QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Paul Joseph Milward**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Ipswich
FILE NO(s):	2015/3395
DELIVERED ON:	5 June 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	1 February 2018, 13 April 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Residential aged care, Huntington's disease, cognitive and swallowing impairments, choking on food, preventative recommendations, Public Advocate review of disability deaths in care

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
Counsel for Bundaleer Lodge:	Ms D Callaghan i/b Barry Nilsson Lawyers
The Public Advocate:	Ms M Burgess

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Introduction

1. Paul Joseph Milward was aged 53 at the time of his death on 31 August 2015. Mr Milward resided at Bundaleer Lodge, an aged care nursing home residential facility at North Ipswich.

2. His current medical history included Huntington's disease (diagnosed 2009), depression, gastro-oesophageal reflux disease and asthma. He was on numerous medications. It was noted in Mr Milward's aged care record that he required assistance with activities of daily living and mobility due to involuntary movements (chorea) as a result of Huntington's disease. He also had cognitive impairment. There was a history of aggressive and at times uncooperative behavior due to the effects of Huntington's disease.

3. The aged care nursing home records indicated that Mr Milward needed supervision when eating, on the basis he was at risk of choking on food. A Discharge Summary sent from Princess Alexandra Hospital and dated 5 September 2014 noted speech pathology recommendations that included he be provided a minced moist diet and thin fluids, with a view to upgrade to other food types as appropriate, if increased supervision was able to be provided at meal times.

4. At around 8am on 31 August 2015, nursing home staff brought him breakfast, partly consisting of two pieces of bread cut into triangles with butter and jam. A staff member assisted him to change before assisting him back to bed and leaving him to eat his bread and jam. The staff member closed the door as Mr Milward did not like to be disturbed when eating.

5. Approximately two hours later the staff member returned to the room and found Mr Milward lying in bed on his right side with his left hand raised to his face. There was a piece of bread in his mouth and bread on the bed underneath his face.

6. The police were called and Mr Milward's death was reported to the Coroners Court.

7. An autopsy examination found the cause of death was due to choking.

8. In February 2016, the Public Advocate of Queensland published a report[1] that identified lack of compliance by support staff with mealtime management plans and periods of non-supervision as the two key factors leading to choking deaths.

9. In Mr Milward's case, Ms Pamela Bridges, an independent expert commissioned by the Coroners Court to provide an opinion on the care provided to Mr Milward, identified exactly these two factors (lack of compliance with Mr Milward's care plan and an unacceptable period of non-supervision) as playing a key role in Mr Milward's death. Ms Bridges essentially made two recommendations:

[1] 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. Mandatory annual training for staff on how to care for persons requiring texture modified diets
ii. Ensure care staff are fully aware of the importance of providing supervision if it is listed as an intervention

Issues for inquest

10. On the basis of the findings of the Public Advocate and the similar issues identified in the coronial investigation as contributory to Mr Milward's death, a decision was made to hold an inquest to better understand how the death occurred and if there are any further recommendations that should be considered. Leave was also granted to the Public Advocate to appear and make submissions pursuant to s. 36 (2) & (3) of the Coroners Act 2003 regarding any comments or recommendations that may be considered pursuant to s. 46.The following issues were determined for the inquest:
    i. The findings required by s. 45(2) of the Coroners Act 2003 namely the identity of the deceased, when, where and how he died and what caused the death.
    ii. Whether there are any matters about which preventative recommendations might be made pursuant to s. 46 of the *Coroners Act 2003.*

Autopsy results

11. Forensic Pathologist Dr Nadine Forde completed an external and full internal examination. A CT scan showed material at the back of the mouth, which extended through the pharynx and into the oesophagus. Similar material was seen in the trachea and branching into the left and right main bronchi.

12. An external examination showed a cachectic middle-aged man. A number of minor pressure related injuries were identified consistent with him being poorly mobile.

13. An internal examination found a large food bolus, which extended from the base of the tongue, through the pharynx and into the upper oesophagus. The epiglottis was in an open position and congested. There was further food bolus in the trachea extending to both the left and right main bronchi.

14. The right lung showed areas of acute on chronic inflammation. There was foreign material and an associated foreign body reaction. The features were consistent with acute on chronic aspiration pneumonia. Coronary atherosclerosis and peripheral vascular disease were identified.

15. Neuropathology confirmed the presence of Huntington's disease.

16. Toxicology analysis noted non-toxic levels of valproic acid, oxazepam, mirtazapine, paracetamol and tetrabenazine.

17. Dr Forde stated in the Autopsy Report that Huntington's disease is a progressive neurodegenerative condition characterised by uncontrollable movements, cognitive decline and affective disorders. As the disease progresses, higher cortical function declines leading to dementia and depression. Simple tasks such as walking, speaking and swallowing become difficult.

18. Swallowing impairments predispose an individual to aspiration and choking. Aspiration of food contents into the lungs causes a severe necrotising pneumonia, which can lead to death. If a food bolus is large enough, obstruction of large airways can occur resulting in sudden death. In this case, Mr Milward showed evidence of aspiration events with resultant pneumonia, with ongoing swallowing difficulties. However, death has occurred at this time due to choking on a large food bolus obstructing the pharynx.

19. The presence of coronary atherosclerosis was a significant contributing factor as death is likely to occur more rapidly in the setting of hypoxia from airway obstruction.

Background information to circumstances leading up to Mr Milward's death

20. Mr Milward was first diagnosed with Huntington's disease in 2009. He came into care in 2013 after he could no longer live independently or live with his family.

21. It is apparent from a review of the nursing home records that Mr Milward was approved to receive permanent residential care at a high level in September 2013. His Aged Care Client Record, which was completed by the Aged Care Assessment Team supporting that decision, noted he would need supervision when eating as he may choke on his food. Mr Milward was reported to have difficulty with feeding himself due to chorea (jerky involuntary movements) and that he may spill food. During the Aged Care assessment Mr Milward was observed feeding himself without incident or food spillage. It was noted his ability in this area varied.

22. It was also noted that due to Huntington's disease, Mr Milward engaged in challenging behaviours and at times engaged in socially offensive behaviour. It was reported he was stubborn and defiant to family and doctors alike and had been non-compliant with medication. It was noted Mr Milward now required an intense level of support and supervision in all activities of daily living. He had previously been supported by the Department of Disability Services Queensland but they were not able to provide the necessary care to meet his needs and were now seeking appropriate care for him in a residential aged care facility.

23. Mr Milward had previously been residing at another residential aged care facility. At that facility it was noted there were several behavioural symptoms including agitation and aggression towards co-residents and staff. This adverse behavior trait culminated in a serious assault on a co-resident. Mr Milward was admitted to Princess Alexandra Hospital on 5 July 2014 after the aged care facility decided it could no longer provide the specialist care required for him. He was admitted to a specialised care unit for people with cognitive impairment at PAH whilst alternative accommodation could be sought. Mr Milward was discharged to Bundaleer Lodge aged care nursing home on 5 September 2014.

24. A discharge advisory letter was prepared by the PAH specialized care unit and this discharge letter stated Mr Milward was independent with eating his food, once the food had been set up for him. It was noted he liked to be independent with feeding himself and he could become quite upset with others if they stepped in to food preparation without his permission. On occasion he was physically abusive towards staff. The discharge letter provided advice about effective strategies to manage his behavior and considered his present symptoms presented no

management issues that fall outside of adherence to standard principles of care for people with dementia and more specifically Huntington's disease patients.

25. During the course of Mr Milward's stay at Bundaleer Lodge there were recorded numerous incidents of aggressive and non-compliant behaviour towards staff and other residents.

26. Sandra Logue, the Nursing Care Manager at Bundaleer Lodge, acknowledged she received the PAH discharge letter of advice. She stated that even though Mr Milward was to have a minced, moist diet, Mr Milward was determined at times to eat what he wanted and took food from others. The Behaviour Management strategies plan was to allow him to feed himself with the meal set up. This was initially tried but Mr Milward spilt much of his meal on the floor as he stood up to eat and he had very poor coordination with his cutlery. He would allow staff to feed him some portion of his meal or totally refuse to be fed. Staff had not reported any coughing or choking with his food or fluids. Mr Milward was not suitable to take meals in the dining room as this proved to be a slip risk to other residents. Staff said he would snatch at his food and point to the door for staff to leave. His cooperation with any supervision was poor as he liked his own space and often refused to allow staff to tidy his room.

27. A diet analysis form was completed on 5 September 2014. This noted Mr Milward required a Mouli meal consisting of minced and moist diet texture B. A Care Plan dated 12 August 2015 noted his meals were to be served by way of a tray in his room. He was to receive partial assistance with fluids. He required full assistance with solid food. Otherwise his meal texture was to be a minced and moist diet.

28. Sandra Logue described Mr Milward as a difficult resident to care for. He was very difficult with his meals and did not like anyone entering his room. Staff tried on many occasions to feed him whilst in the lounge room as he was not able to attend the dining room. He did not sit for meals and had to be fed while he moved about because of his severe chorea. Staff tried to supervise his meals but this was not always possible as he kept shutting his door.

29. Ms Logue stated the care plan identified he required full assistance with solid foods as he needed a mainly liquid component, but he spilled these types of foods over the floor and himself. As well, Mr Milward was not able to be assessed by a speech pathologist as he was not cooperative with the speech pathologist and would not allow a stethoscope to be placed on his neck or chest.

30. Ms Logue reported that staff would often find plates in his room that he had taken from the lounge room and/or from other residents.

31. Ms Logue stated Mr Milward was given sandwiches as a last resort to have him eat something as he would refuse to eat anything at all on some days. He was given bread that was very soft and moist only. Ms Logue stated that, based on her experience in her 35 years as a registered nurse and 14 years as a nursing care manager, she felt Mr Milward could safely manage eating bread. She had seen him eat bread and sandwiches many times and he never displayed any issues with eating bread. His main issues were with coordination of spoon to bowl to mouth. Mr Milward had not shown any deterioration in swallowing since he arrived from Princess Alexandra Hospital. Ms Logue stated that if she thought there was any deterioration she would have contacted their speech pathologist to assess and observe him. She had done that numerous times with other residents.

Events of 31 August 2015

32. In relation to the incident itself, Mr Milward received his breakfast from Rebecca Rouse, an assistant nurse with qualifications in Certificates Ill and IV in aged care work. Mr Milward had experienced some incontinence that morning and he was assisted with changing his clothes and helped back to bed. Ms Rouse stated the breakfast was brought to Mr Milward at approximately 8:10am and consisted of cereal, spaghetti, bread and jam and juice in a drink bottle with a straw. Ms Rouse says she fed Mr Milward the cereal and spaghetti and left him with the bread and jam and juice. She closed the door behind her when she left being aware Mr Milward did not like his door being open. At the time he appeared to be in good health and lying on his right hand side in his bed.

33. Ms Rouse stated that she was required to assist Mr Milward with eating any moist food due to the risk of it spilling on the floor and creating a slip hazard but she was allowed to leave Mr Milward with his sandwiches. Ms Logue confirmed that the supervision of his moist meal was to address spillage and was not related to concerns about choking.

34. Ms Rouse returned two hours later at about 10:10am when she was conducting a nursing round and re-stocking the bathrooms with razors and completing a general tidy of the bedrooms and ensuite bathrooms. Ms Rouse immediately contacted more senior staff when she found Mr Milward.

35. Queensland Police Service and family were then called. Staff members of the nursing home changed his clothing and moved Mr Milward on to his back while awaiting the arrival of police and family. Queensland Ambulance Service also attended and confirmed Mr Milward was deceased.

36. Bundaleer Lodge stated in a response to concerns expressed about the incident, that the two hour gap was one of poor judgement on the part of Ms Rouse. Ms Rouse reported she fed Mr Milward his full breakfast and felt he did not require supervision to eat his bread and therefore attended to him two hours later on her next nursing round. Ms Logue told the court the two hour gap was unusual but regular informal observation was made more difficult for by Mr Milward insisting on his door being shut.

Independent report of Pamela Bridges

37. Ms Pamela Bridges provided an independent expert review of the appropriateness of care provided to Mr Milward during his stay at the nursing home, particularly in regard to the management of his eating and swallowing. Ms Bridges has social work and nursing qualifications and extensive experience as a nursing manager in the Aged Care field and more recently as a consultant to the industry, particularly relating to education, regulatory oversight and policy development.

38. .Ms Bridges reviewed the extended care plan provided for Mr Milward and assessments pertaining to activities of daily living including nutrition, mobility and dexterity, personal hygiene and confidence toileting.

39. On admission to the nursing home a speech pathologist assessment listed the following requirements for feeding:-

i. Position and cut up for easy access
ii. Serve meals one course at a time
iii. Supervise when feeding
iv. Feed resident only when alert
v. Resident to be upright for any food/liquid intake

40. Ms Bridges noted the care plan subsequently developed mentioned all of the above except the issue of the resident to be upright for any food/fluid intake. Ms Bridges noted that there was evidence that Mr Milward seemed to like bread and requested this regularly. He also appeared to like biscuits. He exhibited strong preferences for what he wanted to eat at times, sometimes contrary to speech pathology/nutrition advice.

41. Ms Bridges also noted that Mr Milward required full assistance with personal hygiene tasks but it appears that staff assistance on this was a day by day proposition depending on his mood and wishes. She saw evidence of staff being present with Mr Milward on many occasions. She also saw evidence of Mr Milward reacting aggressively to staff and others.

42. Mr Milward also exhibited a wide range of difficult behaviours that included intrusiveness in inappropriate areas, physical aggression and verbal outbursts to staff and other residents. The only constant was the unpredictability of his outbursts.

43. Ms Bridges noted there were times when behaviours were quite manageable and this appears to be linked to his medication regime.

44. Ms Bridges commented that the care plan documentation supports the speech pathology/nutritionist assessments and management strategies prior to admission from PA hospital. The management of Mr Milward was very complex due in part to his medical condition but also because of his behaviours. She also found he frequently refused the minced moist diet offered and chose to eat bread, biscuits etc.

45. Ms Bridges noted it appears that when offered bread, it was soft with the crust removed and Mr Milward coped with this quite well. There was no evidence in the documentation indicating to her that Mr Milward had any episodes of coughing, gagging or choking during his stay at the nursing home.

46. Ms Bridges stated that the provision of assessed care needs was complicated by Mr Milward's behaviours, varying moods and his determination to have his door closed etc.

47. She formed the opinion that the staff at Bundaleer Lodge made every effort to provide care consistent with assessment and care plans. There was also evidence that Mr Milward took food from the dining room, etc. and took it back to his room. She feels sure this was most likely not minced and moist food.

48. Ms Bridges stated that her concern is that some things in the care plans were not adhered to, including:-

    i. Serving meals one course at a time-Ms Bridges was unable to establish

if this was done but suspects that all items would have been put on Mr Milward's tray and left with him.

ii. As a result of the difficulty in assisting Mr Milward with meals, staff were not present to supervise his ingestion of meals at all times.

iii. The speech pathologist management plan included that the resident be upright for any fluid or food intake. It was certainly not the case on the day of his death that he had been positioned upright.

iv. It appears that no staff went into Mr Milward's room until a staff member doing a cleaning round entered at 10:10 am at which time he appeared to be deceased. Ms Bridges stated that whilst she appreciated the challenges in caring for Mr Milward, she finds it quite unusual and unacceptable that two hours elapsed and no one entered his room to check on him.

49. Ms Bridges stated that based on her review of the records, generally the staff at Bundaleer Lodge had cared for Mr Milward quite well during his residence there. They seemed to have managed his behavioural outbursts and did not appear to depend on medication, and in fact his medications had been reduced. She considered the staff did a good job at juggling his care needs and day by day needs even though he could be determined about what he wanted. She noted his weight had stabilized and there had been only some little deterioration of his overall functioning in the time spent there.

50. Ms Bridges stated there was no indication in the ongoing progress notes to indicate there was anything of any significance that had changed with Mr Milward's daily cares. Ms Bridges stated that unfortunately there does not appear to be staff compliance with the management as outlined in the care plan.

51. Ms Bridges stated that although the circumstances surrounding this tragic event are quite atypical, staff need to provide monitoring and supervision as set out in the care plan.

52. Ms Bridges stated it is apparent that Mr Milward presented as a particularly challenging resident. Admitting a resident, particularly with Huntington's disease, requires careful assessment and ongoing care interventions to provide the resident with a safe and comfortable environment. Ms Bridges said it appears that despite the challenges, Mr Milward settled quite well. His weight stabilised despite the variations to his minced and moist dietary requirements.

53. Ms Bridges said it is also critical to ensure that care staff (who quite often only have Certificate Ill qualifications) are fully aware of the importance of providing supervision, if it is listed as an intervention. The responsibility to ensure the staff were acting appropriately is with registered nursing staff as part of their Scope of Practice responsibilities.

54. Ms Bridges stated she believed that ongoing training about the care of someone with Huntington's Disease or any disease where texture modified diets are required due to dysphagia, should be included in the mandatory training that is conducted annually for all care and catering staff.

55. Ms Bridges noted that since Mr Milward’s death comprehensive staff education has been conducted at the nursing home on Dysphagia and Texture Modified Food and Fluids. A total of 85 staff attended over three sessions. Following this education the

nursing home has reviewed and developed a policy on Nutrition and Hydration.

56. Ms Bridges concluded that the death of Mr Milward was a tragic event. The consequences for his family as well as for care staff were overwhelming.

57. Whilst acknowledging how difficult it would have been for staff to carry out care plan interventions if Mr Milward did not want them to occur, and she was not sure whether the situation could have been avoided, Ms Bridges believed the following negatively impacted on the potential outcome for Mr Milward:

    i. Staff not complying with the care plan interventions set out by speech pathologists and as part of the ongoing assessment processes e.g. serving one course of the time; monitoring ingestion of food and fluids and sitting upright to eat or drink.
    ii. It appears that Mr Milward consumed food whilst lying in his bed. Once again she was not sure the staff had much control over this if this is what Mr Milward was intent on doing.
    iii. A much timelier checking on how Mr Milward was managing his breakfast. Two hours between staff assisting Mr Milward to bed to eat his breakfast and subsequently finding him deceased was in her opinion unacceptable.

Cognitive capacity

58. The issue of the extent of Mr Milward's cognitive capacity to make such decisions and the extent to which he would have understood any advice given regarding how he should go about food and fluid intake was an issue that was raised.

59. Ms Logue was of the view that Mr Milward had impaired capacity but he could make decisions about who he liked or did not like; whether he wanted his door open or not. He recognised his family, he chose the clothes he wore and the music he liked.

60. On 5 March 2015 his GP provided a letter to Bundaleer Lodge stating the GP believed Mr Milward did not have the capacity to make decisions regarding financial matters or his medical/personal care.

61. Ms Bridges stated there was evidence Mr Milward had some cognitive capacity to make decisions about routine aspects of his daily living, including what clothes he wore and where he ventured. His speech was difficult to understand.

62. Ms Bridges noted that aged care services are required to provide care consistent with the *Charter of Resident Rights and Responsibilities Aged Care Act 1997.* This included for residents to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect. Further that they should be able to maintain personal independence, which includes a recognition of personal responsibility for his or her actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should not then be used to prevent or restrict those actions.

Response from Bundaleer Lodge

63. In this case, it appears the non-compliance with the mealtime management plan was potentially due to staff members' fear of and/or inability to manage other behaviours (verbal and physical aggression), making it difficult for them to

implement the plan or even supervise appropriately. It was unclear if Bundaleer Lodge explored other, more appropriate strategies first (e.g. liquid supplements), in consultation with a dietician, before giving Mr Milward bread/sandwiches as a "last resort to have him eat something".

64. The Public Advocate's report, essentially identified lack of compliance by support staff with mealtime management plans and periods of non-supervision as the two key factors leading to choking deaths.

65. Since Mr Milward's death and also in response to Ms Bridges' report, Bundaleer Lodge has undertaken the following changes:

    i. The facility completed comprehensive *Dysphagia and Texture Modified Diet* training with all staff following the incident. This training has now been made mandatory annually and has been added to the yearly training calendar (consistent with Ms Bridges' first recommendation). It has also been added to the orientation training for all new staff.
    ii. The facility is currently (as at 10 August 2017) providing *Care Plan* training for all staff on how to review and comply with a resident's care plan (consistent with Ms Bridges' second recommendation). This training will ensure that all staff know how to access the care plans on their internal system 'iCare' and to instruct staff that it is their responsibility to keep up to date on a resident's care plan and to follow the care plan interventions for each resident. This has also been added to orientation for all new staff.
    iii. Any changes to a diet plan for a resident on a texture modified diet outside the prescribed diet, will not be allowed without the assessment of a speech pathologist. If such assessment is not possible, the change will not be made.
    iv. Only the nurse clinical manager may make any permanent dietary modifications in consultation with a speech pathologist and dietician as necessary.

66. The menus for texture controlled diet were completely reviewed by a speech pathologist and some changes were made to the menus as a result.

67. Regarding the gap in supervision of Mr Milward, to minimise the risk of this occurring again a full care plan review was being conducted to assess all residents who require supervision with their meals. Essentially the facility will ensure that any resident who eats meals in their room is either someone who has been appropriately assessed as being 'independent' i.e. not requiring supervision at mealtime, or if they require supervision e.g. due to a choking risk, they will be provided one staff member to assist at all times during the consumption of their meal (relevant to Ms Bridges' second recommendation about supervision, but from a planning and resource perspective rather than a staff education perspective).

Public Advocate Submissions

68. The Public Advocate was granted leave pursuant to s 36(2) and (3) of the *Coroners Act 2003* to make submissions on any other 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 Milward's 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.

69. 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.

70. 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.

71. 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.

72. 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:

    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.

73. In reviewing the material in this case the Public Advocate submitted the issues identified in this matter have equal application and relevant in both the disability care and residential aged care systems.

[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

74. The Public Advocate acknowledged that from the material it was evident that the staff at Bundaleer Lodge demonstrated a high degree of care and respect for Mr Milward's personal dignity and made every effort to provide him with care took into account his views and preferences in terms of his personal care and the meals that were provided to him.

75. The Public Advocate agreed with the submission that many of the actions taken by Bundaleer Lodge were appropriate but also submitted that there could be consideration to broader recommendations for implementation of those actions across the residential aged care and disability care systems in relation to the care were residents with high needs.

76. The Public Advocate noted that in relation to Bundaleer Lodge's 'Care Plan' training for staff on how to review and comply with a resident's care plan, included instructing them that it is their responsibility to keep up-to-date on a resident's care plan and to follow it for each resident. The Public Advocate expressed a concern that placing this expectation on staff may not be sufficient, given the number of residents staff are likely to care for and their ability to be able to recall all of the residents' care requirements as outlined in their care plans, especially if they have not consulted those plans for more than two or three months.

77. The Public Advocate submitted that consideration should be given to recommending that Bundaleer Lodge and other residential aged care and disability care facilities providing care for residents with high needs such as Mr Milward require:
    i. All staff involved in the provision of care to a resident be informed immediately (or at least at the commencement of their next shift) after any material change to the residents' care plan;
    ii. That all staff review residents' care plans at least monthly, with a reminder to staff to be built into their systems and for this to occur on the same day of each month, e.g. on the first of the month.

78. In relation to Bundaleer Lodge's 'Care Plan Review' to ensure all residents requiring supervision with meals were receiving supervision consistent with their assessed needs, the Public Advocate expressed a concern that a one-off Care Plan Review will not deal with those issues on an ongoing basis, either in Bundaleer Lodge or in the residential aged care or disability sectors.

79. The Public Advocate submitted that a broader recommendation should be considered for the residential aged care and disability care sectors, that residents' care plans should be subject to routine review. The frequency of those reviews should depend upon the residents' health and other relevant conditions and whether those conditions are subject to deterioration and the rate of that deterioration over time.

80. The Public Advocate also noted evidence of aspiration pneumonia in Mr Milward's lungs at autopsy and expressed a concern that if Mr Milward's death had been as a result of aspiration pneumonia rather than a choking event, it is possible his death may not have been reported to a coroner, even though, in the Public Advocate's submission, such a death would be '*a preventable death resulting from lack of appropriate care and mealtime supervision*'.

81. The Public Advocate also noted that in eight of the 73 cases reviewed in the Public Advocate's 2016 report, the underlying cause of death was aspiration pneumonia, with late or no diagnosis of the condition in many of those cases.

82. Given evidence of aspiration pneumonia in Mr Milward's lungs, and in light of this being an issue in other cases of deaths in care of persons with a disability, the Public Advocate submitted there should be consideration for two additional recommendations, as follows:
    i. That all aged care and disability service providers who care for people with conditions that affect their ability to swallow should ensure these residents undergo regular medical examinations to assess their respiratory health in order to identify and treat aspirational pneumonia. The frequency of these examinations should be subject to advice from a medical practitioner. Where evidence of food aspiration is identified upon examination, the resident's diet plan and mealtime supervision should be reviewed to determine whether they remain current and should be amended as appropriate.
    ii. That the State Coroner consider establishing a Residential Aged Care Death Review Process (or alternatively, an Elder Abuse Death Review process that could include the review of deaths in residential aged care where definitions of program and institutional elder abuse are included) and a Disability Care Death Review Process.

83. The Public Advocate stated that her submission as to the recommendation for a specialist death review process was made on the basis of the following:
    i. The wide-ranging care and systemic issues that have been identified in this and other coronial matters that demonstrate the value of taking a broader systemic view in certain types of coronial investigations;
    ii. The specialist knowledge and skills that can be developed from the adoption of specialist death review processes that could help to reduce unexpected and potentially avoidable deaths;
    iii. The risk that without these specialist review processes, the limitations of the definitions in the *Coroners Act 2003* for reportable deaths or deaths warranting coronial investigation could result in missed opportunities to identify systemic issues in the residential aged care and disability care systems that are causing or contributing to potentially avoidable deaths.

84. In relation to the Public Advocate's submission it is noted there is increasing focus across government, relevant stakeholders and community members of the need to systemically review these types of deaths, and of the critical role the coronial jurisdiction can play in undertaking this work. Following on from recommendations made by the Public Advocate in the report *Upholding the right to life and health (2016)*, and at the direction of the State Coroner a trial systemic review process of a group of natural causes deaths in care was undertaken in late 2016 within the Coroners Court. With the assistance of a range of external experts, this report made a number of findings and recommendations which are currently being considered as part of the broader coronial investigation into those deaths, and as such will not be explored in detail within the context of these findings.

85. A clear outcome of this trial however was that, while there is a need for dedicated resourcing to support such an initiative, there are significant benefits to undertaking this work within the coronial jurisdiction, given the existing powers of coroners to investigate these types of deaths. This would expand on the current systemic review capability of the Coroners Court, and ensure that coroners have access to the necessary expertise to support their investigations into a broader range of reportable deaths then is currently available.

86. As part of the process of government agency response to the Public Advocate's report, the trial systemic review process conducted at the instigation of the State Coroner has been referenced and will no doubt be addressed by government in due course.

87. The Public Advocate supported the recommendation suggested by Counsel Assisting in her submissions that '*choking deaths of persons in care with a disability be specifically acknowledged as a systemic issue, and strategies to manage, monitor, review and report on this particular issue should be built in to the NDIS quality assurance and reporting framework if this has not already occurred*'.

88. The Public Advocate further submitted that there should be consideration to broadening this recommendation to also apply to the residential aged care sector and be adopted in the *Aged Care Quality Accreditation Standards*.

89. The Public Advocate expressed a concern that the current standards of care and quality that have been, and are being, developed and adopted by the Commonwealth agencies with responsibilities for disability service funding and aged care services are very 'broad-brush', with a lack of detail about the service and resourcing inputs expected and a strong focus on outcomes expressed in very general terms.

90. The Public Advocate cited as an example '*Standard 2.5 Specialised nursing care needs*' of the *Aged Care Quality Accreditation Standards*, which requires that '*Care recipients' specialised nursing care needs are identified and met by appropriately qualified nursing staff*'. The Public Advocate submitted this standard was inadequate to provide the level of guidance to service providers and their staff for providing specialist nursing care to residents, and expressed a concern that there is some evidence aged care facilities are reducing the number of qualified nursing staff in favour of 'personal care workers' who have no formal clinical training or qualifications, which may further impact on the provision of specialised nursing care to residents in aged care facilities such as Mr Milward.[3]

[3] The Public Advocate also sought to make submissions as to whether Bundaleer Lodge had met the requirements of Standard 2.5 in its care of Mr Milward, and whether this should be investigated further by examining outcomes of compliance monitoring or re-accreditation audits conducted by the Aged Care Quality Agency in relation to Bundaleer Lodge prior to Mr Milward's death. However given such submissions would go to findings of fact pursuant to section 45 of the *Coroners Act 2003*, which is outside a public interest intervener's role pursuant to section 36 (2) and (3), I have not included those submissions in my deliberations.

91. The Public Advocate acknowledged the new Draft Aged Care Quality Standards released by the Commonwealth Department of Health in February 2018, which she submitted appear to be an improvement on the current standards. However the Public Advocate stated that despite these improvements, she remained of the view that without complementary local-level clinical and care procedures that provide detailed guidance to residential aged care staff, the new draft standards will still fall short in achieving positive health and wellbeing outcomes for aged care residents.

92. The Public Advocate further submitted that the problem with outcome-focused human services quality standards is that by the time it becomes clear that the standards are not being met or are not achieving the desired outcome, the consumers in these systems have suffered significant, if not dire, consequences in terms of their health and wellbeing.

93. The Public Advocate submitted that I consider making specific recommendations in the context of this case about the standards and quality of care that should be delivered to consumers of residential aged care and disability care services in order for service providers to meet their legal obligations to their vulnerable consumers.

94. Without having approached the Aged Care Quality Council or Aged Care Quality Agency for comment, and given no doubt much work has gone into the development of the new draft standard, it would be inappropriate to make such broad recommendations at this point. As well the issue of the establishment of outcome based performance measures as distinct from output measures is one that has no doubt been the subject of much consideration and debate on which reasonable minds may differ and is beyond the scope for comment by a coroner. However, it is intended to refer the decision and comments of the Public Advocate to the Aged Care Quality Council for its consideration.

Submissions from Bundaleer Lodge in response to the Public Advocate's submissions

95. Bundaleer Lodge was offered an opportunity to respond to the submissions made by the Public Advocate.

96. On the basis that the Public Advocate's role was limited to one of public interest intervener pursuant to section 36 (2) and (3) of the *Coroners Act 2003*, Bundaleer Lodge essentially submitted that consideration should only be given to those parts of the Public Advocate's submission that concern matters about which recommendations pursuant to section 46 can be made.

97. In relation to the Public Advocate's proposed recommendation that all staff involved in the provision of care to residential aged and disability care residents be informed immediately, or at least at the commencement of their next shift, of any material change to a resident's care plan, Bundaleer Lodge submitted that the 'iCare' software used by Bundaleer Lodge and widely in aged care in Australia transfers any updates in the care plans to the progress notes and handover sheets, so these are readily available to oncoming staff at each shift.

98. In relation to the Public Advocate's proposed recommendation that residential aged and disability care residents' care plans be subject to routine review, Bundaleer Lodge submitted that Care Plans at Bundaleer Lodge are reviewed at least every two to three months, as evidenced in the statement of Bundaleer Lodge's Director of Nursing.

99. In relation to the Public Advocate's proposed recommendation that residential aged and disability care residents with conditions that affect their ability to swallow should undergo regular medical examinations to assess their respiratory health in order to identify and treat aspirational pneumonia, Bundaleer Lodge submitted that the residents of Bundaleer Lodge undergo at least three-monthly medical assessments, as evidenced in the statement of Bundaleer Lodge's Director of Nursing.

Conclusions

100. 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.

101. Mr Milward was a difficult resident to manage given his cognitive impairment, challenging behaviours and physical difficulties. These issues were recognised and care plans were put in place by his nursing home. Relevantly to this case this included care plans for Mr Milward's food/fluid intake, given he had been assessed as a swallowing/choking risk.

102. Unfortunately staff did not strictly apply the care plan strategies put in place for food intake. Although there had been no previous incidents recorded where he had experienced swallowing difficulties or coughing due to food intake, on this particular occasion he had been left alone in a closed room with a bread sandwich and was not checked on for two hours. During that time he choked on his sandwich and died. In so finding, it is apparent the individual staff member was attempting to balance Mr Milward's needs for safety and autonomy in the context of her understanding that she was to feed Mr Milward with his soft and moist food but was permitted to allow him to eat his sandwich on his own, there having been no observed problems in the past with soft bread.

103. It was noted at autopsy that there was evidence of aspiration events with resultant pneumonia, probably due to ongoing swallowing difficulties. Potentially that is concerning although to some extent has been addressed by Bundaleer in the provision of three monthly medical checks by a doctor.

104. The actions recommended by Ms Bridges and since undertaken by Bundaleer Lodge are consistent with the preventative recommendations suggested by the Public Advocate in its report, which include strict compliance with mealtime management plans, regular review of these plans, and increased understanding and training for staff in relation to the importance of their roles for ensuring plans are complied with. The Public Advocate also suggested resourcing and rostering be considered and addressed when developing plans, which it appears Bundaleer Lodge has done in undertaking a full care plan review.

105. In those circumstances it is not considered that any further recommendations need to be made directly to Bundaleer Lodge, but I do consider some of the direct preventative recommendations made by the Public Advocate should be considered seriously by those engaged in the aged care industry and other carers providing residential services to similarly vulnerable people, such as within the NDIS. This is reflected in the submission of counsel assisting that '*choking deaths of persons in care with a disability be specifically acknowledged as a systemic issue, and strategies to manage, monitor, review and report on this particular issue should be built in to the NDIS quality assurance and reporting framework if this has not already occurred*'. That recommendation will be made and forwarded to the appropriate NDIS authority for its consideration. Other recommendations made by the Public Advocate will be promulgated amongst appropriate aged care agencies for consideration.

Findings required by s. 45

Identity of the deceased – Paul Joseph Milward

How he died-

Paul Milward was residing in an aged care nursing home and had been assessed as being vulnerable to swallowing difficulties including choking. Care Plans had been put in place to manage this risk of choking including supervision whilst he was eating and the provision of a moist minced diet. The care plan with respect to food/fluid intake was not strictly adhered to by staff because of a number of challenging behaviours on Mr Milward's part. Unfortunately, Mr Milward choked on a sandwich, whilst he had been left unsupervised in a closed room, and provided food that was not in accordance with the care plan that had been put in place.

Place of death – Bundaleer Lodge, 100 Holdsworth Road
NORTH IPSWICH QLD 4305 AUSTRALIA

Date of death- 31 August 2015

Cause of death –

1(a) Choking
1(b) Food bolus in pharynx

2 Huntington's disease; coronary Atherosclerosis

Recommendations

It is recommended that:

1. That choking deaths of persons in care with a disability be specifically acknowledged as a systemic issue, and strategies to manage, monitor, review and report on this particular issue should be built in to the NDIS quality assurance and reporting framework if this has not already occurred.

2. That all staff involved in the provision of care to residential aged and disability care residents be informed of any material change to a resident's care plan prior to the commencement of their next shift. Whether this be in the form of an oral handover or some other form of information sharing should be a matter for each organization to determine.

3. That residential aged and disability care residents' care plans be subject to routine review at least three monthly and sooner if health or other personal circumstances have changed.

4. That residential aged and disability care residents with conditions that affect their ability to swallow should undergo regular medical examinations, at intervals as recommended by a medical practitioner, to assess their respiratory health in order to identify and treat aspiration pneumonia.

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
5 June 2018