept there may have been a few minutes pass while he cleared some space, placed him in an appropriate recovery position and checked his airway, and there may have been some time before the 000 call went through to QAS but I do not believe Mr Oderinde did nothing for a number of minutes.

154. What happened from there was not optimal in that there was a clear difficulty in the transfer of accurate information between Mr Oderinde and the 000 EMD. What was evident to me, and a reason why Dr Rashford was asked to review the call, is that it was possible what I was hearing was perhaps agonal breathing some minutes before CPR commenced. Dr Rashford is of the opinion that was the case. I am not critical of Mr Oderinde in being unable to

recognise this for what it was as it is clearly out of the scope of practice of DSWs to make such clinical judgments.

Whether the resuscitation performed by the Queensland Ambulance Service was adequate and appropriate.

155. The issue of the call received by the QAS EMD was very robustly analysed by Dr Rashford where he concluded that on balance the call was not handled optimally.

156. Dr Rashford stated that from listening to the call the EMD found the case very difficult due to the conflicting information being presented. Having listened to it on a number of occasions I can only agree.

157. Dr Rashford found there were understandable human factors at play that resulted in a delay in recognising the choking episode complicated by cardiac arrest. Despite that, there was no delay to paramedics arriving on the scene.

158. Given Dr Rashford's evidence about the significant education in this area that has been undertaken and is continuing to be developed, I do not see the need to further comment or consider further recommendations in this regard.

159. QAS also investigated the actions of the various paramedics at the resuscitation and subsequent to it. The investigation considered two paramedics failed to adequately identify and manage a patient with a foreign body airway obstruction. This finding is mitigated to some extent by the relative rarity of the paramedics coming across foreign body airway obstruction conditions and infrequent experience of real-time direct visualisation laryngoscopy by ACPs.

160. The two paramedics concerned have received further training in airway management and in the use of laryngoscopes and have otherwise been performance managed.

161. The evidence supports a finding that by the time paramedics arrived Mr Davis had been in cardiac arrest for some time and would have already suffered a degree of hypoxia from which it was unlikely he could recover. That being said, it evident the earlier CPR commenced (likely to have been ineffective until the obstruction was removed) and the earlier the removal of the food bolus obstruction occurred, then the better the chance of a more favourable outcome eventuating.

Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

162. I do not consider any recommendations need to be made to QAS in respect

to its findings on its investigation as there is clearly ongoing improvement processes as part of its organisational ethos and it is best placed to drive those forward.

163. The Public Advocate raised the issue of specific recommendations being made in the context of this case regarding the actions that should be taken by all those involved in the care of people with swallowing issues when they are identified.

164. Multicap independently of this case identified some deficiencies in the CHAP document with respect to nutrition and swallowing and developed and is using successfully a *Nutrition and Swallowing Checklist*. The Public Advocate stated the checklist certainly looks comprehensive and should assist to identify future residents who may have swallowing/choking risks. The checklist was adapted from a document produced by the NSW Department of Ageing, Disability and Home Care.

165. I will therefore forward these findings to an appropriate disability care association to note the findings and pass on to its members a recommendation that similar checklists be considered generally for use by care providers who are providing disability care services to those who would be considered in a risk category for swallowing difficulties. Multicap have advised it is a member of National Disability Services.

Findings required by s. 45

Identity of the deceased – John Davis

How he died – John Davis was aged 50 and had a number of disabling comorbidities primarily due to complications of an acquired brain injury from birth. For a number of years he had resided at supported residential premises and his death is a reportable death in care. There had been previous investigations performed regarding recurrent aspiration pneumonia in the context of possible swallowing issues but at the time of his death there was no documented concerns regarding his capacity to swallow and eat a relatively normal diet. On 8 April 2018 he had just eaten his lunch when he was heard by his carer to collapse to the ground. Emergency services were called by his carer. At the time of the call it is apparent Mr Davis was breathing but during the emergency call his breathing deteriorated to the extent that it was likely to be agonal and ineffective. At no point in the emergency call was there any indication by the carer of any airway obstruction or

information which would have led a listener to believe that a food obstruction of the airway was an issue. Some further minutes later Mr Davis appears to have stopped breathing and at this point the carer was instructed to commence CPR. On review it is considered that CPR could have commenced some minutes sooner. Ambulance officers arrived shortly after and took over CPR. It became evident to them that his airway was obstructed due to the failure to be able to successfully ventilate him. An officer checked the airways and used a laryngoscope but unfortunately due to a combination of inexperience in the use of the device and a faulty laryngoscope a food bolus that was lodged in the airway was not observed.

It was not until an advanced Clinical Care Paramedic attended that the problem was quickly observed and the food bolus removed. Unfortunately, by that time and probably well before the arrival of paramedics, Mr Davis had been without oxygen for a period of time such that his brain was deprived of oxygen and he suffered from hypoxic brain damage. Although he was subsequently ventilated this damage was irretrievable he passed away a few days later.

Place of death – Sunshine Coast University Hospital BIRTINYA QLD 4575 AUSTRALIA

Date of death– 10 April 2018

Cause of death – 1(a) Hypoxic-ischaemic encephalopathy
1(b) Choking on food bolus
1(c) Acquired brain injury

Comments and recommendations

I recommend that National Disability Services note the findings and pass on to its members that they consider implementing as part of their respective policies and guidelines a Nutrition and Swallowing Checklist similar to one in use by Multicap and adapted from a document of the NSW Department of Ageing, Disability and Home Care for use by care providers who are providing disability care services to those who could be considered to be in a risk category for swallowing difficulties.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
17 April 2019