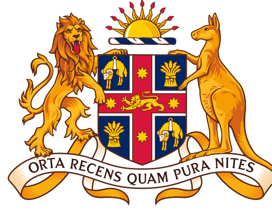

New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquests into the deaths of Dimosthenis Gesios & Maureen McGreevy
Hearing dates:	7, 8, 9, 10 &15 August 2023 and 2, 3, 5, 9 & 10 February 2026
Date of Findings:	27 February 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, dysphagia risk, choking risk, residential aged care facility, chewing and swallowing, International Dysphagia Diet Standardisation Initiative, minced and moist diet, speech pathology, gelled bread, incident reporting, Aged Care Quality and Safety Commission, *Health Practitioner Regulation National Law (NSW)*
File numbers:	2019/00184731; 2020/00083104
Representation:	Mr H Chiu SC, Counsel Assisting, instructed by Ms E Riley (Crown Solicitor's Office) Mr S Beckett SC for Dr P Calligeros, instructed by Avant Law Ms G Marsen for A Khanal, instructed by Gilchrist Connell Ms A Rose for Columbia Aged Care Services, N Koirala, Dr I Stein, W He, M Bagura, N Stojevska, M Anderson, T Boys & L Flaherty, instructed by Russell Kennedy Mr T Saunders for S Prasad, instructed by Meridian Lawyers

Findings:

In relation to the Inquest into the death of Dimosthenis Gesios:

Dimosthenis Gesios died on 7 June 2019 at Marrickville NSW 2204.

The cause of Mr Gesios' death was choking.

Mr Gesios, who was a resident of an aged care facility, died after being fed bread and scrambled eggs which resulted in a large bolus of food forming in his oropharynx and causing complete occlusion of the airways.

In relation to the Inquest into the death of Maureen McGreevy:

Maureen McGreevy died on 13 March 2020 at Marrickville NSW 2204.

The cause of Ms McGreevy's death was choking.

Ms McGreevy, who was a resident of an aged care facility, died after eating bread which resulted in a food bolus obstructing the airways.

Recommendations pursuant to section 82 of the *Coroners Act 2009*

1. To the Aged Care Quality and Safety Commission:

I recommend that a copy of the findings from the *Inquests into the deaths of Dimosthenis Gesios and Maureen McGrevy* be provided to the Aged Care Quality and Safety Commission for consideration.

It is recommended that the Commission consider developing consistent minimum training expectations for kitchen and nursing staff in residential aged care facilities, specifically directed to the identification and management of choking risk among residents, including alignment with the International Dysphagia Diet Standardisation Initiative Framework.

In developing this guidance, it is also recommended that the Commission consider including a structured approach to assist aged care providers to: (a) assess and document the competency of nursing staff, particularly Assistants-in-Nursing, in recognising and managing choking risk; and (b) implement periodic review or quality assurance processes to promote consistency and ongoing effectiveness.

2. To the Board of the International Dysphagia Diet Standardisation Initiative:

I recommend that a copy of the findings from the *Inquests into the deaths of Dimosthenis Gesios and Maureen McGreevy* be provided to the Board of the International Dysphagia Diet Standardisation Initiative for consideration of whether (a) gelled bread ought to be removed as a permissible food as part of a minced and moist diet; or (b) gelled bread, and its preparation, ought to be more well defined and described.

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1. Introduction

1.1 These inquests concern the deaths of two residents of the same residential aged care facility within nine months of each other. Although the deaths are separate and distinct, they were heard together for convenience and because there were certain common issues to both inquests.

1.2 Dimosthenis Gesios was a resident of the Grevillea Wing at the Acacia Centre, a residential aged care facility that previously operated in Marrickville. Mr Gesios had been prescribed a specific diet, known as a minced and moist diet, which restricted what he could and could not eat.

1.3 On the morning of 7 June 2019, Mr Gesios was fed breakfast by an Assistant-in-Nursing (**AIN**). After about eight to ten minutes, Mr Gesios' eyes started to flicker and his upper body began to shake. Mr Gesios coughed and some food flew out of his mouth. Assistance was sought from a Registered Nurse (**RN**) and a suction machine was used to remove some food from Mr Gesios' airway.

1.4 Emergency services were contacted and arrived on scene a short time later. Mr Gesios was found to have no pulse and to be showing no signs of life. In accordance with Mr Gesios' existing advanced care plan, no resuscitation was initiated and Mr Gesios was later pronounced life extinct.

1.5 Maureen McGreevy was a resident of the Banksia Wing at the Acacia Centre. She was also prescribed a minced and moist diet.

1.6 At around 5:00pm on 13 March 2020, an AIN delivered a meal tray to Ms McGreevy's room which was different to the meal tray that had actually been prepared for her in accordance with her dietary requirements.

1.7 At around 7:00pm, Ms McGreevy was observed by staff at the facility to be walking in a corridor and having difficulty breathing. Staff came to assist Ms McGreevy and emergency services were contacted. Attending paramedics removed some food from Ms McGreevy's airway and resuscitation efforts were initiated. However, Ms McGreevy could not be revived and was later pronounced life extinct at the scene.

2. Why were inquests held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 The deaths of Mr Gesios and Ms McGreevy were considered reportable because both the cause and manner of their deaths were not immediately clear. This is because for both Mr Gesios and Ms McGreevy a question arose regarding whether they were provided with food and fed in accordance with their dietary restrictions. Another question arose in relation to

whether kitchen and nursing staff at the Acacia Centre were sufficiently aware of these dietary restrictions. Finally, in Mr Gesios' case, other questions arose regarding whether he had in fact died of natural causes and whether the circumstances of his death were appropriately documented and reported. For these reasons, it was determined that inquests should be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

3. Mr Gesios' life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Gesios, who was affectionately known as Jim, was born in the small farming village of Monospita which is in the Macedonia region of Greece. He was the youngest of three siblings. As a young man, Mr Gesios was well travelled throughout Europe and had lived in the United Kingdom. He was very active and enjoyed playing football.

3.3 In 1980, Mr Gesios migrated to Australia. He lived in Sydney's inner west in Marrickville, Enmore and Stanmore. Mr Gesios later met his partner, Donna Dickson, and together they had twins, Angelo and Angela.

3.4 Mr Gesios found work in construction. He was good with his hands. His family used to say that there was nothing Mr Gesios could not permanently fix or destroy.

3.5 Whilst physically strong, Mr Gesios had an even stronger character. He was known to be upfront with a unique way of expressing himself. Mr Gesios had a big heart and was the type of person who would go without to see others happy. He often took his grandson out if he was feeling down or surprise him with a toy to cheer him up. He was known to share gifts with others and take joy out of seeing their reaction.

3.6 Mr Gesios' grandson describes him as having a boyish enthusiasm which brought a smile to the faces of others. He had way of telling stories and saying things in his unique way that

would delight. He showed strength tempered with love, was passionate whilst being nonchalant, and was a man of conviction, believing strongly in righteousness and accountability.

3.7 There is no doubt that Mr Gesios' family have been greatly saddened by his passing and that his loss is still deeply felt.

4. Mr Gesios' medical history

4.1 Mr Gesios had previously been diagnosed with cancer in 1991 and underwent surgical removal of an intracranial glioma. Following the surgery and radiation treatment, Mr Gesios experienced complications leading to increasing immobility of the left side and seizures. From 2003, Mr Gesios' health began to deteriorate significantly.

4.2 In 2006, Mr Gesios was diagnosed with non-convulsive status epilepticus and experienced recurrent cerebral seizure activity. Between 2006 and 2008, Mr Gesios was admitted to hospital on several occasions after suffering from falls.

4.3 In 2009, Mr Gesios was admitted to the Grevillea Wing of the Acacia Centre in Marrickville as he was no longer able to care for himself independently in the community. The Acacia Centre was an aged care facility formerly operated by Columbia Aged Care Services (**Columbia**) and was comprised of three properties – the Grevillea Wing, the Banksia Wing and the Waratah Wing – within the one residential aged fare facility.

4.4 According to a speech pathology assessment in May 2018, Mr Gesios was experiencing dementia, non-convulsive status epilepticus, hemiplegia, mixed astrocytoma, paranoid psychosis and falls. By 2019, Mr Gesios was non-verbal and non-mobile.

5. The events of 7 June 2019

5.1 At around 7:30am on 7 June 2019, RN Nagendra Koirala went to Mr Gesios' room, sat him in an upright position, and gave Mr Gesios his medications before breakfast.

5.2 At around 8:00am, AIN Aaraju Khanal entered Mr Gesios' room having collected his breakfast tray which contained scrambled eggs, porridge, a cup of Milo and two slices of bread. AIN Khanal placed a bib on Mr Gesios and began to feed him breakfast. Whilst doing so, AIN dipped the bread in the Milo before feeding it to Mr Gesios.

5.3 According to AIN Khanal, after about eight or 10 minutes of feeding, Mr Gesios' eyes started to flicker and his upper body began to shake. Mr Gesios coughed and some food flew out of his mouth onto his lap and bib. AIN Khanal called out for assistance.

5.4 AIN Saras Prasad responded and entered Mr Gesios' room. She subsequently called for RN Koirala who also entered the room a short time later. RN Koirala saw that Mr Gesios was in the high Fowler position (a seated position where a person is sitting at an angle of between 60 to 90 degrees), blue in colour and unresponsive to motor functions.

5.5 A suction machine was obtained and RN Koirala used it to remove some pieces of food from Mr Gesios' throat. The Facility Services Manager for the Acacia Centre, Dr Irene Stein, was

notified and she contacted Triple Zero. It was reported that Mr Gesios was choking and that he had aspirated some food.

5.6 At around 8:47am, NSW Ambulance paramedics arrived on the scene and found that Mr Gesios was not breathing and had no pulse. In accordance with an existing Do Not Resuscitate order that was in place for Mr Gesios, no resuscitation efforts were initiated. Mr Gesios was later pronounced life extinct.

5.7 At around 9:15am Dr Peter Calligeros, Mr Gesios' long-term general practitioner (**GP**) arrived at the Acacia Centre and completed a Medical Certificate of Cause of Death (**MCCD**) which recorded Mr Gesios' cause of death as being a seizure while being fed.

5.8 Following Mr Gesios' death, an anonymous complaint was made to the Aged Care Quality and Safety Commission (**Commission**) alleging "*a cover-up of the incident*".

6. Post-mortem examination

6.1 Mr Gesios was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Kendall Bailey forensic pathologist, on 19 June 2019. This identified the following relevant findings:

(a) a large bolus of food which had the appearance of scrambled eggs and bread in the oropharynx completely occluding the airways;

(b) copious small fragments of cream/yellow material which had the macroscopic appearance of bread and scrambled eggs filling the trachea and main bronchi;

(c) foreign material in the large airways; and

(d) chronic information in the lungs which may represent past aspiration events.

6.2 In the autopsy report dated 15 April 2020, Dr Bailey opined that the cause of Mr Gesios' death was choking (foreign material obstruction of the airway).

7. Ms McGreevy's life

7.1 Ms McGreevy was born in Liverpool, England. She was the eldest of three sisters. After their parents died during World War II, Ms McGreevy and her sisters were placed in an orphanage.

7.2 In 1950, under the child migration scheme, Ms McGreevy and her sisters came to Australia with other orphans. Ms McGreevy was raised in St John's Orphanage until the age of 16.

7.3 Ms McGreevy lived in several boarding houses in the Marrickville area where she maintained limited social interactions with others who lived in the area. She also remained in contact with one of her sisters although they did not live close to one another.

7.4 Sadly, little else is known about Ms McGreevy's life and background.

8. Ms McGreevy's medical history

8.1 Ms McGreevy's sister died when Ms McGreevy was around 17 years old. Ms McGreevy was later admitted to a mental health hospital following a self-harm attempt. During this admission, Ms McGreevy was diagnosed with schizophrenia.

8.2 Ms McGreevy had a long history of smoking, rheumatoid arthritis, high blood pressure and indigestion. She had previously undergone a partial thyroidectomy.

8.3 In 2003, Ms McGreevy was found to have been suffering from multiple strokes which led to significant cortical blindness in both eyes. Ms McGreevy's impaired vision left her unsteady on her feet. Following discharge from hospital in October 2023, Ms McGreevy moved into the Acacia Centre.

8.4 Following this, Ms McGreevy remained active and mobile but due to unsteadiness on her feet she experienced several falls requiring hospitalisation. Ms McGreevy was also diagnosed with Bell's palsy, a condition where sudden weakness in the muscles on half of the face can lead to chronic obstructive airways.

9. The events of 13 March 2020

9.1 Sometime prior to 5:00pm on 13 March 2020, Ms McGreevy's evening meal was prepared by kitchen staff. It consisted of mince, rice and capsicum as requested by Ms McGreevy. A kitchenhand placed the meal tray onto a trolley for collection by an AIN.

9.2 At around 5:00pm, AIN Bruce Sun delivered a meal tray to Ms McGreevy which contained pumpkin soup, coffee and half a slice of buttered bread. AIN Sun did not stay with Ms McGreevy after delivering the tray.

9.3 Sometime between 5:00pm and 5:45pm, RN Wenting He gave Ms McGreevy her medication in her room. At around 5:45pm, AIN Sun returned to Ms McGreevy's room to collect the meal tray.

9.4 At around 7:00pm, AIN Reginald Beniat saw Ms McGreevy outside her room in a corridor having difficulty breathing. Other staff were called to assist and emergency services were contacted. Attending paramedics found that Ms McGreevy had a complete airway obstruction and showed no signs of life. Resuscitation was initiated and a lump of bread was found in Ms McGreevy's airway which was removed with forceps.

9.5 Despite continued resuscitation efforts Ms McGreevy could not be revied and was later pronounced life extinct at the scene.

10. Post-mortem examination

10.1 Mr McGreevy was subsequently taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 18 March 2020. This identified the following relevant findings:

(a) food bolus in the upper airways; and

(b) facial and conjunctival congestion.

10.2 In the autopsy report dated 15 April 2020, Dr Maistry opined that the cause of Ms McGreevy's death was choking.

11. What issues did the inquest consider?

11.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficient interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

In relation to Mr Gesios:

(1) What was the direct cause of Mr Gesios' death?

(2) What speech pathology recommendations were applicable to Mr Gesios at the time he died with respect to:

(a) the diet, including within the definitions of the International Dysphagia Diet Standardisation Initiative (**IDDSI**) Framework; and

(b) the feeding of Mr Gesios, including as to positioning and supervision?

(3) Was the meal provided to Mr Gesios on the morning he died:

(a) comprised of food and drink permitted under, and prepared in accordance with:

(i) the applicable speech pathology recommendations;
(ii) relevant aspects of the IDDSI Framework; and
(iii) any applicable policies, procedures and guidelines of the Acacia Centre?

(b) fed to Mr Gesios in a manner (including with respect to his position and the degree/quality of supervision) that accords with:

(i) the applicable speech pathology recommendations;
(ii) relevant aspects of the IDDSI Framework; and
(iii) any applicable policies, procedures and guidelines of the Acacia Centre?

In relation to Ms McGreevy:

(4) What speech pathology recommendations were applicable to Ms McGreevy at the time she died with respect to:

(a) the diet, including within the definitions of the IDDSI Framework; and

(b) the feeding of Ms McGreevy, including as to positioning and supervision?

(5) Was the meal provided to Ms McGreevy on the evening she died:

(a) comprised of food and drink permitted under, and prepared in accordance with:

(i) the applicable speech pathology recommendations;
(ii) relevant aspects of the IDDSI Framework; and
(iii) any applicable policies, procedures and guidelines of the Acacia Centre?

(b) fed to Ms McGreevy in a manner (including with respect to her position and the degree/quality of supervision) that accords with:

(i) the applicable speech pathology recommendations;
(ii) relevant aspects of the IDDSI Framework; and
(iii) any applicable policies, procedures and guidelines of the Acacia Centre?

The following factual issues are relevant to the exploration of this issue:

(a) What meal was prepared for Ms McGreevy on the evening she died?
(b) What meal was presented to Ms McGreevy on the evening she died?
(c) If the meals prepared and presented were different, in what way were they different and how did those differences arise? In particular: if Ms McGreevy was provided a meal prepared for another resident, how did that occur?

(6) Did Ms McGreevy access food – in particular, bread – on the day she died other than that which was presented to her as part of her evening meal? If so:

(a) where, or from whom, did Ms McGreevy access that food/bread (e.g. from a fridge, from another resident's meal tray); and

(b) was Ms McGreevy able to access that food/bread due to any non-compliance with any of the Acacia Centre's policies, procedures and guidelines governing the storage and residents' access to food that does not form part of the meals prepared for them?

(7) Did clinical staff respond appropriately to Ms McGreevy's presentation, from the time she presented with difficulty breathing to the time paramedics arrived; in particular, did staff administer adequate and effective first aid and cardiopulmonary resuscitation

Common to Mr Gesios and Ms McGreevy:

(8) How were speech pathology recommendations implemented under the policies, procedures and guidelines in force and/or available at the Acacia Centre?

(9) Were the Acacia Centre's policies, procedures and guidelines adequate and appropriate for:
(a) the implementation of speech pathology recommendations, including the means by which such recommendations are communicated and made visible to staff;
(b) the preparation and provision of food and drink in accordance with the IDDSI Framework;
(c) preventing access to food and drink not permitted under prescribed diets; and
(d) the resolution of any conflict that may arise between speech pathology recommendations and the IDDSI Framework?

(10) Did kitchen and clinical staff of the Acacia Centre have sufficient knowledge, and are they provided sufficient training, on the implementation of the speech pathology recommendations and IDDSI Framework, to ensure the safe provision and supervision of food and drink to clients?

(11) To the extent there were any deficiencies in Acacia Centre's policies, procedures and guidelines, what if any improvements have been made?

11.2 As many of these issues overlap, some issues have been dealt with together for convenience below. In addition, as a result of the coronial investigation and evidence given during the inquest, some issues no longer require consideration and they have not been dealt with below.

11.3 In order to assist with consideration of some of the above issues, opinions were sought from the following independent experts as part of the coronial investigation:

(a) Dr Julie Cichero, speech pathologist and Co-Chair of the IDDSI; and

(b) Professor Mark Cook, consultant neurologist and epileptologist.

12. What was the cause of Mr Gesios' death?

12.1 Following Mr Gesios' death, Acacia Centre staff completed an incident report on 7 June 2019 (**Incident Report**). Records indicate that the incident report was started by RN Koirala at 12:36pm with a last entry made by Dr Stein at 1:09pm on the same day. The narrative of the incident report relevantly records the following:

> Whilst being assisted one-to-one with breakfast Mr Demosthenis [sic] had a seizure, eyes rolled back in his head and he was twitching. He coughed out last mouthful of food he had been offered by AIN Arju Khanal. AIN raised the alert, resident was immediately attended by RN Nagendra, checked and clean oral cavity. FSM notified, FSM contacted 000. RN Nagendra commenced suction with Yanka sucker via twinovac on oxygen cylinder.

12.2 Dr Calligeros later completed a MCCD in which he recorded the direct disease or condition leading to Mr Gesios' death as complication of seizure disorder. Right temporal astrocytoma was listed as an antecedent cause of death with advanced dementia and schizophrenia with paranoid psychosis listed as other significant conditions contributing to the death but not related to the disease or condition causing it.

12.3 Together, the above two records suggested that that Mr Gesios had died of natural causes, namely a complication of seizure disorder. However, as noted above, the post-mortem examination indicated that Mr Gesios did not die of natural causes and that the cause of his death was choking.

12.4 Dr Bailey gave evidence that it is not possible from a post-mortem examination to identify any seizure activity and relate it temporally to a seizure that a deceased person may have had in life. Dr Bailey noted that terminal seizures are very common, and that it can be difficult to distinguish between a seizure which precipitates cardiac arrest, and vice versa.

12.5 Dr Bailey also noted that Mr Gesios' lungs showed signs of inflammation which might represent chronic aspiration which can relate to issues that a person experiences when they have difficulties with swallowing. That is, seizure activity can make a person prone to aspirate. In addition, Dr Bailey noted that Mr Gesios had no teeth which is also a risk factor for aspiration.

12.6 In his report, Professor Cook explained that the observations of Mr Gesios becoming shaky and stiff, with his eyes rolling back might be manifestations of seizure activity but are more likely manifestations of hypoxia. Professor Cook went on to explain that:

(a) aspiration resulting in low brain oxygen can give rise to the changes observed in Mr Gesios;

(b) during generalised tonic-clonic seizures, people may aspirate food or liquid but that the description of the circumstances of Mr Gesios' episode was atypical of such a seizure;

(c) whilst minor seizures (often described as partial or focal seizures) can cause impaired awareness raising a concern that a person will aspirate food, such events are extremely rare;

(d) in his experience, having personally observed thousands of seizures, he has never seen a person aspirate food during a minor seizure; and

(e) people are quite often eating during seizures and whilst a patient may sometimes stop swallowing (with food remaining in their mouth), minor seizures do not result in aspiration.

12.7 Professor Cook gave evidence that the possibility of a person dying from an acute episode of long convulsive seizures is "*very rare*". Whilst Professor Cook could not exclude this as a possibility, he gave evidence that this is something that he has never encountered in the literature or in his own practice.

12.8 Professor Cook gave evidence that a general practitioner would not have the same degree of knowledge regarding seizures as a neurologist and epileptologist. Professor Cook also gave evidence that it would be difficult for an experienced neurologist, let alone a RN or AIN, to be sure whether a seizure precipitated a choking event or vice versa.

12.9 **Conclusions:** Although it is not possible to demonstrate seizure activity in the post-mortem setting, the expert evidence of Professor Cook establishes that whilst the possibility of Mr Gesios experiencing a seizure leading to death cannot be entirely excluded, it is far more likely that Mr Gesios experienced a choking episode leading to airway obstruction and death. The cause of Mr Gesios' death was therefore choking.

13. History and applicability of relevant guidelines

13.1 The Dietitians Association of Australia and The Speech Pathology Association of Australia Limited previously undertook a joint project to develop consensus standards for number of levels, labels and definitions of thickened fluids and texture modified foods within the Australian context. This resulted in publication of the Australian Standardised Definitions and Terminology for Texture Modified Foods and Fluids (**Australian Standards**) in 2007.

13.2 The Australian Standards set out a food texture modification grading scale for the clinical management of dysphagia ranging from unmodified, regular foods, soft foods (Texture A), minced and moist foods (Texture B), and smooth pureed foods (Texture C). For minced and moist foods, gelled bread is listed as a recommended food whilst "*gelled breads that are not soaked through the entire food portion*" is listed amongst foods to avoid.

13.3 The IDDSI was founded in 2013 with the goal of developing new international standardised terminology and definitions to describe texture modified foods and thickened fluids used for individuals with dysphasia of all ages, in all care settings, and all cultures. This resulted in the 2017 publication of the IDDSI Framework consisting of eight levels which provides common terminology to describe food textures and drink thickness.

13.4 Level 5 of the 2017 IDDSI Framework related to minced and moist foods. The description/characteristics of minced and moist foods are set out as follows:

- Can be eaten with a fork or spoon
- Could be eaten with chopsticks in some cases, if the individual has very good hand control
- Can be scooped and shaped (e.g. into a ball shape) on a plate
- Soft and moist with no separate thin liquid
- Small lumps visible within the food
    - Paediatric, 2 mm lump size
    - Adult, 4mm lump size
- Lumps are easy to squash with tongue

13.5 The 2017 IDDSI Framework listed testing methods for a number of food specific or other examples. For bread, it set out the following:

> BREAD
> Pre-gelled soaked breads that are very moist and gelled through the entire thickness
> No regular, dry bread

13.6 The 2017 IDDSI Framework was adopted in Australia on 1 May 2019. Even though Mr Gesios died on 7 June 2019, Dr Cichero gave evidence that the Australian Standards would have applied at the time of his death. Dr Cichero gave this evidence:

> So, although 1 May 2019 was Australia's official adopt date, it was widely recognised that many organisations were in the process of that transition and there were no penalties in place, and that that is entirely possible in the aged care community, in particularly where we knew resources were scarce.

13.7 In July 2019, an update to the IDDSI Framework was published. Apart from some additional information provided regarding the size of small lumps visible within food, the

description/characteristics of minced and moist food remained the same in the 2019 IDDSI Framework as the 2017 IDDSI Framework.

13.8 However, the 2019 IDDSI Framework also provides the following:

> BREAD
> No regular, dry bread, sandwiches or toast of any kind
> Pre-gelled "soaked" breads that are very moist and gelled through the entire thickness

13.9 A photo of piece of bread and a YouTube link to a Minced & Moist sandwich recipe video were also provided. In oral evidence, Dr Cichero agreed that the 2019 version is more detailed than the 2017 version and also agreed that gelled bread is not well described or defined in either document.

13.10 Although the 2019 IDDSI Framework was published in July 2019, it is unclear whether it applied in March 2020 at the time of Ms McGreevy's death.

13.11 Dr Cichero gave evidence accepting that there was a period of time after May 2019 before aged care providers would have been able to fully implement the 2017 IDDSI Framework. Dr Cichero also gave evidence that if, hypothetically, she had visited an aged care facility in June 2019 she would not have been critical if staff at the facility were unaware of the 2017 IDDSI Framework.

13.12 On this issue, records from Columbia indicate that the transition from the Australian Standard to the 2019 IDDSI Framework was still occurring by mid-2020. Minutes from a Columbia Clinical Governance Meeting on 11 June 2020 indicate that the 2019 IDDSI Framework was still being implemented with reference made to revision of diet analysis documentation with consequent updating of diet analysis documentation, the kitchen database and meal tray cards yet to be completed.

13.13 This is consistent with the evidence of Tiffany Boys, the former CEO of Columbia, who gave evidence that the transition period to implement the 2019 IDDSI Framework "*probably would have been nine to 12 months*" from May 2019. During her oral evidence, Ms Boys explained some of the challenges involved in the transition process:

> [T]he commencement of, yeah, COVID at the beginning of 2020 put a stop to a whole lot of things. So, really, in the first six months with new managers and changing all the policies, but it was ongoing. Where we say there was a business services meeting and a clinical governance, there was also hotel services meetings as well at group level and it certainly would have been quite detailed in those as well.

13.14 The effect of the above material is that:

(a) the Australian Standards were still in effect as at 7 June 2019;

(b) the Australian Standards provided that gelled bread was a recommended food for a minced and moist diet;

(c) the Australian Standard did not define gelled bread or described how it was to be prepared other than providing that gelled bread which was "*not soaked through the entire food portion*" was to be avoided;

(d) as discussed further below:

(i) some Acacia Centre staff considered that bread could be fed to residents on minced and moist diet it was "*wet*", "*soaked*", or dipped in liquid, although it is not entirely clear whether this constituted gelled bread for the purposes of the Australian Standard; and

(ii) Mr Gesios had previously been fed bread that had been dipped in liquid prior to 7 June 2019;

(e) regardless of whether the 2017 IDDSI Framework or 2019 IDDSI Framework was in effect as at 13 March 2020, regular, dry bread was not permitted for a minced and moist diet; and

(f) as also discussed further below, there is no suggestion that Ms McGreevy was provided with bread that was "*wet*", "*soaked*", or dipped in liquid on 13 March 2020.

14. What speech pathology recommendations were applicable to Mr Gesios?

14.1 In 2013, Mr Gesios was admitted to hospital with a reduced level of consciousness and increased seizure activity. During this admission, Mr Gesios was assessed several times by a speech pathologist who trialled foods of different textures and liquids of different thickness. The last speech pathology assessment occurred on 7 July 2013 when it was recommended that Mr Gesios have a minced and moist diet with mildly thickened fluids. It was noted that oral intake was to cease if there was coughing, wet voice or shortness of breath.

14.2 In 2017, Mr Gesios was admitted to hospital again due to decreased wellness and behavioural changes. A nursing discharge report at the time recommended a soft diet and mildly thick fluids.

14.3 On 8 April 2019, Mr Gesios was admitted to hospital with fevers, drowsiness and tachypnoea. According to the discharge report of 12 April 2019, Mr Gesios was noted as being on a puree diet with thickened fluids.

14.4 However, progress notes from early May 2018 indicate that Mr Gesios attended a speech pathologist at that time and it was noted that a minced diet was suitable with nil change.

14.5 Available records indicate that Mr Gesios had previously been placed on a minced and moist diet, and a pureed diet, both with thickened fluids. Although it appears that Mr Gesios' last formal speech pathology assessment occurred in July 2013, progress notes from May 2018 indicated that Mr Gesios attended a speech pathologist at that time. On both occasions, it was noted that Mr Gesios was suitable for a minced and moist diet with mildly thickened fluids. Therefore, at the time of his death, Mr Gesios was on a minced and moist diet.

15. What speech pathology recommendations were applicable to Ms McGreevy?

15.1 In 2018, 2019 and 2020, speech pathology assessments were carried out for Ms McGreevy. In 2018 it was noted that Ms McGreevy's poor dentition contributed to longer mastication time.

15.2 On 15 October 2019, a speech pathology assessment noted that Ms McGreevy presented with oropharyngeal dysphagia characterised by inefficient mastication. It was noted that she was able to tolerate a minced and moist diet with thin fluids. It was also noted that Ms McGreevy was to be kept in an upright 90 degrees position during meals and for 30 minutes past meals.

15.3 Dr Cichero explained that the oesophagus is designed to reflexively use peristaltic movements to transport a chewed food bolus down into the stomach. A large and unchewed requires additional "*work*" by the oesophagus and can cause:

(a) oesophageal obstruction requiring emergency removal; and

(b) contribute to feelings of heartburn and discomfort.

15.4 On 3 February 2020, Ms McGreevy presented to hospital with overt signs of aspiration on thin fluids. She was downgraded to mildly thick fluids and it was noted that she required a private speech pathology review to determine if she was suitable to an upgrade to a baseline of thin fluids.

15.5 On 1 March 2020, it was noted that Ms McGreevy had sparse dentition and that partial meal assistance was required.

15.6 Dr Cichero noted that a minced and moist diet that is designed to have small particles would alleviate both Ms McGreevy's dentition and oesophageal issues. She noted that a speech pathologist had observed Ms McGreevy's chewing skills and minimal dentition and recommended that she be placed on a minced and moist diet. Dr Cichero considered this to be appropriate and that due to her clinical presentation and medical history, and that supervision whilst feeding was required.

16. Understanding by kitchen and nursing staff regarding the requirements of a minced and moist diet

16.1 The inquest received evidence from multiple kitchen and nursing staff at the Acacia Centre as to their understanding of the requirements of a minced and moist diet, particularly in relation to whether residents on this diet were permitted to have bread.

16.2 Marion Bangura was working as a cook assist in March 2020. She gave evidence that she was familiar with the IDDSI framework and knew that a person on a minced and moist diet was not be given bread and that she never did so.

16.3 Niumai Qimanavanua worked as a cook at the Acacia Centre in 2019. She gave evidence that residents who were on a minced and moist diet were not allowed to have bread but that there were some exceptions. Ms Qimanavanua explained that, for example, a resident's

family might give the "*green light*" for bread to be provided to that resident. Mr Gesios did not fall within this, or any other, category of exceptions. Instead, Ms Qimanavanua gave this evidence regarding Mr Gesios:

> He's not - not allowed bread any at all. If he's on a minced and moist and if we didn't get the green light from the - the family then he's not allowed period.

16.4 Siteri Suga worked as a kitchenhand at the Acacia Centre in 2019. She gave evidence that residents who were on a minced and moist diet were not permitted to have bread. However, Ms Suga also gave evidence that she was aware of nurses feeding bread to residents on a minced and moist diet only if it was "*wet bread*" and the nurses "*have to soak it*".

16.5 RN Koirala gave evidence that it was his understanding that bread was not to be given to residents on a minced and moist diet. However, he also gave evidence that he was aware that other staff considered that bread could be given to residents on a minced and moist diet if it was soft and dipped in a liquid like tea.

16.6 Roslyn Lal worked as a senior RN at the Acacia Centre in 2019. She gave evidence that it was her understanding that whilst dry bread could not be given to residents on a minced and moist diet, bread that was soft and "*dunked in soup or something*" could be given to residents although "*ideally [she] wouldn't risk it*" as there are "*so many varieties*" of bread.

16.7 RN Wenting He gave evidence that she was aware that Ms McGreevy was on a minced and moist diet and needed to be supervised whilst eating. RN He also gave evidence that it was a "*strict rule*" that residents on a minced and moist diet were not permitted to have bread even if the bread was dipped into liquid first. RN He gave evidence that she did not know what gelled bread is and had never seen that bread had been moistened with or dipped in liquid.

16.8 AIN Beniat gave evidence that in 2020, whilst he fed residence on a pureed diet he never fed any residents on a minced and moist diet. He said that he understood a minced and moist diet and a soft diet to be the same thing, and that residents on a minced and moist diet should not be fed bread.

16.9 AIN Dagdag similarly gave evidence that residents on a minced and moist diet were not permitted to have bread, and that she had never seen gelled bread, or pieces of bread moistened with liquids, being given to residents.

16.10 AIN Saras Prasad gave evidence that residents on a minced and moist diet could be given bread if it was on their meal tray and cut into "*very, very small pieces*" (smaller than a five cent coin) and then dipped or soaked in tea, coffee or milk.

17. Availability of bread to residents on a minced and moist diet

17.1 The inquest similarly received evidence from different kitchen and nursing staff who worked at the Acacia Centre regarding the availability of bread to residents generally and those on a minced and moist diet.

17.2 Ms Bangura gave evidence that bread was normally left on top of a trolley for residents in the dining room, which was separate from trolleys used to deliver meal trays to residents in their rooms.

17.3 Ms Qimanavanua gave evidence that kitchen staff were directed by the Recreational Officer to leave bread in a bag on top of the meal trolleys, although she never understood the reason for this direction.

17.4 Ms Suga gave evidence that whilst bread was placed on individual meal trays (for residents on diets which permitted bread), spare bread was placed on top of the meal trolleys in a bag "*because most of the residents they need more bread*".

17.5 RN Koirala gave evidence that kitchen staff would place bread on top of meal trolleys so that they could be added to the meal trays for residents who were allowed to have bread.

17.6 AIN Beniat gave evidence that bread and butter and toast was placed on the top of meal trolleys and not on residents' individual meal trays. An AIN would ask a resident if they wanted bread or not which would then be given if this was in accordance with what a resident was permitted to eat. AIN Beniat gave evidence that the "*nameplate*" on a resident's meal tray did not provide this information and that confirmation would be sought from a RN if there was any uncertainty regarding whether a resident was allowed to have bread.

17.7 AIN Prasad gave evidence that bread was kept both on top of meal trolleys and on a resident's meal tray. In relation to why bread was kept on top of a meal trolley, AIN Prasad explained that for residents who were permitted to have bread:

> In case sometimes the resident wanted more bread. So we grabbed from the – the ones we know who can eat bread, so it's there so we give it to them.

18. Was Mr Gesios provided with an appropriate meal on 7 June 2019?

How was Mr Gesios' meal prepared?

18.1 In 2019, food for residents was cooked in a kitchen at the Acacia Centre. After the food was cooked kitchenhands were responsible for placing food on a resident's meal tray in accordance with a resident's dietary requirements.

18.2 Ms Suga gave evidence that each meal tray for a resident contained a card which had a resident's name and what type of diet they were on. Kitchenhands referred to a document called the "Kitchen Bible" which contained information provided by registered nurses and recreational officers regarding what food could be provided to residents on particular diets.

18.3 The meal trays for residents were colour coded: red trays for residents on pureed diet and grey trays for residents on a normal or minced and moist diet.

18.4 After all the residents' meal trays were made up, they were placed on meal trolleys. Ms Suga gave evidence that all the red coloured meal trays were placed on their own trolley whilst grey coloured meal trays were placed on a different trolley with normal diet meal trays and minced and moist diet meal trays placed in separate rows.

18.5 After all the residents' meal trays were made up by the kitchenhands they were placed on a trolley with the bread on top. Kitchen staff then took the meal trolley to the nurses' station where it was left for nursing staff, usually an AIN, to serve the meal trays to residents.

How was Mr Gesios fed on 7 June 2019?

18.6 On 7 June 2019, AIN Khanal worked a morning shift at the Acacia Centre. At around 8:00am a food trolley containing meal trays for residents in the Grevillea Wing was placed outside the nurses' station. Each meal tray contained a name tag for the resident who was to receive the meal, together with information regarding any dietary requirements.

18.7 It is not entirely clear from the evidence whether AIN Khanal collected Mr Gesios' meal tray herself, or whether it was given to her by AIN Prasad. In any event, AIN Prasad asked AIN Khanal to feed Mr Gesios his breakfast. AIN Khanal had fed Mr Gesios on two previous occasions and states that she recalled "*he was a "fast eater*".

18.8 AIN Khanal entered Mr Gesios' room and reportedly observed that Mr Gesios was already seated in an upright 90 degree position. After placing a bib on Mr Gesios, AIN Khanal started feeding him.

18.9 There is some evidence to suggest that AIN Khanal may have fed Mr Gesios whilst he was lying inappropriately in a supine position. Ms Suga gave evidence that whilst collecting meal trays she saw a nurse (who she describes as "*new*" and "*young*"), believed to be AIN Khanal, having just fed a man, believed to be Mr Gesios. Ms Suga described observing the following:

> Then I heard a cough and I look. Then I saw the nurse feeding the - the man. Then I - when I saw the position, I said, "Hey", because she's trying to - she's trying to massage his back. Then I say, "You're supposed to put the head - the head of bed up." Then I just go straight to call - then I said, "Okay, I'll go and call the RN".

18.10 However, Ms Suga's evidence is problematic because she did not correctly identify Mr Gesios' room number. Further the evidence of other witnesses establishes that kitchen hands like Ms Suga did not collect meal trays from residents' rooms; rather that was a task for nursing staff to perform.

18.11 Also, there are differing accounts regarding the position of Mr Gesios at the relevant time. AIN Khanal states that Mr Gesios was already sitting upright when she entered his room to feed him on the morning of 7 June 2019. RN Koirala gave evidence that when he gave Mr Gesios his medication in the morning (before Mr Gesios was fed by AIN Khanal), he raised Mr Gesios' bed to a semi-Fowler position (almost sitting upright, somewhere between 45 and 60 degrees) and left the bed in that position. RN Koirala also gave evidence that when he returned to Mr Gesios' room, after responding to the call for assistance by AIN Prasad, Mr Gesios was seated in a high Fowler position.

18.12 There are several matters relevant to the manner in which AIN Khanal fed Mr Gesios.

18.13 *First*, in her first two written versions of the events of 7 June 2019, AIN Khanal made no mention of feeding Mr Gesios bread. In her third written version of events (a statement made to police on 9 July 2020), AIN Khanal stated that on the morning of 7 June 2019 she was

given a tray of food for Mr Gesios which contained "*two slices of bread*". AIN Khanal goes on to state the following:

> I started to feed Mr Gesios his scrambled egg and bread, I was dipping the bread into the milo to soften it up before I would feed it to him. He ate and finished one slice of bread when suddenly, he started [coughing] everything out.

18.14 This description appears to be consistent with the manner in which bread was dipped in liquid before being fed to Mr Gesios on previous occasions. However, it is not entirely clear whether this constituted gelled bread for the purposes of the Australian Standards.

18.15 *Second*, Dr Bailey initially gave evidence that there are "*way too many variables*" to determine how many mouthfuls of food Mr Gesios might have been fed to form the food boluses seen at autopsy. Dr Bailey also gave evidence that it was not possible to tell whether Mr Gesios continued to be fed after he started choking.

18.16 However, Dr Bailey later gave this evidence in response to questions asked by Counsel for AIN Khanal:

> Q. Is it fair to say a bolus can be formed accumulatively in the course of consuming food?
> A. Absolutely. If you put food in your mouth, chew it, don't swallow it, put more food in your mouth, chew it, don't swallow it, depending on the consistency of the food, it can, you know, stick together and become a larger bolus, yes.
>
> Q. From your examination of the bolus in your autopsy. Would you agree that it was likely formed through accumulative eating?
> A. I cannot say. It was large, but I cannot say if that was a large mouthful of food that was taken all at once, or whether it was several small mouthfuls of food that were not swallowed and then accumulated, both are possible.

18.17 The later evidence given by Dr Bailey therefore establishes that in order to account for the size of the food boluses seen at autopsy, Mr Gesios was either:

(a) fed a mouthful of food that was too large; or

(b) fed more than one mouthful of food and not given an opportunity to swallow the food between mouthfuls.

18.18 *Third*, In her statement of 9 July 2020, AIN Khanal described the process by which she fed Mr Gesios on 7 June 2019:

> I put a bib on Mr Gesios and started feeding Mr Gesios his porridge. He was eating at a good pace. I continually checked his mouth and neck. If he opened his mouth I would check to see if he swallowed the food, if he didn't, I would check to see movement in his neck to see if he was chewing the food. Whilst feeding Mr Gesios his porridge, I would also give him spoons full of Milo to make sure his mouth was not dry.

18.19 On this issue, Dr Cichero expressed the following opinions:

> Swallowing can be observed at the neck by movement of the larynx (voice box). It appears that AIN Khanal either did not have a sufficient understanding and use of English or did not

> have a good understanding of what to be aware of to assist a person with chewing and swallowing problems. The later would be at odds with her skills for having completed the Feeding a Resident Competency Assessment. The situation was further complicated by the fact that Mr Gesios had very limited communication skills, including poor ability to follow instructions.
> […]
> [The size of the boluses seen at autopsy] suggests that little effort was made to provide small pieces of bread to Mr Gesios or that adequate attention was being paid to his oral manipulation of the food as he attempted to eat it without teeth.
> […]
> The manner in which Mr Gesios was fed was unsafe and not appropriate for his needs. AIN Khanal, the person responsible for feeding Mr Gesios, did not know his medical background or appreciate his requirement for the small particle sizes of a Minced and Moist diet

18.20 *Fourth*, the evidence suggests that after Mr Gesios began to choke, AIN Khanal may not have acted promptly in seeking assistance for Mr Gesios. In her written versions of events, AIN Khanal said variously that she screamed and yelled out "*a few times*" for AIN Prasad, and that she "*ran out of the room loudly calling for help*".

18.21 RN Koirala gave evidence that AIN Prasad came to him "*in the panic [sic] way*", said that there was something wrong with Mr Gesios and asked him to come with her to check. RN Koirala said that when he entered Mr Gesios' room he saw AIN Khanal but could not recall what she was doing.

18.22 In contrast, AIN Prasad gave evidence confirming the contents of her statement of 13 July 2020 in which she said the following:

> Whilst I was in room twelve, [AIN Khanal] walked in, I was feeding the resident of that room, [AIN Khanal] said, "Something is happening to Gesios". She spoke normally I [sic] understood what she said, but I did not think much of it, nothing bad crossed my mind at that point.

18.23 AIN Prasad gave evidence that she was sure that AIN Khanal did not specifically tell her that Mr Gesios was choking, and that she did not believe that this was the case based on what AIN Khanal had said.

18.24 As already noted above, Ms Suga gave evidence that at an apparent point in time after Mr Gesios began choking, she looked into Mr Gesios' room and saw AIN Khanal massaging Mr Gesios' back whilst he was in a supine position. This prompted Ms Suga to tell AIN Khanal that she needed to raise the head of Mr Gesios' bed up.

18.25 Given the provisions contained in section 61 of the Act, AIN Khanal was not called to give evidence at the inquests. AIN Khanals legal representatives made no closing submissions on her behalf at the conclusion of the evidence in the inquests.

18.26 **Conclusions:** Whilst AIN Khanal's version of events suggests that she checked to see whether Mr Gesios was *chewing* his food, the evidence suggests that she did not correctly check whether he was in fact *swallowing* his food. This is consistent with Mr Gesios either being fed a mouthful of food that was too large for him to swallow, or being fed more than one mouthful of food without being given an opportunity to swallow between mouthfuls so that the food accumulated in his mouth and could not be swallowed. This is also consistent with the size of the food bolus found during the post-mortem examination.

18.27 In addition, the evidence suggests that AIN Khanal did not promptly seek assistance for Mr Gesios, or convey the urgency of his need for assistance, after it appeared that he was experiencing a choking episode.

18.28 The available evidence therefore indicates that Mr Gesios was not fed appropriately on 7 June 2019.

19. Adequacy of the reporting of the events of 7 June 2019

RN Koirala

19.1 As noted above, the Incident Report made no mention of Mr Geios being fed bread or Mr Gesios choking.

19.2 In his initial handwritten statement on 8 October 2019, RN Koirala described his observations on 7 June 2019 in this way:

> I went to Mr Gesios room, I could see that he was still in the high frawl [sic] position, he was blue in colour, he was still blinking, he was not responding to motor functions, I lifted his hand to see his motor function, his arm just fell back down on the bed. I checked his mouth, there was small amounts of food on either end of his mouth nothing lodged down the back of his throat. He was struggling to breath at that point.
> I asked SARA to get the oxygen and suction machine, which she did.
> I asked SARA to get the manager for me (Irene).
> I asked the Cleaner RAMATU to get me some water, the water is for the suctioning machine and that is where anything that is sucked out ends up.
> I began using the suction machine to remove any lodged objects to remove any food from his throat. As I was doing this Mr Gesios coughed up a small amount of food which was lodged in his throat.

19.3 Later, in his statement of 29 July 2020, RN Koirala said the following:

> I could also see Mr Gesios was turning blue. He was still moving but was blue. I could see that Mr Gesios was choking. I approached Mr Gesios and checked his mouth to see if anything was stuck in there. I looked inside his mouth and removed some scrambled egg that was still in there. I placed my fingers inside his mouth and removed a piece of scrambled egg and small piece of bread. This piece of egg did not look like it was mashed up, the piece of bread was the size of a 10-cent coin. I was unable to tell if the bread had been dipped in anything to soften it. The bread was mixed with the other food in his throat.
>
> At the same time, I could tell he was choking, struggling for oxygen, I elevated the bed to the full fowler position which is at 90-degree angle. I called out for someone to bring me the oxygen. I began to rub his back to assist him in coughing out anything lodged in his throat.

19.4 Mr Koirala went on to state:

> During the incident and whilst it was occurring, I was asking Aaraju numerous questions, I was aware she was the Assistant Nurse feeding Mr Gesios. I was aware of Mr Gesios diet, that he is on a mince and moist diet. I immediately began asking questions. I asked "What did you feed him? Did you feed him bread? How fast were you feeding him? What did you feed him? What was the position?

> Aaraju responded and said yes that she had fed him bread, she told me that she had fed Mr Gesios bread, she also said he was feeding well, opening his mouth to eat the food.

19.5 RN Koirala also stated that at around 2:30pm on 7 June 2019 he "*ran the shift handover*" and "*explained to the staff that Mr Gesios choked whilst being fed bread*" by AIN Khanal. Mr Koirala went on to state that he reminded the staff "*to be extra careful not to feed bread to any of the residents who are on a mince[d] and moist diet*".

19.6 In relation to the Incident Report, RN Koirala went on to state that he made no mention of Mr Gesios choking on bread because he was not meant to have bread as part of a minced and moist diet. RN Koirala went on to state that he "*wanted to keep the [Incident Report] consistent with the care plan*" and that he genuinely believed that Mr Gesios had a seizure due to his observations of Mr Gesios and Dr Calligeros' opinion that Mr Gesios' death was the result of a seizure.

19.7 Finally, RN Koirala stated the following:

> On 8 October 2019, I provided Police with a version of what happened. The version I provided to Police was completely true, I did leave the fact that Mr Gesios was fed bread. I did not mention this to Police, because I wanted the report to be consistent with the care plan and the version, I provided to be consistent with the incident report. I wanted the version, care plan and incident report to be consistent to one another.
> […]
> I should have mentioned the entire truth to Police, but I did not.

19.8 RN Koirala gave the following evidence:

(a) Upon entering Mr Gesios' room, he saw that Mr Gesios was blue in colour, his upper body was moving from side to side, and he was blinking his eyes;

(b) he assumed that Mr Gesios choked from having a seizure because Mr Gesios had a history of seizures and he had never had any difficulties with feeding;

(c) he tried to remove all the food, some of which he recognised to be bread, from Mr Gesios' mouth and throat but realised that some of it was still in there which was causing Mr Gesios to be unable to breathe;

(d) he asked AIN Khanal questions about whether she fed Mr Gesios bread and how fast she was feeding Mr Gesios because he suspected that her answers might be relevant to what caused Mr Gesios to choke;

(e) when he later spoke to Dr Calligeros on the phone he could not remember what he said to him other than Mr Gesios died when he was feeding;

(f) either during one conversation, or in separate conversations, involving Dr Stein and Dr Calligeros it was agreed that Mr Gesios had suffered a seizure and then started choking;

(g) he was aware that Mr Gesios was on a minced and moist diet, that residents on this diet should not be given bread because of a risk of choking, and that there was a real possibility that Mr Gesios had choked;

(h) he did not ask Dr Stein what to put in the Incident Report and only asked her to check it after he was done. She did not ask him to change anything and only corrected a few spelling mistakes;

(i) he made no mention of choking because, following discussions with the team, it was considered that Mr Gesios was "normally a good eater" and that he had never had any issues with his food;

(j) he assumed that Mr Gesios had experienced a seizure, and then choked on his food;

(k) he denied anyone telling him what to write in the Incident Report or deliberately leaving out information regarding bread as he did not want others to realise that rules had been broken during his shift; and

(l) he denied omitting any mention of bread or choking in the Incident Report in order to avoid any trouble for himself or to protect AIN Khanal.

19.9 The following exchange conveniently summarises the overall nature of RN Koirala's evidence:

> Q. So you agree with me then that you must have appreciated, giving someone in Mr Gesios' position bread, could make him choke.
> A. True.
>
> Q. Therefore, you must have known at the time that that's a real possibility that that's what happened on this day. Agreed?
> A. Yeah, agree.
>
> Q. Despite that real possibility, you didn't include it in the incident report.
> A. I - I - I - I - I didn't even - I - I didn't realise on the time. I don't know. Maybe I wasn't aware of the consequences. I - I didn't realise on the day that that could be the reason. Otherwise, I'd definitely report it.
>
> Q. I understand that's your evidence.
> A. Maybe - maybe that was - that was when I was writing the note, maybe there's so many bags [sic] - other - other things going on and maybe that - I missed the part of that one or maybe I didn't realise that could be the bread that caused the death. So that's the way I didn't - I forgot it - to mention.

19.10 **Conclusions:** The evidence establishes that upon entering Mr Gesios' room, RN Koirala almost immediately recognised that Mr Gesios had food, including bread, in his mouth and throat which was obstructing his airway. Consistent with these observations, RN Koirala asked AIN Khanal several questions relevant to what, and how quickly, Mr Gesios had been fed. Later, during a shift handover, RN Koirala informed other staff that Mr Gesios had choked whilst being fed bread. All of this evidence is consistent with a belief by RN Koirala that Mr Gesios had choked on bread.

19.11 Despite this belief, RN Koirala made no mention in the Incident Report of Mr Gesios being fed bread and choking. In his 2020 statement, RN Koirala initially sought to explain that he wanted the Incident Report to be consistent with Mr Gesios' care plan. In other words, RN Koirala omitted any mention of bread (and by implication any mention of choking) as he was aware that Mr Gesios was not meant to be fed bread as part of his minced and moist diet. RN Koirala recognised this in his 2020 statement when he acknowledged that he ought to have told the police "*the entire truth*".

19.12 In his oral evidence during the inquests, RN Koirala provided several different reasons why the Incident Report omitted any mention of Mr Gesios being fed bread and choking. The reasons provided by RN Koirala were inconsistent and none of the reasons were persuasive. For example, RN Koirala initially acknowledged that he knew there was a real possibility that Mr Gesios had choked whilst being fed bread. In his very next answer, RN Koirala gave evidence that he had no such knowledge or belief otherwise he would have included it in the Incident Report.

19.13 Given the varied and unreliable explanations provided by RN Koirala in his oral evidence, and the content of his 2020 statement, the evidence establishes that RN Koirala deliberately omitted information regarding the circumstances of Mr Gesios' death in the Incident Report. RN Koirala's motivation for doing so is unclear. However, RN Koirala recognised that there could be adverse consequences for both himself and AIN Khanal given that Mr Gesios died during their shift.

Dr Stein

19.14 In her statement of 20 August 2019, Dr Stein gave this account of what occurred when she entered Mr Gesios' room on 7 June 2019:

> I made a quick risk assessment in my head and decided to contact 000. I observed Gesios' facial twitching, his eyes rolling back in his head, his breathing laboured and the fact that the Registered Nurse Koirala was conducting the suction. I assumed that Gesios was either choking, had the potential to choke or had an airway blockage. I based this on the facial twitching, the movement in his eyes and the actions of the registered nurse along with his laboured breathing. Given the clinical presentation of Gesios, I made that assumption that he was either choking or had an airway blockage.

19.15 Later in her statement, Dr Stein said the following:

> When I walked into the room. It appeared to me that Gesios was having a seizure. I believe the staff on the day did everything to the best of their ability and from my observation, which was limited, everyone acted in the best way possible and did not do anything they should not have been.

19.16 In oral evidence, Dr Stein disagreed that there was any inconsistency between the above paragraphs. Dr Stein initially gave evidence that "*facial twitching and eyes rolling back in the head are consistent with a seizure regardless of the circumstances*". However, Dr Stein gave evidence that such observations can also be consistent with hypoxia from choking. When asked whether upon entering Mr Gesios' room she knew that he was in fact choking or experiencing a seizure, Dr Stein indicated that she could not recall. When pressed further by

Senior Counsel Assisting about the apparent inconsistency in her statement, Dr Stein declined to answer any questions and simply indicated that she relied upon the contents of her statement.

19.17 Dr Stein gave evidence that in her role as Facility Services Manager one of her responsibilities would be to check the accuracy of the Incident Report before it was finalised. Dr Stein gave evidence that in doing so she relied upon her own observations as well as information provided from other staff in Mr Gesios' room at the time. With these observations and information, Dr Stein agreed that it was possible that Mr Gesios had experience a seizure and equally likely, if not more likely, that Mr Gesios had choked. Dr Stein then gave the following evidence:

> Q. In that case, shouldn't the incident report have referred to both possibilities as the cause of death?
> A. Hindsight's a wonderful thing, sir, isn't it?
>
> Q. I'm asking you. Maybe it is, maybe it isn't, but can you answer my question?
> A. Potentially, yes, but what you've got to understand is that this was a local report and the critical incident phase of the report, because of my newness to the organisation, was being handled by the then CEO and anything that happened, I immediately communicated to her, either by fax or by phone. And I would assume that, as part of the critical incident reporting, that would've been included. I have not seen any critical incident report.

19.18 Dr Stein also sought to explain that Mr Gesios died during her induction period at the Acacia Centre and that she was completing "*corporate orientation*" at this time.

19.19 In oral evidence, Dr Stein denied omitting any reference to choking in the Incident Report in order to avoid attention to the Acacia Centre. Dr Stein also gave evidence that she had no concerns regarding an investigation into Mr Gesios' death. However, when asked why there was no reference to choking in the Incident Report which she signed off on, Dr Stein gave evidence that she had "no idea".

19.20 As part of her role as Facilities Services Manager, Dr Stein obtained a statement from Ms Gabbah. In that statement, Ms Gabbah said the following:

> I saw the AIN running out of Room 3 calling out loudly for the registered nurses saying help [Mr Gesios] is choking.
> I asked what was happening.
> AIN said he was choking.

19.21 Following the lodgement of the anonymous complaint with the Commission, a Complaints Officer from the Commission sent an email to Dr Stein on 12 June 2019. The email asked for an initial urgent response to 2 issues and, relevantly, a summary of the day of Mr Gesios' death. The two issues related to Mr Gesios being fed toast whilst lying flat in bed causing him to choke, and "the facility manager" allegedly changing the Incident Report so that it did not include information that Mr Gesios was given the wrong food while lying flat in bed or that he choked.

19.22 In oral evidence, Dr Stein agreed that in her 12 June 2019 letter of response to the Commission she made no reference to the possibility of Mr Gesios choking. When asked

whether she considered that this might be relevant information to provide to the Commission in her response letter, Dr Stein initially gave evidence that "*the Commission was satisfied with [her] response to their questioning*" and later gave evidence that she *"only had about an hour or so to respond*".

19.23 When asked about the fact that Dr Stein had had an opportunity to speak to several staff members in that time, Dr Stein initially raised an objection "*to the badgering*" despite her Counsel indicating that no such objection was pressed. Dr Stein was later asked whether her letter represented a complete response to the issues raised by the Commission. Dr Stein again objected to answering any questions (and again with no such objection raised by Counsel for Dr Stein), asserting that she had already answered similar questions and that an attempt was being made to have her say something which was "*patently not true*". When the objection was overruled and Dr Stein was informed that she was obliged to answer the question, she gave this answer:

> At the time, this was the response I put together and submitted to the Commission. I stand by the response. I've signed the response. The Commission had no further request for information about the matter and the matter was closed.

19.24 **Conclusions:** Dr Stein acknowledged that it was at least equally possible that Mr Gesios was choking or experiencing a seizure on 7 June 2019. Indeed, based on her own observations and the statement which he obtained from Ms Gabbah, the evidence suggests that the more likely possibility was that Mr Gesios experienced a choking episode. Despite this, Dr Stein did not correct the Incident Report which made no mention of the possibility of choking. Similarly, in her response to the Commission, Dr Stein also made no mention of the possibility of choking.

19.25 Dr Stein's evidence overall was unimpressive. She did not answer questions directly in many instances and declined to answer questions entirely in other instances. She also sought to raise objections to answering questions without any legitimate basis and in circumstances where her Counsel raised no such objections. When pressed about the adequacy of her review of the Incident Report and her response to the Commission, Dr Stein sought to deflect responsibility for these matters and minimise the significance of her involvement. The evidence given by Dr Stein regarding contentious matters of significance is therefore considered to be unreliable.

19.26 The evidence therefore establishes that Dr Stein, with adequate information available to her, omitted to correct factual aspects of the Incident Report and omitted relevant factual information in response to the Commission's enquiries regarding two discrete issues concerning the circumstances of Mr Gesios' death. The available evidence does not establish that the omissions were made with the intent of concealing aspects of the circumstances of Mr Gesios' death to avoid further investigation. However, Dr Stein's omissions tended to avoid inconsistency with the narrative contained in the Incident Report which referred only to the possibility of a seizure event.

Application of the provisions of the Health Practitioner Regulation National Law (NSW)

19.27 Part 8, Division 3 of the *Health Practitioner Regulation National Law (NSW)* (**National Law**) deals with the making of complaints about registered health practitioners (Subdivision 1), how complaints are to be dealt with (Subdivision 2), and the powers that may be exercised by a Tribunal, Council or Committee when dealing with a complaint (Subdivisions 3, 4, 5, 6 and 7). Section 151A of the National Law is found within Subdivision 8. It sets out the "*[d]uty of courts etc to refer matters to [an] Executive Officer*" of a Council for the health profession.

19.28 Sections 151A(2) and (3) of the National Law provide:

> **151A Referral of matter by Courts**
>
> (2) If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession.
>
> (3) If a notice or a transcript of evidence is given to the Executive Officer under this section –
>
> (a) a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates; and
>
> (b) the Executive Officer must give written notice of the notice or transcript of evidence to the National Board for the health profession in which the person is or was registered.

19.29 Relevantly, the Nursing and Midwifery Council of New South Wales is a Council established under section 41B of the National Law.

19.30 Section 151A does not explicitly define, or otherwise provide guidance as to, what may constitute "*reasonable grounds*". However, it is noted that the guiding principles set out at section 3A of the National Law provides the following:

> (1) The main guiding principle of the national registration and accreditation scheme is that the protection of the health and safety of the public must be the paramount consideration.

19.31 Similarly, section 3B of the National Law provides:

> **Objective and guiding principle**
>
> In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.

19.32 Section 144 of the National Law sets out a number of grounds for complaint about a registered health practitioner including complaints regarding unsatisfactory professional conduct or professional misconduct.

19.33 It is noted that the use of the words "believe", "may indicate" and "could" in section 151A(2) of the National Law individually and collectively impose a relatively low threshold by which that provision might be engaged. Therefore, section 151A(2) does not impose any requirement that the evidence in actual or contemplated coronial proceedings establishes a

complaint. Instead, section 151A(2) may be engaged if a coroner has reasonable grounds to believe that the evidence may indicate that a complaint could be made.

19.34 Counsel for AIN Koirala and Dr Stein submitted against the unfair use of hindsight in assessing the actions of AIN Koirala and Dr Stein and submitted that it was not until the post-mortem examination for Mr Gesios was completed that it became apparent that he had a food bolus obstructing his airway. However, any assessment of the actions of AIN Koirala and Dr Stein is based on their own observations and information provided prior to completing the Incident Report, and not with the unfair use of hindsight. As noted above, both AIN Koirala and Dr Stein had sufficient information available to them at the time of the completion of the Incident Report and the response to the Commission as at least the possibility of Mr Gesios having choked.

19.35 Counsel for AIN Koirala and Dr Stein also submitted that it was not the role of either to determine the cause of Mr Gesios' death and that "*any criticism against them for determining the wrong cause of death is misplaced*". As noted above, the conduct of AIN Koirala and Dr Stein that invites consideration of section 151A(2) of the National Law concerns the omission of relevant information known to them regarding the circumstances of Mr Gesios' death. To repeat, AIN Koirala said in his statement to police that he ought to have mentioned the entire truth but did not and Dr Stein appeared to similarly concede in her oral evidence that she possibly ought to have included in the Incident Report information relevant to both a seizure and choking.

19.36 **Conclusions:** As set out at [19.10] to [19.13] above, there are reasonable grounds to believe that evidence during the inquests may indicate that a complaint could be made about the professional conduct of RN Koirala in deliberately omitting relevant information in an incident report relating to Mr Gesios' death. Therefore, in accordance with section 151A(2) of the National Law, a transcript of the evidence in the inquest is to be given to the Executive Officer of the Nursing and Midwifery Council of New South Wales.

19.37 As set out at [19.24] to [19.26] above, there are reasonable grounds to believe that evidence during the inquests may indicate that a complaint could be made about the professional conduct of Dr Stein in deliberately omitting to correct matters of fact in an incident report and omitting to provide relevant information to the Commission regarding the circumstances of Mr Gesios' death. Therefore, in accordance with section 151A(2) of the National Law, a transcript of the evidence in the inquests is to be given to the Executive Officer of the Nursing and Midwifery Council of New South Wales.

19.38 It should be noted that an Assistant-in-Nursing does not appear to be a health profession as defined in section 3 of the National Law or a profession which requires registration with the Australian Health Practitioner Regulation Agency. Therefore, consideration has not been given to section 151A(2) of the National Law with respect to AIN Khanal.

Issuing of MCCD

19.39 At around 9:00am on 7 June 2019, RN Koirala called Dr Calligeros and advise that approximately half an hour earlier, Mr Gesios had experienced a seizure whilst being fed. Dr Calligeros was told that Mr Gesios was observed to have some facial twitching with his eyes

rolling up. Dr Calligeros was also advised that although suction was performed, Mr Gesios was later pronounced life extinct and that resuscitation was not performed in accordance with his advance care plan. In these circumstances, Dr Calligeros was asked whether he would be able to provide a MCCD.

19.40 Dr Calligeros gave evidence that from this conversation, he considered that Mr Gesios had experienced a seizure and that because he was found to have food in his mouth he "probably aspirated" and then died. Dr Calligeros gave evidence that he did not consider choking as a cause of death because he assumed that Mr Gesios was fed the same food every day, and that he was not told that Mr Gesios had sepsis or that he had choked.

19.41 Dr Calligeros gave evidence that he was unsure whether he was able to issue a MCCD because he had not previously had a patient residing at an aged care facility who had died from a seizure. Dr Calligeros therefore called to the Duty Pathologist to seek advice. After providing a brief history and what had been reported to him regarding the events of 7 June 2019, Dr Calligeros gave evidence that the Duty Pathologist advised that he was able to issue a MCCD and to record the cause of death as "complication of seizure disorder".

19.42 Dr Calligeros subsequently attended the Acacia Centre, spoke briefly with RN Koirala and examined Mr Gesios in his bed for the purposes of confirming his death. Dr Calligeros also spoke with the attending paramedics and indicated that he had consulted the Duty Pathologist. Dr Calligeros went to an office where he completed the MCCD.

19.43 Dr Calligeros gave evidence that if he had been told that Mr Gesios might have choked on food whilst being fed, he would have considered this to be a very significant issue and he would not have signed the MCCD. Dr Calligeros explained:

> Well, no - well, no, [the MCCD] wouldn't be accurate. It wouldn't be a seizure disorder, firstly, and secondly, I can't see what's down the airways and what's there.

19.44 **Conclusions:** The evidence establishes that it was appropriate for Dr Calligeros to complete the MCCD based upon information known to him at the time. Dr Calligeros was provided with a narrative by RN Koirala regarding the circumstances of Mr Gesios' death which made no mention of the possibility of choking. Dr Calligeros appropriately recognised that if this possibility had been raised, it would have not been appropriate to complete a MCCD with Mr Gesios' death being complication of seizure disorder.

19.45 Dr Calligeros appropriately sought advice from the Duty Pathologist regarding whether he was able to issue a MCCD and if so, what ought to be recorded as the cause of death. Upon attending the Acacia Centre, Dr Calligeros appropriately examined Mr Gesios to confirm death before completing the MCCD.

20. Was Ms McGreevy provided with an appropriate meal on 13 March 2020?

20.1 Despite Ms McGreevy being on a minced and moist diet, there is evidence indicating that she had been given bread to eat prior to 13 March 2020:

(a) A statement from a nurse consultant indicates that Ms McGreevy "*loved bread and would hoard it and wouldn't let other people to [sic] take it off her*".

(b) In a Mini Nutritional Screening Tool from February 2020, it was noted that during mealtimes, staff were to provide Ms McGreevy with "*1:1 physical assistance with cutting up of food and spreading jam on the bread*".

(c) A Nutrition Diet Analysis Profile last completed on 3 March 2020 recorded Ms McGreevy's food likes which included, "*white bread and better with jam*".

20.2 In her statement, Ms Bangura said that on 13 March 2020, she prepared Ms McGreevy's evening meal before 5:00pm which consisted of mince, rice and capsicum as requested by Ms McGreevy. This meal was consistent with Ms McGreevy's minced and moist diet. After the meal was prepared, kitchen hand Novka Stojevska placed the meal tray onto the meal trolley to be collected by AIN staff. According to Ms Stojevska, each meal tray had a card which lists what diet a resident is on.

20.3 AIN Sun was the AIN who was responsible for delivering the meal tray to Ms McGreevy. In his statement, AIN Sun said the following:

> About 5pm, I served Maureen some food on a tray. The food consisted of pumpkin soup in a Bowl, Coffee in a mug and half a slice of buttered bread. I did not hang around to watch her eat, I was busy. My manager Supervised her eating.

20.4 AIN Sun went on to state that at around 5:45pm, he returned to Ms McGreevy's room and "*cleaned up after dinner*".

20.5 AIN Sun did not give evidence at the inquest. Despite all reasonable attempts made by police he could not be located and was unavailable to give evidence.

20.6 AIN Beniat gave evidence that at around 7:00pm, he saw Ms McGreevy walking from her room along a corridor near the living room, gasping for air and saying, "*I can't breathe*". AIN Beniat looked for an emergency buzzer but could not find one and called for other staff to summon a RN. AIN Beniat gave evidence that due to the change of colour in Ms McGreevy's face, he thought that she was choking. However, AIN Beniat gave evidence that he was unable to check whether Ms McGreevy was in fact choking or to try to assist her (other than by calling for a RN) because he was "*really panicking at [that] moment*".

20.7 One of the attending paramedics, Jordan Aldridge, noted that Ms McGreevy was found to have "*a large amount of bread*" in her airway which was removed by forceps. RN He described seeing the bread that was removed and described it as a "*slice of bread. Look [sic] like it cannot dissolve, like soften*". RN He described the bread as wet and approximately 8cm by 8cm in size.

20.8 The subsequent police investigation located crumbs on the ground next to Ms McGreevy, and also small crumbs on a bedside table in Ms McGreevy's room.

20.9 AIN Beniat gave evidence that there was a fridge in the dining room which usually contained beverages and which was accessible to residents. AIN Beniat gave evidence that he could not remember ever seeing sandwiches in the fridge, and that residents did not have fridges in their rooms. RN He gave evidence that if the families of residents gave them extra food it would possibly be placed in the dining room fridge, despite instructions to the contrary as it was a common fridge and "*because everyone can access it*".

20.10 AIN Beniat gave evidence that in the 10 years that he had worked at the Acacia Centre he had received some training about attending to a choking person and had been shown how to perform the Heimlich manoeuvre. He gave evidence that he could not recall whether he received any training regarding how to manage a choking person or any first aid or anything else that might be performed.

20.11 AIN Jocelia Dagdag similarly gave evidence that in the event of a resident found to be choking a RN needed to be found.

20.12 **Conclusions:** On 13 March 2020, a meal in accordance with Ms McGreevy's minced and moist diet was prepared by kitchen staff. For reasons unknown, a meal tray containing different food was delivered by AIN Sun to Ms McGreevy. That tray contained a slice of buttered bread. As AIN Sun was unavailable to give evidence, the circumstances which resulted in a different tray being delivered to Ms McGreevy could not be explored further at inquest. AIN Sun's statement indicates that when he went to clean up and collect the meal tray about 45 minutes later, it is likely that there was no bread on the tray.

20.13 AIN Beniat's evidence establishes that Ms McGreevy was seen at around 7:00pm walking from her room and to be choking and gasping for air. This suggests that Ms McGreevy had consumed the bread from her meal tray, which was later extracted from her airway, sometime between when her meal tray was collected by AIN Sun and around 7:00pm.

20.14 There was a fridge in the dining room which was commonly accessible to residents and which may have contained food, including bread. However, given that Ms McGreevy was seen by AIN Beniat to be walking from her room, there is no evidence to suggest that Ms McGreevy accessed any food that might have been in the dining room fridge. Rather, this evidence and the evidence of crumbs later found in Ms McGreevy's room indicates that she consumed bread in her room sometime after her meal tray had been collected by AIN Sun and likely shortly before 7:00pm.

20. What improvements have been made at Columbia since 2020?

21.1 In her report and in oral evidence, Dr Cichero identified several deficiencies associated with policy and procedure material at Columbia in 2019/2020 relating to the provision of food and drink to residents, namely:

(a) inconsistences in terminology used by staff and in policy documents regarding the type of diet that a resident may be prescribed, which may lead to inaccuracies with the size and softness of food they are permitted to safety chew and swallow; and

(b) kitchen staff and, in particular, nursing staff, being unclear about different food textures and not always using IDDSI terminology. Dr Cichero acknowledged that the events surrounding Mr Gesios' death in particular occurred during a policy transition period and therefore this lack of clarity was "reasonable";

21.2 The former CEO of Columbia, Lucy Flaherty, provided two statements in 2023 setting out a range of changes and improvements made at Columbia since 2020. Some of these changs and improvements can be summarised as follows:

(a) on 22 July 2022, Columbia decided to close Acacia Centre on the basis that it was no longer fit for purpose due to the age and configuration of the buildings on side being unable to meet the needs of residents;

(b) introduction of mandatory online annual training course for all staff in relation to the IDDSI Framework, and particular online training courses on dysphasia, swallowing difficulties and choking;

(c) implementation of a revised competency for staff to be assessed and supported to feed a resident with specific food and dietary requirements, and a mechanism for monitoring this to ensure the safety of residents. This includes a requirement that all staff must pass a feeding a resident competency assessment, which tests them on their knowledge of the IDDSI food testing methods, at the commencement of their employment to determine if they are competent to provide a compromise resident with nutrition and hydration;

(d) completion of a menu review and revision of Columbia's services with the involvement of dietitians to account for the nutritional requirements of residents;

(e) initiation of a new service that includes the ability to externally refer residents to speech pathology and dietics service;

(f) enrolment and support of kitchen staff to complete the Maggie Beer training package to ensure both foodservice and practice;

(g) completed of a review of documentation especially with regards to food, dietary requirements and nutrition to ensure that all residents had the required documentation to support their food and nutritional needs;

(h) introduction of a first aid policy setting out the steps that clinical staff are to take if a resident starts choking with RNs to have their first aid certification renewed annually; and

(i) initiation of a serious incident response scheme so that approved providers report certain serious incidents to Columbia's Chief Operating Officer and CEO.

21.3 In February 2026, Dr Cichero reviewed the evidence of changes and improvements referred to by Ms Flaherty commented that "*significant improvements have been noted with policies and procedures*". In addition, Dr Cichero some further comments for consideration. These comments relate to: the competency assessment process for food, dining and nutrition; translation of relevant policy material for a multicultural workforce and multicultural residents and family members; and improvement of policy material relating to responding to choking incidents, dysphasia management, first-aid and nutrition and hydration.

21.4 Nick Moutos, the current CEO of Columbia, gave this evidence regarding the matters raised by Dr Cichero:

> What I will say is I'll be bringing this to the attention of my clinical governance manager and work with them to look at ways of implementing the recommendations of Dr Julie Cichero. That's all I can say. But, this will be taken seriously.

21.5 **Conclusions:** Since 2020, Columbia has introduced and implemented several changes and improvements to address the deficiencies identified by Dr Cichero. Such action has strengthened the processes at Columbia for the provision of nutrition and hydration to residents that accords with a resident's dietary requirements and care plan, and the IDDSI Framework.

21.6 Where areas of further improvement have been identified and recommended by Dr Cichero, Columbia has undertaken to consider and implement such recommendations.

22. Is it necessary or desirable to make any recommendations?

22.1 The inquests identified the following matters for consideration of the making of recommendations.

22.2 *First*, the evidence suggested the need for a more standardised approach to the training of kitchen and nursing staff, and in particular AINs, working in aged care facilities. Dr Cichero gave the following evidence:

> I think one of the - in reviewing the two cases, one of the things that struck me was that both Mr Gesios and Ms McGreevy were largely non-verbal and that requires, for someone who is feeding them or assisting with feeding them, to pay very close attention to non-verbal signs, as to whether they - they'd swallowed the previous mouthful. If you have a - an organisation - and this is just speaking generally - where you have a lot of residents who might require assistance, so somewhere between 50 and 60% of residents in aged care have some swallowing difficulties. Not all of them might need feeding but if you have a certain proportion who do need feeding, that increases the reliance on AINs to - to safely provide that ability to - to feed them. Not just safety but also to make sure they get sufficient nutrients as well. It's a time consuming task to do safely.

22.3 Dr Cichero went on to give evidence that whilst AINs are expected to receive such training on-the-job, ideally such would be provided before an AIN commences employment. The

benefits of such an approach would be standardise the type of training provided and to relieve any financial and time burden on residential aged care facilities in providing such training.

22.4 *Second*, Dr Cichero gave evidence that whilst the initial competency testing of staff at Columbia in 2019 and 2020 for, relevantly, management of choking risk was "*actually quite thorough*", there was, and is, a need for that competency testing to be revisited in practice. Dr Cichero explained in oral evidence.

> If there were an opportunity to - if it's done just the once, which it appeared to be, at the time there was a sign off within a couple of days one of the AINs starting, and then I think it might have been ten days later, but it doesn't appear that there is an opportunity to come back and to look and see what happens in practice. So, it's a little bit like doing CPR training, you can talk about it when it actually comes to doing it, can you actually do it on the spot you know, when - when it's time to act.

22.5 Dr Cichero also gave evidence about the way in which any such deficiency might be remedied:

> One of the ways to remedy that might be to - to have either RNs or if there - if there is the use of the train the trainer model, a little bit like the Commission having unannounced visits, having a trainer periodically review an AIN feeding someone with dysphasia, particularly someone with severe dysphasia and who is at higher risk and/or speech pathologists being in and around the facility at meal times so that they can also provide some guidance if they see something that's - that could be improved.

22.6 Dr Cichero gave evidence that ideally a speech pathologist would perform such competency testing or, at the least, a RN with sufficient knowledge. However, Dr Cichero acknowledged the possible practical constraints, both with respect to availability and capacity, regarding such competency testing.

22.7 Having regard to the above matters it is desirable to make the following recommendation.

22.8 **Recommendation:** I recommend that a copy of the findings from the *Inquests into the deaths of Dimosthenis Gesios and Maureen McGrevy* be provided to the Aged Care Quality and Safety Commission for consideration.

22.9 It is recommended that the Commission consider developing consistent minimum training expectations for kitchen and nursing staff in residential aged care facilities, specifically directed to the identification and management of choking risk among residents, including alignment with the International Dysphagia Diet Standardisation Initiative Framework.

22.10 In developing this guidance, it is also recommended that the Commission consider including a structured approach to assist aged care providers to: (a) assess and document the competency of nursing staff, particularly Assistants-in-Nursing, in recognising and managing choking risk; and (b) implement periodic review or quality assurance processes to promote consistency and ongoing effectiveness.

22.11 Third, as noted above, Dr Cichero agreed that gelled bread is not well described or defined in either the 2017 or 2019 IDDSI Framework. Dr Cichero also agreed that there would be utility in considering whether gelled bread should be permitted at all as part of a minced and

moist diet. This is because the evidence in the inquests demonstrated a general misunderstanding by Acacia Centre staff about what actually constitutes gelled bread and how it is to be appropriately prepared.

22.12 Dr Cichero also gave evidence that the IDDSI Board is aware of the references to gelled bread in the IDDSI Framework and that consideration is being given to it as part of a forthcoming review.

22.13 Having regard to the above matters it is desirable to make the following recommendation.

22.14 **Recommendation:** I recommend that a copy of the findings from the *Inquests into the deaths of Dimosthenis Gesios and Maureen McGreevy* be provided to the Board of the International Dysphagia Diet Standardisation Initiative for consideration of whether (a) gelled bread ought to be removed as a permissible food as part of a minced and moist diet; or (b) gelled bread, and its preparation, ought to be more well defined and described.

23. Findings pursuant to section 81 of the Act

23.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Hilbert Chiu SC, Counsel Assisting, and his instructing solicitor, Eloise Ridley from the Crown Solicitor's Office (**CSO**). I also acknowledge the contribution of Gareth Martin and Nicholas Self, the previous solicitors with carriage from the CSO. The entire Assisting Team has provided enormous assistance throughout the coronial investigation and inquest, and have demonstrated objectivity, fairness, thoroughness and sensitivity during all stages of the coronial process.

23.2 I also thank Senior Constable Mostafa Elassaad and Plain Clothes Senior Constable Kelly Wood, the New South Wales Police Force Officers-in-Charge, for their roles in the investigation and for compiling the initial briefs of evidence.

23.3 The findings I make under section 81(1) of the Act in relation to Dimosthenis Gesios are:

Identity
The person who died was Dimosthenis Gesios.

Date of death
Mr Gesios died on 7 June 2019.

Place of death
Mr Gesios died at Marrickville NSW 2204.

Cause of death
The cause of Mr Gesios' death was choking.

Manner of death
Mr Gesios, who was a resident of an aged care facility, died after being fed bread and scrambled eggs which resulted in a large bolus of food forming in the oropharynx and causing complete occlusion of the airways.

23.4 The findings I make under section 81(1) of the Act in relation to Maureen McGreevy are:

Identity

The person who died was Maureen McGreevy.

Date of death

Ms McGreevy died on 13 March 2020.

Place of death

Ms McGreevy died at Marrickville NSW 2204.

Cause of death

The cause of Ms McGreevy's death was choking.

Manner of death

Ms McGreevy, who was a resident of an aged care facility, died after eating bread which resulted in a food bolus obstructing the airways.

24. Epilogue

24.1 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences and deepest sympathies, to the families and loved ones of Mr Gesios and Ms McGreevy for their loss.

24.2 I close these inquests.

Magistrate Derek Lee
Deputy State Coroner
27 February 2026
Coroners Court of New South Wales