



# **CORONERS COURT OF QUEENSLAND**

## **FINDINGS OF INQUEST**

**CITATION:** **Inquest into the death of Bridie Gilligan**

**TITLE OF COURT:** Coroners Court

**JURISDICTION:** CAIRNS

**FILE NO(s):** 2021/1923

**DELIVERED ON:** 3 February 2026

**DELIVERED AT:** BRISBANE

**HEARING DATE(s):** Pre-Inquest Conference  
26 March 2024

Inquest  
26 August 2024 – 30 August 2024

**FINDINGS OF:** Stephanie Gallagher, Deputy State Coroner

**CATCHWORDS:** Coroners: inquest, death in care, appropriateness of care and level of supervision provided by Endeavour Foundation, appropriateness of systems and processes of Endeavour Foundation, response of Queensland Ambulance Service

**REPRESENTATION:**

Counsel Assisting S Lane and J Crawfoot

Family	M.P Murray instructed by Townsville Community Law
Queensland Ambulance Service	A Freeman instructed by QAS Legal
Endeavour Foundation:	B McMillan instructed by Herbert Smith Freehills
Ms Margaret Lowry:	M Benn instructed by Barry Nillson Law

ORDERS

1. Non-Publication order made 8 August  
2024.

2. Non-Publication order made 23 August  
2024

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## Introduction

- [1] On 29 April 2021, Bridie Gilligan choked on a Hungry Jacks ‘Yumbo’ burger<sup>1</sup> at her home at Venus Battery Close, Edmonton. Ms Gilligan lived with a disability in Supported Independent Living (**SIL**) accommodation provided by Endeavour Foundation and was being cared for by a disability support worker, Margaret Lowry. When Ms Gilligan choked on her food, Ms Lowry called 000. Ms Gilligan lost consciousness and was taken to hospital by the Queensland Ambulance Service (**QAS**). After being treated in the emergency department she was transferred to the Intensive Care Unit. Unfortunately, Ms Gilligan had suffered a catastrophic brain injury. On 3 May 2021, Ms Gilligan was pronounced brain dead. On 4 May 2021 Ms Gilligan’s family decided to end her life support. She donated her organs for transplant.

## Coronial investigation

### *Family concerns*

- [2] Ms Gilligan’s death was reported to the Coroner’s Court of Queensland by an Intensive Care Registrar at the Cairns Hospital. The Registrar advised that, while Ms Gilligan was in intensive care, her family had expressed concerns about whether the food on which she had choked was appropriate for her in light of her disability, and particular dietary needs, and whether she had been adequately supervised while she was eating that food.
- [3] Ms Gilligan’s mother, Delia, raised the following concerns with police who were investigating Ms Gilligan’s death on behalf of the Coroner:

*Delia is concerned for the level of care and supervision that was being provided at the time of the incident to Bridie as she states 1.30pm is a late time for Bridie to be fed lunch. Her care routine states she is to have lunch at 11.30am as her behaviour escalates and she becomes agitated if routine is not stuck too and if she is not fed at her normal time. Delia also stated to police that ‘hamburger’ is not something the deceased should have been fed. Her usual foods are soft textured like spaghetti or stews as the deceased was to be completely supervised and assisted with eating as if she was left alone with food then it is likely a choking incident would occur. Delia states Endeavour Care had an assessment of the deceased’s swallowing conducted last year some time (the family do not have a copy of this report). Delia was told by Endeavour Foundation that ‘Margaret’ was on shift with Bridie when the incident occurred and that they were conducting their own investigation.*

*Delia stated in the past she has noticed Bridie’s behaviour escalate when Margaret has been on shift indicating that Bridie is not getting on with her*

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<sup>1</sup> The Yumbo burger is not currently available at Hungry Jacks but has been described in the media as a Hungry Jacks “cult food item”, “[c]onsisting of five slices of hot ham and two slices of melted cheese on a sesame bun”.

*as a carer. Delia has in the past, had a verbal conversation with Ben the manager of Endeavour to express her concerns about Margaret caring for Bridie however stated recently it seemed to of improved and Bridie was happier.<sup>2</sup>*

- [4] Delia and Danny, Ms Gilligan's father, later provided a number of other letters to police and to the Coroner advising that Ms Gilligan's family continued to have questions about her death and her care. These included, but were not limited to, the following questions:
- Why takeaway food was purchased for Ms Gilligan's when she had food available at home;
  - Whether Ms Lowry was adequately qualified, certified and trained to care for a person with Ms Gilligan's complex needs, and to deal with a choking incident;
  - Whether Endeavour's staff assessment, induction and training regime adequately addresses the risk of choking and prevention of choking;
  - Whether Endeavour ensured that any safe eating and swallowing policies were carried out by staff;
  - Whether Ms Gilligan's individual risks were assessed; and
  - Whether the ambulance response was adequate.

### ***Investigations***

- [5] During the coronial investigation into Ms Gilligan's death, evidence was obtained from Ms Gilligan's Support Workers, Endeavour Foundation, Ms Gilligan's treating Dietician, Speech Pathologist and Behaviour Therapist, Cairns Hospital and the QAS. The court also obtained expert evidence from a Forensic Pathologist, a Speech Pathologist and an Emergency Physician.
- [6] Workplace Health and Safety Queensland (**WHSQ**) also conducted an investigation into Ms Gilligan's death. I note that WHSQ were unaware of Ms Gilligan's death until notified by Ms Gilligan's father, some 4 weeks after the choking incident occurred. WHSQ produced a report of that investigation which was considered by the court.
- [7] Following the WSHQ investigation, Ms Gilligan's family made a request to the Office of the Work Health and Safety Prosecutor that a prosecution be commenced in relation to Ms Gilligan's death. After considering the brief of evidence obtained by WHSQ during their investigation, the Work Health Safety Prosecutor determined that he was

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<sup>2</sup> Exhibit E1.

“not satisfied there was sufficient evidence to commence a prosecution against either the Endeavour Foundation or its worker, Ms Lowry”.<sup>3</sup>

## Autopsy results

- [8] Forensic pathologist, Dr Paull Botterill, conducted an autopsy on 12 May 2021. It consisted of an external and internal examination, to the extent necessary, to establish the cause of death.
- [9] Dr Botterill made the following comments in his autopsy report:

*According to the Police Form 1, this 42-year-old woman, with a past history of Cornelia De Lange Syndrome, with intellectual disability requiring home care, was believed to have choked on some food on the afternoon of 29 April 2021. She was subsequently transferred to Cairns Hospital. She subsequently showed features of severe hypoxic brain injury and was declared brain dead on 3 May 2021. Tissues were subsequently removed for transplantation purposes.*

...

*In my opinion, at the time of autopsy, the cause of death was hypoxic brain injury due to choking on food, occurring in a subject with longstanding intellectual disability associated with Cornelia De Lange Syndrome. The possibility of contribution from drug toxicity at the time of the choking incident was difficult to completely exclude at the time of examination. Further investigations were subsequently performed. Microscopic examination showed airspace collapse within the lung tissues, changes with the protuberant trim brain in keeping with hypoxic brain injury, and no evidence of cancer in the remaining sampled tissues. Testing for drugs and poisons showed the presence of a pain killer (fentanyl), sedative (oxazepam), antidepressants (fluoxetine and metabolite), antipsychotics (risperidone and metabolite paliperidone), antireflux antacid (pantoprazole), and an anticonvulsant (valproic acid), all at blood levels below the reported respective potentially toxic ranges. No other drugs, including alcohol, were detected.<sup>4</sup>*

- [10] Dr Botterill concluded that Ms Gilligan’s cause of death was:

- 1(a) Hypoxic brain injury, *due to, or as a consequence of*
  - 1(b) Choked on food.
- Other significant conditions*
2. Cornelia De Lange Syndrome.

## Inquest

- [11] Ms Gilligan’s death meets the definition of a ‘death in care’ in section 9(1)(e) of the *Coroners Act 2003 (the Act)*. As her death occurred in

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<sup>3</sup> Exhibit G3.

<sup>4</sup> Exhibit A6, page 6.

circumstances that raised issues about her care, an inquest is mandatory pursuant to s27(1)(a)(ii) of the Act.

[12] In accordance with section 45(2) of the Act, I am required, if possible, to make the following findings at the conclusion of this inquest:

- a. the identity of the deceased;
- b. how she died;
- c. when she died;
- d. where she died; and
- e. what caused she death.

[13] The inquest was held from 26 to 29 August 2024 in Cairns.

### ***Issues for Inquest***

[14] It was agreed following the pre-inquest conference in this matter that, in addition to the findings required by s45 of the Act, the following issues were to be explored and determined at the inquest:

**Issue 1** Whether the care and level of supervision provided by Ms Lowry to the deceased on 29 April 2021 was appropriate;

**Issue 2** Whether the systems and processes the Endeavour Foundation had in place for the care of the deceased regarding her diet and nutrition was appropriate; and

**Issue 3** Whether the outcome would have been different for Bridie if the first QAS crew who attended had identified and removed the obstruction in her airway.

[15] As well as making findings in relation to these issues a Coroner may also comment, pursuant to s46(1) of the Act, on anything connected to the death relating to public health or safety, the administration of justice or ways to prevent similar deaths from happening in similar circumstances in the future.

### ***Witnesses called***

[16] The following witnesses gave evidence at the inquest:

- a) Patrick Polletschke, Support Worker;
- b) Brad Tanswell, Support Worker;
- c) Fatima Knowles, Support Worker;
- d) Celestine Gasake, Support Worker;
- e) Margaret Lowry, Support Worker;
- f) Ben Groenwald, Home Site Supervisor;
- g) Alyce Rees, Dietician;
- h) Kimberly Campbell, Speech Pathologist;
- i) Shea Flemming, Behaviour Therapist;

- j) Dr Arun Thillainathan, Forensic Physician;
- k) Dr Leisa Turkington, Expert Speech Pathologist; and
- l) David Swain, CEO, Endeavour Foundation.

## **Evidence**

- [17] Ms Gilligan's was born on 23 April 1979 and was 42 years old at the time of her death. She had a congenital condition, Cornelia de Lange Syndrome, which resulted in profound intellectual impairment and a seizure disorder. In addition, she was diagnosed with Broad Spectrum Autism Disorder, Esotropia (turned eyes), Bilateral Keratoconus (blurred vision), Depression, Anxiety and Gastroesophageal Reflux Disease.
- [18] Ms Gilligan was largely non-verbal and communicated with a combination of 20-30 basic signs and gestures. Ms Gilligan required assistance with all her activities of daily living. Her mother Delia was Ms Gilligan's guardian and decision-maker.
- [19] Ms Gilligan lived with her family until July 2015. When she moved out of the family home, she lived in SIL accommodation provided by Endeavour Foundation. Ms Gilligan lived in a house on her own with 24-hour in-home care provided by disability support workers. Ms Gilligan's first SIL accommodation was in a house at St George Close, Westcourt. In 2018, Ms Gilligan moved to a different house, also in a SIL arrangement with Endeavour, at 3 Venus Battery Close, Edmonton. Ms Gilligan's support workers and family felt that the house at Venus Battery Close was much better for Ms Gilligan, as modifications were made to suit her needs and she was able have fewer restrictive practices in that house.
- [20] Ms Gilligan had a number of full-time and part-time disability support workers, employed by Endeavour (or on secondment from other agencies), who provided her in-home care. From September 2018, Ms Gilligan's prime support worker was Patrick Rolletschke, who was employed by Endeavour on a full-time permanent basis. Ms Gilligan's other regular support workers, at the time of her death, were Bradley Tanswell, Fatima Knowles, Ben Groenewoud, and Margaret Lowry. These support workers had known and cared for Ms Gilligan for differing lengths of time, from over 20 years for Fatima Knowles, who had worked with Ms Gilligan at the Endeavour Learning Life Skills Centre when Ms Gilligan still lived with her family, to around 1 year for Margaret Lowry.
- [21] Support workers would work in shifts to provide one on one care to Ms Gilligan. Day shifts began at around 6:00 or 7:00am and finished at around 2:00 or 3:00pm. Night shifts, which usually involved sleeping over at the house, went from 3:00pm to 10:00pm, and then from about 6:00am to 9:00am. Staff on sleepover shifts were responsible for supervision of Ms Gilligan overnight.
- [22] Important information about Ms Gilligan was kept at her home in the support workers' office, in a red folder. Support workers also exchanged

information about Ms Gilligan and her needs either in person when changing shift or by writing messages in the house diary and/or the Communication Book. Progress notes were made on paper or electronically. Any 'customer incidents' were required to be reported in what was referred to as a RiskMan Report, which could be viewed on the house computer by some of the support workers. Customer incidents were defined in the relevant Endeavour policy document as "an action, failure to act, and event or circumstances that occurs in connection with the provision of supports to an Endeavour [customer or employee] which have, or could have, impacted on their physical or mental wellbeing or on their human rights".<sup>5</sup>

[23] After the National Disability Insurance Scheme (**NDIS**) was introduced in Cairns on 1 July 2018, Endeavour provided their services to Ms Gilligan in accordance with her NDIS Plan. Prior to the NDIS, Endeavour had managed and allocated all of Ms Gilligan's disability funding on her behalf, in consultation with her family. After the NDIS came in, Ms Gilligan's funding was split between Endeavour and Ms Gilligan's other NDIS service providers. Ms Gilligan's other service providers were Community Solutions, which provided Specialist Behaviour Support, and Mercy Community, which provided Support Coordination. Ms Gilligan's Support Coordinator was responsible for making referrals to allied health practitioners (including specialist behaviour support practitioners) on behalf of Ms Gilligan and her decision-maker.

[24] Overall, Ms Gilligan's NDIS Plan funded the following aspects of her life:

- Assistive Technology;
- Supported Independent Living;
- Transport;
- Financial Management;
- Improved Daily Living (therapeutic supports such as occupational therapy, physiotherapy, dietician consultation, speech therapy etc);
- Specialist Behaviours Support; and
- Support Co-ordination.

[25] Ms Gilligan's NDIS package did not fund health care. Ms Gilligan paid for medical and dental services out of her Disability Support Pension which was managed by the Public Trustee.

[26] Ms Gilligan had an Endeavour Individual Support Plan (**ISP**) which detailed her diagnoses, needs, preferences, usual health-care providers, therapeutic supports and daily-living activities, and the means by which Endeavour staff could best support her. The ISP was supplemented by a Positive Behaviour Support Plan (**PBSP**) prepared by Community Solutions, which provided more detailed information, advice and strategies for carers to help them support Ms Gilligan, with an emphasis on dealing positively with challenging behaviours.

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<sup>5</sup> Exhibit C4.4, page1.

[27] Ms Gilligan had regular assessments by her GP, psychiatric reviews, occupational therapy (OT), speech therapy, physiotherapy and dietetics input, although these supports were often limited by Ms Gilligan's inability to communicate and her challenging behaviours which arose from her intellectual impairment, autism and anxiety. It was identified in her ISP dated 6 January 2021, for instance, that she had very poor oral health, but it was also acknowledged that there were significant difficulties in finding a dentist who was willing to see her, as well as challenges overcoming Ms Gilligan's anxiety at attending an unfamiliar dental surgery for lengthy treatment.

[28] When it was identified by Ms Gilligan's decision-maker, her support workers and/or her specialist behaviour support that Ms Gilligan needed allied health support which was funded by NDIS, referrals and appointments (in-home or in the community) were organised through Mercy Community. Mercy Community would make a request to the NDIS for a referral for the particular support required.

[29] Ms Gilligan's most recent ISP and PBSP recorded that Ms Gilligan's access to sharp knives and hazardous chemicals was restricted so as to ensure her safety. Other than these restrictions, Ms Gilligan had full access to the remainder of her home and garage environment at all times, including the fridge and pantry.

### ***Endeavour policies and procedures***

[30] David Swain, Chief Executive Officer of Endeavour, gave a statement to the court which outlined the relevant policies, procedures and training which Endeavour had in place at the time of Ms Gilligan's death. Mr Swain gave an addendum statement, which was unsigned and intended as a 'precis' of evidence he could give in court, which described the way in which Endeavour operated under the NDIS and how Endeavour interacted with Ms Gilligan's other providers under that scheme. Mr Swain also gave evidence at inquest.

[31] Mr Swain explained that the following Endeavour policies and procedures were in place which ensured support workers had adequate information and training to respond to a person with eating and swallowing difficulties such as Ms Gilligan's.

- Safe Eating and Swallowing Policy (May 2014);
- Safe Eating and Swallowing Procedure (December 2014);
- Safe Eating and Swallowing Checklist (May 2014);

[32] Endeavour support workers were advised of these policies and procedures at their orientation, they were accessible within the organisation, and if there were changes to them, Endeavour would provide training on those changes to staff.

- [33] In addition to these specific documents relating to safe eating and swallowing, Mr Swain advised that the Individual Support Planning Procedure (8 January 2021) “outlines the process for developing [ISPs] for each Endeavour client, in partnership with their support networks and or decision makers”, and “supports a flexible and inclusive planning process that assists the client to focus on their strengths and abilities and to identify opportunities to live their best life”.<sup>6</sup>
- [34] A support worker’s orientation would include orientation to the ISP of the person they would be supporting, and that specific training as to how to read and implement the ISP for a participant would occur during ‘buddy shifts’ when new support workers would go on shift with a more experienced support worker to learn about the participant they were supporting, and during staff meetings.
- [35] Mr Swain advised that the following, more general, health and safety policies and procedures were also in place for Endeavour Support Workers in April 2021:
- Customer Safeguarding Incident Management Procedure (16 December 2020);
  - Health Management Policy (8 January 2021); and
  - Health Management Planning and Support Procedure.
- [36] The first of these procedures outlined how and when support workers should use the RiskMan system to report incidents, and then how the organisation monitored and responded to those reports to ensure that risks to individuals are being properly managed.
- [37] In respect of Endeavour’s Health Management Policy and Procedure, Mr Swain explained that these provide guidance on specific health conditions, such as dysphagia, and how to manage them and seek community support for those conditions from allied health practitioners. Mr Swain said that, since the implementation of the NDIS, it has become more difficult for Endeavour support workers to seek health support in the community, because they must do that through the participant’s support co-ordinator (in Ms Gilligan’s case, Mercy Community) rather than communicate directly with a relevant allied health practitioner themselves.

### ***Training for Endeavour Support Workers***

- [38] In his evidence at inquest Mr Swain advised that most of the training provided by Endeavour to its staff, including individual participant training such as buddy shifts, was not funded by the participant’s NDIS package. The funding for staff training was provided by Endeavour.

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<sup>6</sup> Exhibit D10 at [30].

- [39] Mr Swain explained in his statement that the Safe Eating and Swallowing Procedure required that “all support workers are required to undergo Safe Eating and Swallowing Training as part of their induction and receive refresher training every three years”.<sup>7</sup> Between 2017 and 2020 this training was delivered by specialist trainers and accompanied by a PowerPoint presentation and a Workbook. Staff were required to keep the Workbook as a reference tool.
- [40] Subsequently, the way in which this training was delivered changed. In 2021, Safe Eating and Swallowing training was delivered to staff through a Safe Swallowing training module on an e-training platform. Following completion of this training, staff would receive a Safe Swallowing Certification.
- [41] The training records provided by Endeavour show that Ms Lowry, Mr Rolletschke, Mr Tanswell and Mr Groenewoud had each obtained a Safe Swallowing Certification prior to Ms Gilligan’s death.
- [42] In addition, Ms Gilligan’s support workers were given the following mandatory training:
- Annual CPR Certificate;
  - First Aid Certificate (every 3 years);
  - NDIS Orientation;
  - MAYBO Conflict and Challenging Behaviour with Lone Working v1 (every 3 years); and
  - Supporting People at Mealtimes (every 3 years).
- [43] The training records provided show that Ms Lowry, Mr Rolletschke, Mr Tanswell and Mr Groenewoud were also up to date with their mandatory training requirements.

### ***Plans, assessments and supports for Ms Gilligan***

- [44] Ms Gilligan had had three previous incidents of choking on her food. These had been reported by support workers in the RiskMan database:
- a. 25 November 2016, RiskMan ID 6196 – support worker reported an incident of Ms Gilligan choking; and
  - b. 22 February 2019, RiskMan ID 4938 – *Bridie was having ripe banana for morning tea and choked on a big piece of the banana. Had difficulty breathing and fell on her back in the lounge area. SW (Ms Knowles) gave Bridie back blows x 2 and dislodged the big chunk of banana. Paramedics were called on around 9:35am and assisted Bridie. Medical report is attached;*<sup>8</sup>

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<sup>7</sup> Exhibit D10 at [23].

<sup>8</sup> Exhibit C41, line 101.

- c. 27 August 2020, RiskMan ID 79417 - *Bridie , Delia and I (Mr Rolletschke) had Afternoon Tea together when Bridie suddenly joked (sic) on a piece of bread. Basic First Aid was given to Bridie and Bridie returned to normal (sic).*<sup>9</sup>

[45] On 30 December 2019 Ms Gilligan's GP completed a Comprehensive Health Assessment Program (**CHAP**) with the assistance of Celestin Gasake, Ms Gilligan's Home Site Supervisor at the time. Because of the first two choking incidents, Mr Gasake noted 'swallowing' as a health concern.

### *Positive Behaviour Support*

[46] Ms Gilligan's most recent PSBP was dated 14 January 2020 and was completed by Community Solutions Behaviour Support Practitioner, Shea Flemming. Ms Flemming's process in drafting the PSBP included interviews/consultations with Ms Gilligan's mother, her Home Site Supervisor and support workers, an assessment of Ms Gilligan in her home and a review of the RiskMan reports.

[47] Under 'Information about the Person', it said that:

*Staff support Bridie to make choices in her day-to-day life (e.g. what activities she wants to engage in and what food she would like to eat) while ensuring to promote good health and well-being (e.g. ensuring a varied diet to avoid constipation from over consumption of Weetabix and buttered bread, which are Bridie's favourites).*<sup>10</sup>

[48] In the section outlining her Functional Behaviour Assessment, Ms Flemming noted that one of the known triggers for Ms Gilligan's behaviours of concern or harm was:

*Difficulties waiting for her needs to be met at times (i.e. low frustration/tolerance and poor impulse control). This includes waiting for a tangible object (particularly food) or waiting for a service (e.g. a queue at the shops).*<sup>11</sup>

[49] In a section which explains important information in relation to Ms Gilligan's Cornelia de Lange Syndrome, Ms Flemming stated that:

*Bridie requires support at mealtimes as the limited movements in her wrist means she has difficulty with balancing food and using utensils. Bridie's movement when eating may seem fast and erratic and this further increases the risk of her food and drink being spilled onto herself or on the floor. She generally tries to manage this by eating with the bowl or plate close to her mouth. Bridie is able to prepare a sandwich using a butter knife to spread the butter and preferred condiment (e.g. jam / vegemite /*

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<sup>9</sup> Exhibit C41, line 47.

<sup>10</sup> Exhibit C124, PBSP, page 9.

<sup>11</sup> Exhibit C124, PBSP, page 9.

*peanut butter) but is supported by having all meals prepared and provided to her by staff. Bridie has a history of putting her hands into food without testing the temperature first, resulting in minor injury (e.g. burn from putting her hand in hot Weetabix water). However, staff have reported some improvement in this area as Bridie will now take a meal and put it in the fridge if it is too hot to eat straight away. Staff assist Bride to engage in safe eating practices by portioning her meals in bite-size pieces, encouraging her to chew carefully and ensuring she does not put too much food into her mouth at once. At times Bridie suffers from dysphagia.<sup>12</sup> (Emphasis added)*

- [50] Ms Flemming made recommendations, based on a review of Ms Gilligan's reported and observed behaviours, for particular supports which would be of benefit to Ms Gilligan. Relevantly, Ms Flemming recommended that:

*Bridie...undergo a swallowing assessment to help promote safer eating practices in the home given an increase in her choking on food over the past 12 months; and*

*A dietician should be consulted annually to review Bridie's dietary plan and to assess the impact and risk of overconsumption of fibre rich foods...If any foods are recommended to be restricted against Bridie's wishes, please consult with the Behaviour Support Practitioner to ensure all less restrictive options are considered first.<sup>13</sup>*

- [51] The PSBP also set out an implementation plan with strategies for support workers to positively address Ms Gilligan's challenging behaviour and teach 'functionally equivalent replacement behaviour'.

#### *Occupational Therapy Review*

- [52] In April 2020 an OT completed a Functional Needs Assessment (**FNA**) Report for NDIS. This report provided recommendations in respect of Ms Gilligan's future needs. Relevantly, the following recommendations were made by the OT:

*Speech and Language pathology – Assessment of swallowing and review of food textures; and*

*Dietician: Ongoing input to liaise with Speech Pathologist and recommend dietary needs/food requirements for swallow and to manage bowel routine. Inclusive of training for support staff as needed.<sup>14</sup>*

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<sup>12</sup> Exhibit C124, PBSP, page 15.

<sup>13</sup> Exhibit C124, PBSP, page 29.

<sup>14</sup> Exhibit D15.3, page 15.

## *Speech Pathology and Dietetic Assessments*

- [53] In August 2020 Mercy Community organised a referral through the NDIS for a Speech Therapy swallowing assessment with Little Sparrows Speech Therapy. The appointment was on 3 September 2020, and Ms Gilligan attended with two of her support workers. Unfortunately, the assessment could not be completed by the Speech Therapist, Kimberley Campbell, because Ms Gilligan “became deregulated and grabbed [Ms Campbell’s] hair, held [her] in a headlock and attempted to bite [her]”.<sup>15</sup> Ms Campbell subsequently provided a Dysphagia Review Report dated 9 September 2020, which gave recommendations in respect of Ms Gilligan’s diet and swallowing.
- [54] In September 2020 Mercy Community organised a referral through the NDIS for dietetic services with Northern Australia Primary Health Ltd (**NAPHL**). Dietician Alyce Rees, who had previously provided services to Ms Gilligan in 2000, was provided with Ms Gilligan’s NDIS Plan and FNA, as well as Ms Campbell’s Dysphagia Review Report. Ms Rees conducted two home visits with Bridie and discussed her dietary issues with her carers. Ms Rees subsequently completed a Meal Plan and Meal Plan Recipe Book, both of which were provided to Mercy Community on 6 January 2021, and a Dietetic Progress Report dated 12 April 2021.
- [55] On 13 January 2021, Ms Gilligan’s support workers were provided training in respect of the PBSP by Ms Fleming and another employee of Community Solutions. A copy of the training presentation has been provided to the court, as have the training records. Ms Lowry, Mr Rolletschke, Mr Tanswell, Mr Groenewoud and Ms Knowles were in attendance. Mr Swain confirmed during his evidence that this training was funded by Bridie’s NDIS plan as part of her positive behaviour support package.
- [56] On 28 January 2021 Ms Flemming sent an email to Mr Groenewoud which attached Ms Rees’ Meal Plan and Recipe Book, and in which she provided Ms Rees’ contact details. The email was sent to Mr Groenewoud as, at the time, he was Ms Gilligan’s Home Site Supervisor, Mr Swain explained in his evidence that it was usual for the support coordinator to communicate information about allied health appointments or assessments with each participant’s Home Site Supervisor. The Home Site Supervisor would then pass information on to the support workers.
- [57] Mr Swain advised the court that it would have been usual for Mercy Community to also provide the Meal Plan and Recipe book to Ms Gilligan’s decision-maker, Delia.

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<sup>15</sup> Exhibit D11, page 2.

### *Individual Support Plan*

[58] Ms Gilligan's most recent ISP was dated 10 February 2021. It was a 38-page, detailed document, and was reviewed and updated by Mr Rolletschke with assistance from Mr Tanswell and Mr Groenewoud.

[59] Under 'Disability/Diagnosis' and 'Chronic Medical Conditions', it stated, relevantly, "At times Bridie suffers from Dysphagia".<sup>16</sup> In the section titled 'Safe Eating/Nutrition', the passage from the PBSP in relation to Ms Gilligan's required support at mealtimes (quoted at para 51 above) was reproduced.

[60] Under 'Dietary Preferences' it was noted that "Bridie has to be careful as sometimes she will choke on her food".<sup>17</sup>

[61] Ms Gilligan's meal and snack times were set out in the ISP. They were noted as "approx.", and were the same for each day of the week:

- Breakfast – 6:30/7am;
- Snack – 10am;
- Lunch – 12 noon;
- Snack – 3pm;
- Dinner – 5:30pm/6pm.

[62] Much of the ISP was devoted to explaining the escalated behaviours that support workers could expect from Ms Gilligan, what may precipitate these behaviours and how support workers could best de-escalate them. It was noted that Ms Gilligan may hit, punch, pull hair, hurt herself by pinching and pulling her own hair, deliberately slam her body onto the ground, inappropriately disrobe and/or defecate. Support Workers were reminded that Ms Gilligan had been assessed as having the mental age of a 3-year-old. It was noted that "Bridie prefers when there is routine and consistency in her life and often tests out new support workers' skills and abilities until they have learned how to meet her needs".<sup>18</sup>

[63] Under the heading 'Positive Behaviours Support' it said:

*Those who support Bridie recognise that she has come a long way in developing her self-regulation strategies and that has led to a significant decrease in her challenging behaviours over the past few years. They say that when you take the time to get to know the "real Bridie" and not just the behaviour, she can be an absolute joy to support.*<sup>19</sup>

[64] Ms Gilligan's ISP was acknowledged and signed by her mother Delia on 11 March 2021.

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<sup>16</sup> Exhibit C37, page 3 and 4.

<sup>17</sup> Exhibit C37, page 31.

<sup>18</sup> Exhibit C37, page 26.

<sup>19</sup> Exhibit C37, page 7 - 8.

### **Application in Ms Gilligan's daily life – evidence of support workers**

- [65] Mr Rolletschke was Ms Gilligan's primary support worker at the time of her death and was one of the support workers who had been with her for the longest. Ms Gilligan was the only person Mr Rolletschke was engaged in caring for, and he worked full-time with her from late 2018. Mr Rolletschke was a qualified nurse in Germany, specialising in aged care. It is clear from Ms Gilligan's progress notes, her house diary and from Mr Rolletschke's evidence that he spent a great deal of time with Ms Gilligan, provided a very high level of care for her and, as her prime support worker, spent a great deal of time advocating for her.
- [66] Mr Rolletschke said in his statement that "Bridie was a delight to engage even though, through past experiences, she presented, at times, several challenging behaviours if stressed".<sup>20</sup> He explained that Ms Gilligan would mainly get stressed with new staff or in unfamiliar or triggering environments. He said that Ms Gilligan responded best to routine.
- [67] Mr Rolletschke set out his knowledge of Ms Gilligan's food and mealtime requirements in his statement as follows:

*Bridie's food was prepared by support workers.*

*The food that was prepared was based on Bridie's preferences and according to Plans; because of her Sri Lankan heritage, she enjoyed curries and those types of flavours.*

*Bridie was always fed soft foods and cut up into small pieces. The food had to be easy for Bridie to chew as she had issues with her teeth and difficulties swallowing because of her dysphagia. Bridie also had reflux, so one had to be careful with acidic food.*

*Bridie's dental care had been neglected over a long period and this caused her some difficulty in chewing. The dental issue was in the process of been addressed until the tragedy of April, 2021.*

*We would always eat together. I would never eat a meal without Bridie also eating with me. Sometimes I would feed her some of my food. She enjoyed camembert cheese, salmon, pikelets and fruit such as bananas. I would feed Bridie healthy foods and did not purchase takeaway food for her.*

*Bridie could eat bread and toast as long as it was cut into small portions, and I had to be vigilant at all times; small pieces of bread were always eaten with butter and/or cheese as a lubricant to enable smooth swallowing. Bridie managed these very well and really enjoyed them, but the portions were very small and, as I sat with her, I maintained a focused vigilance. Prior to April 2021 Bridie had previously choked (not bread) with*

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<sup>20</sup> Exhibit D13, at [14].

*another Staff member and had been rushed to hospital by Ambulance where that issue was addressed.*

*I never left Bridie alone with food. She was not able to prepare her food herself, but I always involved her in preparing meals as she liked to be involved. For example, she was able to get the butter out and spread bread.*

*The times of Bridie's meals would vary depending on when she was hungry. Lunch might be at 11am, or 12pm or 1pm. The schedule was adjusted to Bridie's needs.<sup>21</sup>*

- [68] In his evidence at inquest, Mr Rolletschke clarified that he would cut Ms Gilligan's food into pieces about 1 to one and a half centimetres square. He gave the following evidence in respect of the precautions he took when Ms Gilligan was around food:

*Okay. And just explain to us why did you have to be aware of Bridie around food like that?---Because she could be very fast and I wo – I was aware of it, you know. I just – I always prepared my day with Bridie and what I do and circum –circumstances, you know, I always was – try to be on the spot and, you know, because hot water, you know, putting into the Weet-Bix you need to be aware of it that she wouldn't put her fingers in it or be very quick. You know, you need to be there and – and, you know, it never could happen. You'd always be with her and fully aware where she was or what she was doing, and that's just how – what it was. So even when she gets up at night time I wouldn't sleep deeply. I would just wake up and check on her.*

*Okay. Just to go back when you're preparing the food, you mentioned you ran hot water for the Weet-Bix?---Yes.*

*That she might get her fingers in the hot water if you didn't look out, is that right?---Yeah.*

*What about when you're cutting things up? Did you have to be careful that Bridie might put her fingers near the knife?---Um, I – probably. I would – just always make sure I'm a step ahead with her.*

*Okay?---And what she thinks and what she would – could do and so I learned a lot, you know. She had a mental age for three year old one but she had the experience of 42 years. So sh – she was very smart and had always to learn more things and new tricks and – - -*

*All right. And you said she was very fast?---Yeah. And very strong, so – - -*

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<sup>21</sup> Exhibit D13, at [19 - 25].

*So when you're preparing food did she sometimes try to grab the food before it was ready for her?---She could but it wouldn't happen with me. I don't – I would, you know, make sure that she can't.*<sup>22</sup>

[69] In cross-examination Mr Rolletschke was asked about an incident recorded in RiskMan which had occurred on 11 March 2021. The report concerned an accident which occurred when Mr Rolletschke was preparing afternoon tea for Ms Gilligan and Delia and, despite all his efforts, he recorded that “[s]omehow this time we were not fast enough to prepare Afternoon Tea”.<sup>23</sup> Ms Gilligan ran into the kitchen to get some spoons before he and Delia were ready, and grazed her forehead when she dropped a spoon and bent over to pick it up. Mr Rolletschke conceded that sometimes, “despite doing the very best [he could] to make sure that Bridie is getting fed when she would be hungry, that things like this can happen”.<sup>24</sup>

[70] Mr Groenewoud was Ms Gilligan’s Home Site Supervisor at the time of her death. He gave evidence in cross-examination that he did not recall buying takeaway food for Ms Gilligan as it was against procedure. He recalled that this practice had been discussed at staff meetings and staff had been told “that it had to cease”.<sup>25</sup> Mr Groenewoud clarified in response to further questions that this was a general procedure, which was that support workers should not buy anything (food or gifts) for any of their clients, and was not specific to Ms Gilligan.

[71] Mr Groenewoud said in his statement, and confirmed during cross-examination, that:

*Bridie had issues with her food and would grab and throw the food we would prepare for her. Bridie would stand right next to when cooking and preparing food. Bridie would grab what you were preparing and run off with it and shoving it down her throat.*<sup>26</sup>

[72] In his statement, support worker Mr Tanswell said:

*I have had experiences with Bridie grabbing food and running. She has taken ice cream and taken off. If I ever set any food down, she would usually take it.*<sup>27</sup>

[73] In his evidence at inquest Mr Tanswell clarified that he never left Ms Gilligan alone with food because he knew it was a choking hazard, and

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<sup>22</sup> Transcript, Day 1, T14 – T15.

<sup>23</sup> Exhibit C41, line 8.

<sup>24</sup> Transcript, Day 1, T34L40.

<sup>25</sup> Transcript, Day 4, T18L35.

<sup>26</sup> Exhibit D14, at [24] and Transcript, Day 4, T25L25.

<sup>27</sup> Exhibit D12, at [37].

sometimes Ms Gilligan would try to take the food before it was cut up properly.

[74] Mr Tanswell gave evidence at inquest that he would sometimes buy takeaway food and share it with Ms Gilligan. He would cut up pizza small for her to eat or if he bought a Hungry Jacks meal he would eat the burger and chips himself and let Ms Gilligan eat the ice cream. Mr Tanswell was familiar with a Hungry Jacks Yumbo burger, which he agreed was ham and cheese on a soft bun, and his view was that Ms Gilligan would be able to eat this food if it was cut up small enough for her.

[75] Support worker Ms Knowles gave evidence that she had never had any incidents with Ms Gilligan when she had grabbed food from her. In respect of the incident on 22 February 2019 when Ms Gilligan choked on a piece of banana, Ms Knowles explained that this happened when she thought Ms Gilligan was asleep, but Ms Gilligan got up and went into the kitchen. Some cut-up banana had been left on the kitchen table and Ms Gilligan choked on two of the pieces.

[76] Ms Gilligan's former Home Site Supervisor, Mr Gasake, gave evidence at the inquest. He said that Ms Gilligan would grab food when he was preparing it, and so he would make her sit at the table while he prepared the food in the kitchen. When she was eating, she would often put too much food into her mouth or try to eat too quickly.

[77] Ms Gilligan's support workers all said that they provided 'person-centred care' to Ms Gilligan, and that, under this model of care, Ms Gilligan was to be subject to the fewest possible restrictions and have as much choice as possible in her day-to-day decision-making.

[78] Mr Swain advised that, in respect of restrictive practices:

*I think our philosophy isn't so different to the philosophy – philosophy of the NDIS Quality and Safeguards Commission, which is that restrictive practice should be the least restrictive and only used absolutely as necessary and should be regularly reviewed and should absolutely be undertaken – um – with the approval of the substitute decisionmaker.<sup>28</sup>*

[79] When asked whether Endeavour had any protocol or policy in respect of takeaway food for participants, Mr Swain said he was not aware of any, and that:

*In – in fact, I would – um – suspect that it would be something that – that may be encouraged from time to time as part of community access – um as a – a general support to promote that independence but – ah – I would say that that's something that needs to be – ah – communicated with and*

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<sup>28</sup> Transcript, Day 4, T 46L8.

*resolved with the substitute decisionmaker depending on who the decisionmaker is.*<sup>29</sup>

## **Findings on issues**

### ***Issue 1: Whether the care and level of supervision provided by Ms Lowry to the deceased on 29 April 2021 was appropriate.***

[80] On 29 April 2021, Margaret Lowry was the support worker on shift caring for Ms Gilligan. As outlined above, Ms Gilligan's family expressed concerns about Ms Lowry's care of Ms Gilligan, particularly on that day.

#### *Ms Lowry's evidence*

[81] Ms Lowry did not provide a statement during the investigation but gave a contemporaneous account of the incident in a RiskMan Report and an account of the incident to another employee of Endeavour in a 'Fact finding' interview. Ms Lowry also gave evidence during the inquest.

[82] Ms Lowry advised the court that she started working as a disability support worker with Endeavour in June 2020, at which time she was employed on a permanent part-time basis. She had worked as a disability support worker for 12 months with St John's, and she had attained her Certificate 3 in Individual Support. Previous to working in disability support she was a Kindergarten Inclusion Support Assistant working with children with disabilities.

[83] Endeavour records show that Ms Lowry had completed the Endeavour Safe Swallowing training module and was issued with a certificate of completion on 19 August 2020.

[84] Ms Lowry was asked what her first impression of Ms Gilligan was when she began working with her, and said that:

*My impression of Bridie, she's – she was a – a lady that had a disability. She was – how could I say? I guess she was very young in the mind and she didn't trust people when she first met them. And it took a while to, you know, get a bond with her and – but she was – she had plenty of life in her. Like, she loved music and she loved being outside. She loved drives in the car. She was just a – a beautiful – beautiful girl, lady.*<sup>30</sup>

[85] Ms Lowry was asked about how she got to know Ms Gilligan and find out information about her, and she said that she started on buddy shifts with Fatima, who introduced her to Ms Gilligan and showed her some hand signs and ways to interact with Ms Gilligan. Ms Lowry asked for extra time to go in on a Saturday and read Ms Gilligan's paperwork, because she found that when she was on shift Ms Gilligan didn't like it when her

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<sup>29</sup> Transcript, Day 4, T 48L7.

<sup>30</sup> Transcript, Day 2, T44L24.

attention was on the paperwork. She recalled reading Ms Gilligan's ISP, her PSBP and other paperwork usually kept in the office. After about 5 buddy shifts, she started doing shifts on her own.

[86] Ms Lowry was asked if it took Ms Gilligan a while to warm up to her, and she said:

*Definitely. Definitely. We – you know, it did take a long time and the – the – when I noticed her – she would come up to me, you know, and just put her head on my shoulder and, you know, sit next to me, that was a – a definite sign that she was starting to warm up to me. I was told by nearly every support worker that worked with Bridie that it would be 12 months before she fully trusted me and that until she fully trusted me I was going to see the escalations with the shower and the toilet and everything like that.<sup>31</sup>*

[87] Ms Lowry gave evidence that she often had conversations about Ms Gilligan with other support workers during shift changeover, and that she was “always asking questions”<sup>32</sup> about how to deal with Ms Gilligan's escalations in behaviour.

[88] Ms Lowry said that she recalled Ms Rees' Meal Plan and Recipe book, and that they were in Ms Gilligan's folder in the office. She didn't recall if she referred to them when making meals for Ms Gilligan, but she thought she must have because she remembered making zucchini slices from the Recipe Book. She knew that Ms Gilligan's dinner meals were already in the fridge, and she would offer Ms Gilligan oats or Weetbix for breakfast. At lunch, she would give Ms Gilligan whatever was in the fridge or make a ham and cheese sandwich or give her Weetbix if she wanted it.

[89] Ms Lowry gave evidence that she knew she had to cut Ms Gilligan's food up into small pieces because she'd been told to do that by the other support workers, but she also recalled the safe eating training she'd done with Endeavour and in her previous job with children. She said she had an understanding of what 'soft foods' were from her training, and she was aware the food should be able to be cut with a fork, had to have moisture in it to help it go down.

[90] Ms Lowry told the court that she had never purchased a Yumbo burger for Ms Gilligan before, but that she had given her a MacDonalds cheeseburger about three or four times previously as a treat. Ms Lowry said that she'd talked to other support workers and that Mr Tanswell said he had got Ms Gilligan takeaway food from MacDonalds. She explained that she would cut or break the burger and the mince patty into small pieces for Ms Gilligan and that she had been fine eating them on the previous occasions.

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<sup>31</sup> Transcript, Day 2, T49L22.

<sup>32</sup> Transcript, Day 2, T50L1.

### *The choking incident*

[91] Ms Lowry's RiskMan report of the incident during which Ms Gilligan choked on 29 April 2021 was as follows:

*The day with Bridie began with Bridie waking at 0700. Bridie showered but was choosing to not get dressed. Bridie sat and had Weetabix and prunes for breakfast. Medications were given. Bride would communicate that she wanted assistance with getting dressed by bringing me her clothes. Bridie would then pull away and choose to not get dressed. SW tried putting music on and using distraction and redirection to get Bridie to engage appropriately. Utilising music, massage and contact to reduce Bridies anxiety. Bridie continued to urinate on the floor. Eventually Bridie responded well to the music and drifted off to sleep. Sleeping for half an hour. Once awake Bride was responding calmly and communicating well and following prompts. SW took Bridie for a drive and to get some take away as a treat and drove around the neighbourhood listening to music. Once back on site Bride exited the vehicle safely. SW put food on the bench to prepare the food for Bridie. Bride grabbed the burger and ran outside before SW could prepare the burger in small cut pieces. Bridie shoved most of the burger into her mouth while running. Bride turned and began to pull what she could out of her mouth. Some of the food was still lodged in her mouth. Bride was at this stage showing signs of choking. Bridie Was assisted by SW to try dislodge the food. Failing this SW tried placing Bridie in to recovery position to open airways and began to call for assistance. Bride still conscious at this stage being resistant to help being offered. 000 gave specific instructions to attempt to dislodge the food and then directives to begin CRR as Bride had become unconscious at this stage. Not breathing and not responding. SW continued to perform non breathing single person CRP. Ambulance arrived and took over. Phone operator remained on the call till Ambulance arrived. Response time was 10 minutes. SW was advised to stride her to massage and press the food from lodgement. SW followed this. Strategies utilised to dislodge the food were Finger inserted into mouth to attempt to remove food. Bride had her mouth clenched at first making it impossible to dislodge the food. At one stage Bride did sit up lent forwards seemingly attempting to breath and dislodge the food. Bridie was loosing colour and lips turning blue.<sup>33</sup>*

[92] During her evidence at the inquest, Ms Lowry said that she and Ms Gilligan had had a difficult morning, but when she said they'd go and get lunch out, Ms Gilligan got dressed straight away and "away we went".<sup>34</sup> during their drive, they ended up at Mount Sheridan, and she thought they would though the drive though and get a burger, thinking of a cheeseburger. She then saw there was a new burger called a Yumbo

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<sup>33</sup> Exhibit C4.1, page 2.

<sup>34</sup> Transcript, Day 2, T60L4.

burger, and she knew Ms Gilligan liked ham and cheese. Ms Lowry said that she thought the Yumbo burger might be a healthier version of a cheeseburger. She did not know if the Yumbo burger had any sauce on it, but she thought that it was soft enough for Ms Gilligan to have cut up.

[93] Ms Lowry's evidence was that, after she bought the Yumbo burger:

*So then we got – we drove back to the house and I got out of the vehicle and Bridie was still in the car. So Bridie didn't like to get – didn't like you to open the door for her or try and get her out of the car like – she would just slam the door shut again. And so to – to help her exit the car, we – I would walk away from the car, and so I went inside and I heard the – when, you know, I was in the – put everything down on the – the table outside the – because there was chips and all that involved, so I put all that down. And then I took the two burgers and put them on – because I had one, too. Put them on the bench in the kitchen. And then the – I heard the car door close and Bridie came in and walked up to the bench. And it just looked like she was just going to do what she normally would do and stand there and watch while you cut it all up. So I turned away to get the knife and – and then she just grabbed the burger and went out the sliding door. And then the kitchen is shaped – like, I was in the kitchen and she was on the side next to the door. So she went outside and she was eating the burger and I come around and I said to her, "Come on, Bridie, you know, I've got to cut that up. You need to let me do that" and she just kept pushing it in her mouth. And then I – I saw that she dropped the burger on the ground and then she was walking towards me. She was – there was no sound. And I realised she was choking. So I – I started walking towards her and she's come towards me and I turned her around and I hit her on the back a couple of times and put my finger in her mouth to try and get it out. She bit down on my finger and she didn't understand what I was trying to do and she was trying to wriggle away and pinch me and I realised that I wasn't going to get anywhere with doing what I was doing. So she lay down, I lay her down on the ground and then I went and got my phone and I called Triple O.<sup>35</sup>*

#### Call to QAS

[94] Ms Lowry's phone records show that the call to 000 was made at 1:09pm. Ms Lowry gave evidence that a call shown in her records between 12:53 and 12:57pm was to her husband. She did not recall that phone call by the time of the inquest. However, she was sure that she was not still on the phone when Ms Gilligan took the burger from the kitchen bench. She thought that the time between when Ms Gilligan grabbed the burger and when she made the 000 call was a few minutes.

[95] The 000 call was recorded, and the recording lasts for 10 minutes and 27 seconds. Ms Lowry says Ms Gilligan is choking. She is heard

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<sup>35</sup> Transcript, Day 2, T60L30.

encouraging Ms Gilligan, and says Ms Gilligan is spitting it up. Ms Gilligan was noted to be still choking but spitting some of it out. Ms Lowry was trying to roll Ms Gilligan on her side, her mouth was tight shut, she was alert, but she was choking and could not spit it out. Ms Lowry noted Ms Gilligan was going blue around the lips. She was not breathing. The QAS call taker provided instructions to try and push Ms Gilligan's stomach to dislodge the obstruction. Ms Gilligan became unconscious. Ms Lowry was unable to provide mouth to mouth due to the choking. She was provided instructions on chest compressions by the QAS call taker. Ms Lowry noted Ms Gilligan's head kept bumping on the concrete. Ms Lowry commenced and continued CPR until the paramedics arrived.

[96] Ms Lowry confirmed that, after the paramedics took over, she called Mr Groenewoud to tell him what had happened. Her phone records show that this call was made at 1:23pm.

#### *Expert evidence*

[97] Dr Aran Thillainathan is a Forensic Physician at the Queensland Government Clinical Forensic Medicine Unit (**CFMU**). At an early stage in the coronial investigation, Dr Thillainathan was asked by a Coronial Registrar to review the investigation material and provide an opinion as to the care and supervision provided to Bridie. In a report dated 7 May 2021, Dr Thillainathan provided the following opinion:

*In my opinion, Ms Gilligan was provided with adequate and appropriate care at the home.*

*The carers at the facility would prepare her food and supervise mealtimes according to her care plan. Other measures were in place to manage Ms Gilligan's behaviours. For example, cupboards were all secured with childproof locks. She was learning to better manage her food and had started to put hot foods in the fridge to cool down prior to eating them.*

*This incident did not occur as a result of the care staff feeding Ms Gilligan an inappropriate diet. This occurred as a result of impulsive behaviour by MS GILLIGAN during meal preparation. Overall, MS GILLIGAN appears to have had the appropriate level of supervision. She was not left alone and unattended. The care staff responded immediately as best they could and provided appropriate basic life support.<sup>36</sup>*

[98] Later in the investigation, Dr Thillainathan was asked to provide an opinion in respect of:

- a. Ms Lowry's response to the choking incident and her care of Ms Gilligan during the emergency; and

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<sup>36</sup> Exhibit B1, page 2.

- b. Whether Ms Gilligan's diet and meal plan would include a burger as a suitable food for Ms Gilligan.

[99] Dr Thillainathan provided a statement dated 3 February 2022 in which he answered those questions as follows:

- a. In my opinion the emergency care and response provided by the carer was adequate given her expected level as a carer; and
- b. In my opinion, a burger and bun are NOT considered suitable food as per the diet and management plan as prepared by the nutritionist.

[100] Clarification was subsequently sought from Dr Thillainathan as to whether the description of the Yumbo burger as "a soft bun with ham and cheese and...not what is typically described as a "burger" in the ordinary sense" would alter his view as to whether this food was compliant with Ms Gilligan's Meal Plan. Dr Thillainathan's response was, effectively, that he relied on Ms Rees view that a 'burger' was not an appropriate meal for Ms Gilligan.

[101] Dr Thillainathan gave evidence at the inquest and confirmed the evidence in his report and his statement. He advised that, because he was not a nutritionist and a dietician, he could not give further evidence about whether there was a material difference between the Yumbo burger and the sandwiches prescribed in the Meal Plan.

#### *Witness evidence*

[102] Various of Ms Lowry's co-workers gave evidence at the inquest and were asked for their opinions of Ms Lowry's work and care of Ms Gilligan.

[103] Patrick Rolletschke, Bridie's prime Endeavour support worker at Venus Battery Close. When asked his opinion of Ms Lowry as a support worker for Ms Gilligan, Mr Rolletschke gave the following evidence:

*And what was your opinion of Margaret as a support worker for Bridie?---Yeah. I mean, she tried her very best, you know, to support her. And she had some experience with autistic children. But – I don't know with Bridie – if she – it was known she was maybe not the best-suited person to work with Bridie. But she put a lot of energy in it and was dedicated to her. And she would have done maybe in a different place much better.*

*Can you explain a little bit [indistinct] why you think she wasn't the best-suited person? What are your reasons?---I guess it was depending on Bridie.*

*I'm not sure entirely what you mean. Do you mean it was whether or not Bridie got along with her, with Margaret? Is that what you're saying?---I*

*guess it's like this – not everyone warms up with anyone, you know. With some people you warm up. With some people, you don't warm up. Not – it has nothing to do with any patient and what the person brings in. So it's – in some places, you do really well. It's not necessarily the qualification or what you bring in, you know, to work with someone.<sup>37</sup>*

[104] Mr Rolletschke went on to confirm the view he gave in his statement, that “Margaret sincerely cared for Bridie and was dedicated to her care”.<sup>38</sup>

[105] Mr Groenewoud acknowledged, in cross-examination, that Danny had told him that Ms Gilligan wasn't getting along with Ms Lowry, and that Ms Lowry needed to be removed from the house. Mr Groenewoud gave evidence that he escalated Danny's concerns by raising them with his Endeavour manager, John Wilson.<sup>39</sup> He was asked if he ever raised this with Ms Lowry as a formal complaint, and said that:

*---Um – it wa – I believe we'd had brought up a few times that – um – her – um – continuous incident reports had been a small issue – um – and I had spoken to her about – um – that that had been brought up and that I had spoken to John about it – um – but it was also – she was brand new to the house. Um – what she was doing with Bridie on those occasions I couldn't fault. Her care level was there, her attendance was there. Um – her heart and soul was into trying to make that work.*

*Okay, so it wasn't the case – when you say the number of RiskMans that – it's not the case that you spoke to her about what was in them or anything like that, is that right?---Ah – Ms Lowry was – um – often second guessing her capabilities as a support worker. Ah – I'd seen Ms Lowry work in both my sites and – um – her – her work is above and beyond – ah – any given day, you couldn't fault it. Um – many support workers would not report a lot of the incidents that – that Margaret did. Um – she was straight down the line and upfront with everything she did.*

*And very diligent, then, in - - -?---Absolutely.*

*- - - reporting?---Yeah.<sup>40</sup>*

[106] Bradley Tanswell was asked for his opinion of how Ms Lowry interacted with Bridie and replied “very well”.<sup>41</sup> He advised the court that he had never observed anything that caused him concern about Ms Lowry's interactions with Ms Gilligan. He agreed with questions put to him in cross-examination that Ms Gilligan did not warm to him instantly, and it took months for her to get used to him as her support worker.

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<sup>37</sup> Transcript, Day 1, T23L28.

<sup>38</sup> Exhibit D13, at [34] and Transcript, Day 1, T24L10.

<sup>39</sup> Transcript, Day 4, T22 – T23.

<sup>40</sup> Transcript, Day 4, T26L30.

<sup>41</sup> Transcript, Day 1, T71L21.

## Conclusions

[107] I find that the care and level of supervision provided by Ms Lowry to the deceased on 29 April 2021 was appropriate.

[108] Although Ms Gilligan did not warm to Ms Lowry immediately, the general opinion of Ms Lowry's co-workers was that Ms Gilligan always took some time (up to a year) to adjust to new support workers, and Ms Lowry was good at her job and genuinely did her best to care for Ms Gilligan. Ms Gilligan's family raised concerns about Ms Lowry working with Ms Gilligan, and these concerns were escalated to management. The concerns expressed by Ms Gilligan's family must be balanced against the fact that Ms Gilligan was a challenging client who did not cope well with new support workers. Accordingly, any change to Ms Gilligan's regular support workers would have been approached with caution by Endeavour.

[109] Further, although Ms Lowry provided Ms Gilligan with takeaway food, there were no Endeavour policies or rules against support workers giving clients takeaway food. Despite some disagreement among individual support workers about whether this was an appropriate thing to do, Mr Swain confirmed there was no formal policy about takeaway food and that, in some circumstances, it might be encouraged to promote a client's independence. He noted that this is something which should be discussed with a client's decision-makers.

[110] In written submissions, Ms Gilligan's family point out, as I did during the inquest, that Ms Gilligan did not have capacity "to make informed choices and to accept the risk of eating a more diverse diet".<sup>42</sup> On this basis, the family said, in their submissions, that:

*Where a person is unable to make an informed choice to accept the risk, then it falls to the substitute decision maker to make such a choice. In this case, the substitute decision maker was Bridie's mother, Delia Gilligan. Ms Gilligan was not given the opportunity, nor did she make the decision, to provide Bridie with fast food in the form of the Burger. This decision was made by Ms Lowrey on the day in question.<sup>43</sup>*

[111] There is no evidence before me that any of Ms Gilligan's support workers (or other Endeavour staff) raised the question of the suitability of takeaway food for Ms Gilligan with Delia. I will consider this point further below in respect of Issue 2.

[112] In respect of Ms Lowry, I agree that there is no evidence which suggests that Ms Lowry asked Delia whether the Yumbo burger specifically was a suitable food for Ms Gilligan. I accept that it is reasonable for support

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<sup>42</sup> Written submissions on behalf of the family, [53].

<sup>43</sup> Written submissions on behalf of the family, [54].

workers to make day-to-day choices for their clients based on their knowledge of the client and the client's documented plans, assessments, reports and supports. In Ms Gilligan's case, I note that the evidence is that Delia, as decision-maker, had signed Ms Gilligan's ISP, been provided with a copy of her PBSP, and likely been provided with copies of the Meal Plan and Recipe Book.

[113] Ms Lowry's evidence, which was not challenged, was that she had given Ms Gilligan cheeseburgers before, and Ms Gilligan had been able to eat them when they had been cut up into small pieces in accordance with the way in which all Ms Gilligan's food was prepared. On the day she bought the Yumbo burger as a treat for Ms Gilligan, she considered that a Yumbo burger might be healthier for Ms Gilligan than a cheeseburger, she knew Ms Gilligan liked ham and cheese, and she intended to cut it up before Ms Gilligan ate it.

[114] I will consider questions as to whether the Yumbo burger was a food which complied with Ms Gilligan's prescribed diet below in respect of Issue 2. In respect of Ms Lowry's assessment of this food as suitable for Ms Gilligan, I find that it was not unreasonable for Ms Lowry to assume that it was suitable in circumstances where Ms Gilligan's meal plan included sandwiches, support workers had not been provided training by Ms Gilligan's dietician or the speech pathologist as to the specific requirements of either a 'soft food' or 'soft and bite-sized' diet, and there was some latitude allowed in Ms Gilligan's diet to allow preferred foods even if they were not strictly in accordance with her recommended diet.

[115] There is no evidence that Ms Lowry did not take appropriate care when she went to prepare the burger for Ms Gilligan. The evidence of Ms Gilligan's support workers, generally, was that they had to be aware of Ms Gilligan around food, because she sometimes tried to grab the food, or the knife, but that they tried to let her be as involved in meal preparation as they could. Unfortunately, on this day, Ms Gilligan did grab the burger before it was cut up.

[116] Finally, I find that Ms Lowry took appropriate steps in response to Ms Gilligan choking. Ms Lowry gave evidence that when Ms Gilligan grabbed the burger, she did not chase Ms Gilligan immediately because she knew doing so might escalate Ms Gilligan further. She spoke to Ms Gilligan calmly and asked her to give the burger back so it could be cut up. When she went outside and realized Ms Gilligan was choking, she called QAS immediately and followed their instructions while the ambulance was on its way.

***Issue 2: Whether the systems and processes the Endeavour Foundation had in place for the care of the deceased regarding her diet and nutrition was appropriate.***

[117] I note at the outset of this discussion that, as Mr Swain outlined in his evidence:

*Endeavour is not a hospital or health provider. In the case of Bridie, it provided services to enable independent living and provide supports that promote individual choice and control.*

*Endeavour, and organisations like ours, are reliant on third party health practitioners, often engaged or approved by (external) Support Coordinators or decision makers (such as family) to provide health related advice or guidance.<sup>44</sup>*

[118] As outlined above, Ms Gilligan's Endeavour support workers obtained guidance in relation to Ms Gilligan's diet and nutrition from dietician Ms Rees and Speech Pathologist Ms Campbell. The advice and information provided by those third-party health providers is then incorporated into Ms Gilligan's Endeavour support framework, most notably her ISP, and communicated to her support workers through that document and/or via training or informal discussion.

[119] Accordingly, Endeavour, and Endeavour staff, were responsible for implementing systems and processes regarding Ms Gilligan's diet and nutrition and ensuring that they complied with the advice given by the Dietician and the Speech Pathologist, while allowing Ms Gilligan individual choice and control.

[120] However, in Mr Swain's view, it was Ms Gilligan's support co-ordinator, Mercy Community, who had responsibility for ensuring follow-up appointments with allied health were made, specifically, to re-book an appointment for Ms Campbell to finish Ms Gilligan's dysphagia review. Mr Swain explained that this was the role of the support co-ordinator under Ms Gilligan's NDIS funding package.

[121] Mr Swain was frank about the difficulty this split in responsibilities posed to Endeavour:

*It's an uncomfortable position, though, for the – for Endeavour, though, isn't it? It's – for Endeavour, though, isn't it? Because you're on notice that she has dysphasia and you're on notice that there needs to be some review of her diet and you're not in control of when that will occur and your people aren't informed of what immediate steps should be taken to mitigate risk?---Your*

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*So ---?--- --- Honour, it – it – it is a very difficult position and fundamentally – um – you know, our staff, and I think you would have seen it through some of the e – evidence tendered here, are very strong advocates and – um – you know, advocating for, you know, appropriate services to be provided and so forth. Um – but with the change to the NDIS, we're not the ones procuring that - - -*

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<sup>44</sup> Exhibit D10, [92] – [93].

*[indistinct]?--- - - directly. So – so that is frustrating. Having said that – um – it is still our responsibility to make sure that we’re providing safe care.*

*Indeed?---That’s - - -*

*Okay?---That’s funda – fundamentally important. In this case, when I look at it, there were recommendations provided by the speech pathologist that – um – were then taken into consideration by the dietician and that was providing ins – instruction to our staff. So there was evidence for me that – um – the staff were – there was increasing instruction for them to ensure that they were providing safe support.*

*Like the dietetics input? Okay, thank you.<sup>45</sup>*

### *Evidence of Ms Rees and Ms Campbell*

#### Ms Rees

[122] Ms Rees gave a statement in which she advised that she conducted two home visits with Ms Gilligan and was also sent documentary information about Ms Gilligan by Mercy Community for the purpose of her assessment. This information included Ms Campbell’s Dysphagia Review Report.

[123] Ms Rees gave evidence at inquest that her purpose in providing her Meal Plan and Recipe Book for Ms Gilligan was to assist Ms Gilligan’s support workers who in her view, had “very limited nutritional knowledge regarding what [Ms Gilligan] should be eating”<sup>46</sup> at the time of her assessment. She said that she included bread and sandwiches in her meal plan even though “they’re not traditionally prescribed on a soft diet”,<sup>47</sup> because on the information she was given, Ms Gilligan could eat bread.

[124] Ms Rees said she included muffins and pikelets in her plan, which were not traditionally part of a soft food diet, because “they were a similar texture to bread and could be chopped with a fork and in small pieces”<sup>48</sup> and Ms Gilligan could self-feed with those foods which gave her some independence and a sensory experience. Ms Rees described these types of foods as “eat at own risk”.<sup>49</sup>

[125] Ms Rees gave evidence that she would not consider a burger, or a bun, to be suitable food for Ms Gilligan, and would not have included any type of burger in her plan, even if it was cut up. She explained that a bun with a crust would be too hard and have too much volume to be chewed

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<sup>45</sup> Transcript, Day 4, T51 -T52.

<sup>46</sup> Transcript, Day 2, T8L9.

<sup>47</sup> Transcript, Day 2, T9L19.

<sup>48</sup> Transcript, Day 2, T12L17.

<sup>49</sup> Transcript, Day 2, T12L37.

easily and could not be swallowed easily without condiments to soften the bread. Her opinion, based on a photo of the Yumbo burger, was that it was a burger as it was on a bun, it would have little to no nutritional value, and it would not be suitable for Ms Gilligan to eat. In response to a clarifying question from Your Honour, Ms Rees said that she would have considered the Yumbo burger as an “eat at own risk” food, but not suitable for a meal plan.

[126] Although Ms Rees gave evidence that “[w]e always work with the speech pathologist when we’re designing these types of plans”,<sup>50</sup> she did not work directly with Ms Campbell on Ms Gilligan’s case. Instead, Ms Rees relied on the information in Ms Campbell’s Dysphagia Report.

[127] Ms Rees said in her statement, and confirmed in her evidence, that when she attended Ms Gilligan’s house for a follow-up visit on 26 March 2021, she saw her Meal Plan on the wall, but the support worker (Ms Lowry) wasn’t able to locate the recipe book. She recorded on that day that “Bridie has been loosely following the prescribed meal plan”.<sup>51</sup>

[128] In cross-examination, Ms Rees said that she expected that Ms Gilligan’s support workers would follow her Meal Plan strictly and not, for instance, vary her prescription of egg or tuna sandwiches with a ham sandwich. She said that a ham sandwich would not be suitable food for Ms Gilligan, even when cut up, because it would not have enough condiments on it, and would be too dry to swallow easily. Ms Rees accepted that providing information in respect of ensuring that bread was sufficiently lubricated with liquid would have been important, and that, in hindsight, she might have given better specific guidance to Ms Gilligan’s support workers about this.

### Ms Campbell

[129] Ms Campbell gave a statement in which she described the appointment with Ms Gilligan on 9 September 2020 at Little Sparrows, and the circumstances in which Ms Gilligan’s dysphagia assessment had to be discontinued. Ms Campbell gave evidence that her Dysphagia Review Report set out what she was able to observe, which was that Ms Gilligan did not chew her food completely, would hold food in her mouth, and would not swallow completely. Ms Campbell said that her advice in her report to “continue soft diet”, was based on information provided to her about Ms Gilligan’s diet in a very short conversation after Bridie’s behaviour deteriorated.

[130] Ms Campbell gave evidence in her statement, and confirmed in cross-examination, that she did not apply the IDDSI ‘soft and bite sized diet’ framework because in September 2020 the NEMO ‘soft diet’ framework

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<sup>50</sup> Transcript, Day 2, T9L26.

<sup>51</sup> Exhibit D15.5, page 2 and Transcript, Day 2, T12 – T14.

was still being used in Cairns, as not all dysphagia suppliers had adopted the IDDSI framework at that stage.

[131] Ms Campbell gave evidence that she was not aware that a dietician would also be consulted for Ms Gilligan, but that dietetic information would have assisted her assessment. However, she would have required an additional appointment with Ms Gilligan in order to complete a full dysphagia review. She said that she expected that she would be contacted in respect of making a further appointment, but this did not occur. Ms Campbell had a telephone call with Ms Gilligan's Support Coordinator from Mercy Community, and explained that the assessment was not complete, but after an email from Mercy Community on 15 September 2020, did not hear further from Mercy Community, or Endeavour, regarding future appointments.

[132] When asked in cross-examination about her recommendation "continue soft diet" being relied on by Ms Gilligan's support workers, the following exchange occurred:

*And so my question to you is you understood, didn't you, that the report that you ultimately delivered to the support coordinator would likely then be passed on to those supporting Bridie to inform how they continued supporting her, did you understand that? ---Typically, this report isn't passed on. Typically a mealtime plan is, but this is a subsequent document that I produced that is in really big detail and it has exactly how to prepare foods, foods that are avoidable, things like that. I wasn't able to produce one of those because the assessment was incomplete.*

*And that's a document that normally you're engaged to prepare, not a dietitian?---Yes.*

*I see. All right. So did you expect in this case that you might then be given some further - a further referral to prepare that mealtime plan?---Absolutely.*

*I understand. All right. Or, in a different situation, you might be told that a dietitian had been engaged to prepare that plan?---If I was told that?*

*Yes?---Then I would inform the staff that that wasn't necessarily - so the document the dietitian produces, I suppose there's a difference between the two ---*

*Yes. Can you tell us - explain that for us?---Yes. So the document the dietitian produces should only include nutritional information, should be food only, and the particular meals that they want to eat to meet a calory goal. My particular report goes into texture and the style of food that are safe. So my document is then usually used to inform the type of foods placed in the dietitian's report. So mine usually has all - the current ones, but the previous ones would have the previous standard, but my current*

*ones have the IDDSI standard on it, exactly how to test fluids, test foods, exactly what those different standards look like and things to avoid.*

*Okay, all right. So where you've got a client, as in this case, that you knew was previously having a soft diet, you have an understanding as a speech pathologist about what that term means?---Yes.*

*And you would expect that, after delivering your initial report, which recommended the continuation of a soft diet, that there would be a further engagement to get you to provide information about what that actually means, is that right?---Yes. So in a complete assessment, it's built into the original bill. So it's usually a non-negotiable that I produce in order to keep clients safe. In this case there was not enough information to produce that non-negotiable document.<sup>52</sup>*

[133] Ms Campbell went on to give evidence, in answer to a question about whether she would do anything differently today, that:

*In all honesty, today, I would refuse to provide [any report at all] in order to encourage staff to return for a further assessment, because I do find that if they are provided documents like this, they will take them as law and not realise that necessarily a follow up assessment, despite that being made clear, is necessary. So I likely wouldn't have shared this document publicly, I would have insisted they come back so they could get a complete document.*

[134] Ms Campbell also advised that since the IDDSI framework has been adopted in full, she now sends out the IDDSI handout to support workers in addition to her own reports and mealtime plans.

#### *Expert evidence*

[135] The court briefed Dr Leisa Turkington, Senior Speech Pathologist at the Royal Brisbane and Women's Hospital, to give her expert opinion as to whether the dysphagia review completed by Ms Campbell and the meal plan developed by Ms Reece were appropriate for Ms Gilligan.

[136] In her report dated 26 July 2024, Dr Turkington advised that she had reviewed Ms Rees' Meal Plan and Recipe Book, and noted that:

- *The meal plan and recipe book include textures (e.g., pizza muffins) which are not compliant to IDDSI soft, bite sized texture as per IDDSI guidelines...*
- *As the meal plan and recipe book both include items with bread, which are not compliant with soft & bite sized textures or older definitions of soft developed in 2007..., a decision may have been made to have hamburgers cut up into small pieces with full assistance for quality of life reasons or within the context of informed*

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<sup>52</sup> Transcript, Day 2, T40L10.

*choice.... However, this is not documented so cannot be assumed. Hamburger, (whether presented in bite sized pieces or whole) is not compliant with sift, bite sized diet as per IDDSI guidelines.<sup>53</sup>*

[137] In respect of Ms Campbell's Dysphagia Review Report, Dr Turkington noted that it acknowledged "[t]he limitations of the clinical swallow assessment" and "specific guidelines were provided with regard to pacing of meal and size of bolus". However, "[i]t may have been useful to specifically comment on Ms Gilligan's history of impulsivity and to ensure food was kept out of reach".<sup>54</sup> She also noted that:

*Speech Pathologist made a recommendation for soft diet (small bites with supervision). This is not a currently recognised descriptor for texture modification for individuals with dysphagia. Under current [International Dysphagia Diet Standardisation Initiative (IDDSI)] labelling (2019) this could be interpreted as soft & bite-sized diet. It is not clear if this recommendation was meant to reflect soft & bite-sized diet...as per IDDSI framework for people with dysphagia....or whether this recommendation was meant to reflect older definitions of soft diet developed in 2007.<sup>55</sup>*

[138] As noted above, the soft/soft and bite-sized diet question was addressed by Ms Campbell in her evidence.

[139] Dr Turkington reviewed Ms Gilligan's ISP and made the following comments:

- *Given documentation of Bridie refusing or declining support, clear documentation of food textures that represent choking hazard and ensuring food preparation was not within Bridie's reach may have been beneficial. Given the length of this support plan a prominent alert positioned within the introduction section regarding choking may have been useful.*
- *Restrictive practices (page 6) may also have included limiting access to unsuitable food which may cause choking.*
- *Page 7 describes safe eating and description of impulsive behaviour....Mealtime management and food preparation activities may have benefited from consideration that Bridie did not always respond to cues to enable safe eating.*
- *...*
- *It was also documented that 'at times Bridie suffers dysphagia'. Dysphagia in people with Cornelia de Lange Syndrome is related to the genetic disorder with accompanying intellectual disability and is not episodic in nature. Therefore, the description of 'at times 'is not accurate. Bridie had dysphagia, with a need for constant risk management always.*

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<sup>53</sup> Exhibit H2, page 2.

<sup>54</sup> Exhibit H2, page 3.

<sup>55</sup> Exhibit H2, page 2.

- *'Impacts of customer if outcomes against NDIS goal are not achieved' (page 9) describes regression & increase in negative behaviours causing physical and mental health problems to manifest. Specific reference to choking on more challenging textures such as bread may have been beneficial.*
- *....Within the descriptions highlighting that Bridie could have unpredictable behaviour and self-regulation difficulties that could result in harm to herself or others, potential choking events at meals including on textures not meeting descriptors of soft, bite sized texture may have been beneficial.<sup>56</sup>*

[140] Dr Turkington also gave evidence at the inquest. She had been provided with Ms Campbell's statement which explained that her dysphagia assessment of Ms Gilligan had been cut short. Dr Turkington said that this explained to her why Ms Campbell's report was not as detailed as it could have been. She said that, notwithstanding the lack of information, Ms Campbell did have enough information on which to find that Ms Gilligan did have dysphagia. In cross examination, Dr Turkington agreed that without having sought more collateral information, Ms Campbell may not have had enough information on which to make a recommendation that Ms Gilligan continue on a 'soft' diet, and that her report did not clearly state that further assessment of Ms Gilligan was necessary.

[141] Dr Turkington explained that she would usually expect to see some collaboration between the speech pathologist and the dietician in creating a meal plan for a person with dysphagia. She was asked whether any of the food in Ms Rees' Meal Plan did not comply with the NEMO standards for 'soft diet', and advised that:

*Yeah, so from, um, um, a NEMO point of view, um, er, any of those baked products that were not, um, soft, um, so, um, even the fritters if they were, er, overly cooked may present as a problem so, um – and, um, the pikelets and the muffins. Certainly the muffins would not be compliant, um, because, um, of – er, the – on the old NEMO diet you could have soft sandwiches but no crusts and you had to have moist fillings, um, and certainly that pizza, muffin, particularly if it was, um, under the toaster for a bit long, that would comprise, um, being more of an easy chew or a full diet option.<sup>57</sup>*

[142] Dr Turkington's view was that the egg and tuna sandwiches from Ms Rees' Meal Plan would comply with the NEMO standard if the crusts were cut off and the sandwich was cut up into small pieces, and that a ham and cheese sandwich with butter, similarly prepared, would also comply. Dr Turkington was of the view that a Yumbo burger, although made of the same ingredients, would not comply because the greater volume and thickness of the bread in the bun would be more difficult to

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<sup>56</sup> Exhibit H2, page 4.

<sup>57</sup> Transcript, Day 3, T30L12.

chew and swallow. Dr Turkington confirmed that whole bread products were not included in the IDDSI soft and bite-sized diet.

[143] Dr Turkington explained that best-practice standards relation to the management of dysphagia, based on the most up-to-date guidelines and standards in relation to dysphagia circulated by Speech Pathology Australia,<sup>58</sup> would be to have multidisciplinary team involvement where and if possible, and for the risk of choking to be clearly explained in any meal plans so that carers are aware of the reasons for the modification of the patient's food. In respect of any modifications recommended, Dr Turkington gave the following evidence:

*Dealing with Bridie who was still in the community and being cared for by support workers and by her family, if there had been collaboration between the speech pathologist and the dietitian and they'd come up with a meal plan which said, "No bread products for Bridie because of her dysphagia" there could then have been a conversation, couldn't there, with Bridie's support workers and Bridie's family about whether that would suit Bridie?---Yes.*

*Because we have been told she did love bread, or she enjoyed eating toast and things like that. There could have been a conversation about balancing the risks of Bridie eating those products and her quality of life and how much she enjoyed certain things and whether certain things gave her independence and positive results. That's right, isn't it? Isn't it?---Yes. Yeah. Um, I – I obviously can't speculate because I don't have the information but we – we would actually usually discuss with family whether finger foods would give someone more independence or autonomy or if they really love something and it was a selective thing that they had from a quality of life, yes. And we would talk to families about how much risk they would accept or be prepared to accept, yeah.*

*Okay. And we also had some evidence this morning from the behaviour support practitioner who was working – who was engaged to do a positive behaviour support plan for Bridie that if she had been able to speak to the dietitian and the speech pathologist she could have determined the least restrictive ways for their recommendations to have been implemented. Is that something you've got any experience with?---Um, yes. So, yeah, I think it's, um, certainly, um, the actual method of delivery of the food or fluid, um, as in, um, how someone likes to be, um, given the food, um, the meal set up and all of those things that happen before you're even thinking about swallowing are important and certainly if someone knew her well from a behavioural point of view, um, that's really important information.<sup>59</sup>*

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<sup>58</sup> Dr Turkington provided the court with a copy of Speech Pathology Australia's (SPA) updated Dysphagia Clinical Guideline, which had not been released at the time of the inquest. The updated version was released on 17 March 2025 and is available to members of SPA through their website.

<sup>59</sup> Transcript, Day 3, T34L13.

### *Evidence of support workers*

[144] Ms Gilligan's support workers gave evidence during the inquest about their knowledge of the recommendations made and the information provided by Ms Rees and Ms Campbell. While all were aware of Ms Gilligan's dysphagia and that her food had to be cut into small pieces and be soft and easy to swallow or chew, they had varying knowledge of the Meal Plan and Recipe Book.

[145] When shown these documents in court, Mr Rolletschke said that he wasn't sure if he had seen the Recipe Book, and that he might have seen the Meal Plan. He commented that some of the recipes were not food which Ms Gilligan would have liked or that he wouldn't have given her because he knew it would cause reflux – for example, the lasagne. Mr Rolletschke said that he got his information about what foods to prepare for Ms Gilligan from staff members, Ms Gilligan's family, and from his own experience with Ms Gilligan.

[146] Mr Groenewoud said that he recalled that meal plans were up on the wall outside the kitchen but did not specifically recall Ms Rees' Meal Plan. He recalled seeing a recipe book but did not remember specific items in it. Mr Groenewoud said he recalled that "Bridie was very...set in certain food types and...there were some foods within the house that she would prefer".<sup>60</sup> He recalled some changes in Ms Gilligan's diet but could not be specific about those.

[147] Mr Tanswell said that the Meal Plan and the Recipe Book looked familiar, but he didn't really recall looking at them when he was preparing food for Ms Gilligan. He recalled that Ms Gilligan ate meals that had been prepared by her family, but other than that, he could not recall where he got his information about what Ms Gilligan should or should not eat.

[148] Ms Knowles could not recall seeing the Meal Plan or the Recipe Book. She said that she got advice from Ms Gilligan's parents about what Ms Gilligan should eat, how much to give her, and how small it had to be cut up.

### *Changes to Endeavour systems and processes*

[149] Mr Swain provided the court with information about the changes Endeavour had made to its policies, procedures and systems following Ms Gilligan's death. These changes included the following:

- A Safe Swallowing Safety Pause was carried out in May 2021, during which all Endeavour team leaders had discussions with their teams

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<sup>60</sup> Transcript, Day 4, T15L5.

of support workers “regarding the risk of choking and response to choking”;<sup>61</sup>

- The Workplace Health and Safety Team updated their processes regarding mandatory reporting to Workplace Health and Safety Queensland;
- The Safe Swallowing Learning Module was renamed ‘Supporting people at Mealtimes’ and updated;
- Mealtime management and safe eating practices are now outlined in Endeavour’s Complex Health (including High intensity Support) Procedure.

[150] Mr Swain advised that Endeavour has an internal auditing program but is also externally assessed against the NDIS Practice Standards and Quality Indicators. In assessments conducted in February and March 2024, Endeavour was assessed against these standards, which included ‘Mealtime Management’ and ‘Severe Dysphagia Management’, and “achieved conformity to all required indicators with no corrective actions identified”.<sup>62</sup>

[151] In response to a question about whether Endeavour had systems in place to ensure that recommendations or requests for input from allied health practitioners were managed in a timely way, Mr Swain advised that, at the time of the inquest, Endeavour was transitioning to an electronic care management system, which he expected would ensure better monitoring of requests for allied health services and accordingly, more time responses to those requests.

[152] I asked Mr Swain about the understanding by support workers of terms used by allied health practitioners, and the following exchange occurred:

*One of the matters that’s concerned me in this matter is the use of a term of art under the NEMO guidelines of soft foods and I think, at this point in time, having heard the evidence, there was an entire disconnect between what your carers thought that meant - - -?---Mmm-hmm.*

*- - - what the term of art meant. So if we’re looking at soft food you can crush with a fork or crush against the palate – soft palate with your tongue - - -?---Mmm-hmm.*

*- - - as compared to food that is soft, has there been – and you’ve just said it would have gone to the person who had that role, which was Ben at the time - - -?---Mmm-hmm.*

*- - - and he talked about soft food this morning and he said food that was soft. So that disconnect between clinical language and people who aren’t trained in clinical language, how is that captured so as to ensure that the*

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<sup>61</sup> Exhibit D10, [76] and Exhibit C93.

<sup>62</sup> Exhibit D10, [82] – [90].

*training these people get is what NEMO says soft food is?---Yeah. Your Honour, it – it highlights the importance of – ah – once that assessment’s undertaken, that there’s training from the health practitioner directly to the staff. That’s vitally important.*

[153] Mr Swain went on to say that, at the time of Bridie’s death, direct training by the speech pathologist or the dietician to his staff was not occurring, but that:

*---[t]hat’s certainly part of our procedures now and that’s our expectation now. Ah – whilst that’s in our procedures which – um – has – has been tendered as evidence as well, the challenges come whether that’s funded under the NDIS. So we have this circular loop that we know that it’s a – a good thing. More than a good thing. It’s – it’s really important – um – but whether there’s funding in a package and – um – and then what the wait time is for the timely intervention.<sup>63</sup>*

### Conclusions

[154] In written submissions, Ms Gilligan’s family submitted that, on the basis of Dr Turkington’s evidence, which was uncontested, I should find that:

- a. *Ms Gilligan [s]uffered from CdLS;*
- b. *Ms Gilligan [s]uffered from Dysphagia;*
- c. *Neither disorder was episodic in nature;*
- d. *Both disorders heightened [Ms Gilligan’s] risk with respect to swallowing and choking; and*
- e. *As a result, there was a need for continuous, best-practice, and consistent risk management.<sup>64</sup>*

[155] I accept those submissions.

[156] Ms Gilligan’s family also made the following submissions:

*The Gilligan Family submit that Bridie’s death was a preventable death. Bridie’s death was directly caused by Bridie being provided with, and attempting to eat an inappropriate food item – the Burger.*

*This submission raises a number of contentions:*

- (a) *Bridie had a high and unique risk profile with respect to her mealtime requirements and supervision due to her conditions;*
- (b) *There was neither timely nor appropriate assessment of Bridie’s risk by Endeavour Foundation, and as a consequence, their employees or agents;*
- (c) *There was no appropriate meal management plan put in place by Endeavour Foundation;*

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<sup>63</sup> Transcript, Day 4, T44L40.

<sup>64</sup> Written submissions on behalf of the family, [17].

- (d) *There was inadequate communication between Endeavour Foundation, their employees & agents, disability service providers and medical professionals with respect to Bridie's needs and risk; and*
- (e) *There was a lack of understanding of Bridie's risk by Endeavour Foundation employees & agents.*

*While the cause of Bridie's death has been viewed and crystallised through this singular incident, the Gilligan Family submit that, on the evidence, it is open for Her Honour to find that the cause of Bridie's death was a series of individual and systemic failures in the care provided to Bridie. This included missed opportunities to:*

- (a) *Properly assess Bridie's needs;*
- (b) *Develop an appropriate Dysphagia safe eating plan; and*
- (c) *Implement, monitor and update that plan.*<sup>65</sup>

[157] I accept that the submission that Ms Gilligan's death was preventable. Ms Gilligan's death was caused by her having access to a food item on which she choked.

[158] Whether that food item, the Yumbo burger, was inappropriate is a separate question. I find, on the basis of Ms Turkington's expert evidence, that the Yumbo burger was not a food, even if cut up into small pieces, which would have complied with the NEMO standards for 'soft diet' or the IDDSI standards for 'soft and bite-sized diet'. However, I also find that Ms Gilligan's Meal Plan and recipe book contained other foods which did not comply with those standards, and which Ms Gilligan was allowed to eat because she liked those foods and/or they gave her some level of autonomy or independence.

[159] I find that to have restricted Ms Gilligan's diet to foods meeting the recommended NEMO and/or IDDSI standards may have amounted to a restricted practice. If such a restriction was to be put into place, it would have required a clear recommendation from Ms Campbell (preferably after collaboration with Ms Rees) and input from Ms Gilligan's decision-maker, Delia.

[160] However, I do not accept, on the evidence before me, that the responsibility for the circumstances which led to Ms Gilligan's death lies with Endeavour Foundation or their employees and agents.

[161] As is outlined above, Mr Swain explained, during his evidence, the services which could be provided to Ms Gilligan by Endeavour. I note that Mr Swain's evidence was uncontested. In written submissions made on behalf of Endeavour, the following submissions were made in respect of the evidence given by Mr Swain:

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<sup>65</sup> Written submissions on behalf of the family, [30] – [32].

*The evidence, particularly Mr Swain's precis, highlights the difference between the Supported Independent Living (SIL) support provided to Bridie under the NDIS by Endeavour and the support and services provided to her by allied health professionals and arranged through Bridie's Support Coordinator, Mercy Community. In particular:*

- a. Mr Swain explained in his statements that Endeavour is not a health provider and its support workers are not health professionals. Endeavour relies on third party health practitioners to provide health related advice or guidance relevant to its clients.*
- b. Mr Rolletschke explained in his oral evidence at the inquest that a key difference between working as a disability support worker and working in a hospital or aged care environment is that, in a disability support setting, the support worker's aim is to support the client to live as independently as possible.*

*It is within this context that Endeavour's systems and processes must be assessed and considered.<sup>66</sup>*

[162] Endeavour's written submissions referred to the following evidence given by Mr Swain in his Precis of Evidence in respect of the role of a Support Co-ordinator under the NDIS:

*When a Support Coordinator is in place, they play a critical role. Unless there is an emergency situation, Endeavour or its support workers cannot refer a person to another allied health professional. That is the role and responsibility of the client themselves (or substitute decision maker) and choice and decision making is paramount.*

*On behalf of the client or substitute decision maker, the Support Coordinators actively support referral to other allied health professionals or services. They are the ones that make referrals to allied health practitioners and any other service that is required.*

*For more complex supports, there would typically be more funding for Support Coordination, and other supports, including (for example) positive behaviour or allied health supports.*

...

*In Bridie's case, the substitute decision maker would have appointed the Support Coordinator. The substitute decision maker would engage the services of the dietitian and speech pathologist through the Support Coordinator who facilitates this. These reports should be distributed to all those supporting Bridie including Endeavour by either the Support Coordinator or substitute decision maker for implementation.*

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<sup>66</sup> Written submissions on behalf of Endeavour, [35] – [36].

*I do not know if the meal plan and recipe book prepared by Alyce Rees was directly provided to Delia Gilligan. However, this would have been the roles of the Support Coordinator.*

*In relation to the Little Swallows dysphagia review report, it was clear the speech pathologist was not able to complete her assessment. In my view, this should have triggered a follow up appointment for an assessment to be undertaken. However, that is based on my professional knowledge and experience. Support workers are not health professionals and may not have recognised the need for further assessment given the report recommended “continue a soft diet” and advised that “any new concerns” should be referred back to Little Sparrows. If any further assessment was recommended or requested by the substitute decision maker, this would have involved the Support Coordinator and substitute decision maker.*

...

*If the speech pathologist thought a further assessment was needed for Bridie, I would expect that this would have been conveyed by the Speech Pathologist to the Support Coordinator and it is the Support Coordinator’s job to liaise with the client or substitute decision maker to ensure a follow up appointment happens, with the approval of the substitute decision maker.*

*If support workers had concerns with something, such as the safety of a particular type of food, I expect that they would have flagged it and this would have resulted in further advocacy for a repeat assessment, for example from a speech pathologist. While Endeavour can advocate for that, they are not the decision makers and this is up to the Support Coordinator and substitute decision maker.<sup>67</sup>*

[163] Endeavour acknowledged in written submissions that:

*[T]he introduction of the NDIS and the Support Coordinator role has created a separation between providers like Endeavour, who support clients to live independently, and the allied and other health services those NDIS participants need and consume.<sup>68</sup>*

[164] Endeavour also accepted that, in Ms Gilligan’s case, this separation resulted in:

- (a) No follow up speech pathology appointment being arranged for Bridie with Ms Campbell after the initial (partial) assessment.*
- (b) No communication or collaboration between Ms Rees and Ms Campbell with respect to Bridie’s meal plan or foods that were safe for Bridie having regard to her dysphagia.*

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<sup>67</sup> Precis of evidence by Mr Swain, [11]– [25].

<sup>68</sup> Written submissions on behalf of Endeavour, [40].

- (c) *No guidance or training being provided by Ms Rees or Ms Campbell, in their specialist capacities, to Endeavour support workers on the meaning of “soft diet” or the types of foods that were safe for Bridie having regard to her dysphagia.*<sup>69</sup>

[165] What is common ground between Ms Gilligan’s family and Endeavour is that the system under which Ms Gilligan was provided care did not properly identify and manage Ms Gilligan’s risk of choking which arose from her Cornelia De Lange Syndrome and her dysphagia. Ms Gilligan’s assessment by appropriate allied health practitioners was slow to occur and was not appropriately followed-up. In addition, the information provided to Endeavour and its staff by allied health practitioners was not sufficient for them to identify the real risk that bread products posed to Ms Gilligan, nor to prompt them to discuss with Delia whether she gave informed consent to Ms Gilligan being given foods of this type, including takeaway foods.

[166] I accept that Endeavour was not responsible for arranging assessments by allied health practitioners, nor for arranging follow-ups when required. Neither was Endeavour responsible for ensuring that correct and complete information about Ms Gilligan’s diet and nutrition was conveyed to Endeavour staff.

[167] I find that the systems and processes that Endeavour had in place for Ms Gilligan’s care regarding her diet and nutrition were appropriate. I also find that Endeavour has made sensible and appropriate changes to its systems and processes since Ms Gilligan’s death to ensure that a similar tragic outcome does not occur in the future.

***Issue 3: Whether the outcome would have been different for Bridie if the first QAS crew who attended had identified and removed the obstruction in her airway.***

[168] Dr Stephen Rashford, Medical Director of QAS, provided information to the court regarding the care and treatment provided to Ms Gilligan by the two QAS crews who attended on her. Dr Rashford provided the following information about the QAS response to Ms Lowry’s 000 call:

*...The incident was allocated a Code 1B (lights and/or siren) priority and an Advanced Care Paramedic (ACP) crew, comprising of ACP Patrick Joyce and ACP Liana-Ta Van Hoorn, were dispatched to the incident at 1.12 pm.*

*Additional information was provided by the support worker during the Triple Zero (000) call; Ms Gilligan had begun to develop cyanosis around her lips and she eventually became unresponsive. The Emergency Medical Dispatcher began to provide cardio-pulmonary resuscitation*

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<sup>69</sup> Written submissions on behalf of Endeavour, [41].

*(CPR) instructions over the telephone to the support worker, upgraded the incident to a Code 1A response priority, and dispatched a Critical Care Paramedic (CCP) and a second ACP crew to the incident. Code 1A is the highest-level priority response, reflecting the likelihood of cardiac arrest occurring.*

*The primary ACP crew arrived on scene at 1.18 pm and found Ms Gilligan to be in cardiac arrest, with the support worker performing effective CPR. The support worker advised the crew that Ms Gilligan was eating a burger and then collapsed. ACP Van Hoorn performed an airway manoeuvre to visually inspect Ms Gilligan's oropharynx, noting no foreign body was seen.*

*The crew continued to provide CPR and inserted an oropharyngeal airway, in an attempt to maintain Ms Gilligan's airway patency whilst providing assisted ventilations with a bag valve mask (BVM). ACP Van Hoorn specifically noted that there was no resistance on the BVM to indicate an airway obstruction. After six minutes of CPR, ACP Van Hoorn inserted a laryngeal mask airway (LMA), noting that no resistance was felt when ventilating Ms Gilligan.*

*At 1.28 pm the backup ACP crew, comprising of ACP Linda Goodman and ACP Davina Phillips, arrived at the scene. At 1.29 pm the CCP crew, comprising of CCP Megan Brown and CCP Joshua Elliott, arrived at scene. The CCP crew assumed management of Ms Gilligan's airway. Almost immediately, CCP Elliott noted that the LMA was in situ but was not providing adequate ventilation, with significant resistance to air flow being present when ventilating Ms Gilligan.*

*CCP Elliott subsequently removed the LMA and visualised Ms Gilligan's airway via direct laryngoscopy using a laryngoscope. CCP Elliott found Ms Gilligan's airway to be completely obstructed with ham and a bread bun. It required CCP Elliott multiple attempts to remove the obstruction using Magill's forceps and suctioning. Ms Gilligan subsequently achieved a return of spontaneous circulation and was transported Code 1 (lights and/or siren) to the Cairns Base Hospital.<sup>70</sup>*

[169] Dr Rashford advised that a review had been conducted of the incident and the QAS response, and that:

*...It was evident from this review that the primary ACP crew potentially missed a critical opportunity to remove the foreign body from Ms Gilligan's airway. Whilst this was corrected by the CCP crew upon their arrival, by this time, Ms Gilligan's airway had been obstructed for a total of 22*

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<sup>70</sup> Exhibit B4, pages 1 – 2.

*minutes (1.09 pm – 1.31 pm), including 13 minutes in the QAS’s care (1.18 pm - 1.31 pm).*<sup>71</sup>

[170] In response to this finding, Dr Rashford determined that both ACPs should undertake additional training in relation to foreign body airway obstructions and referred the matter to the Office of the Health Ombudsman (**OHO**) for independent assessment of the paramedic performance. Dr Rashford also advised of systemic steps QAS had taken to increase staff knowledge and education in respect of foreign body airway obstructions.

[171] The OHO referred the matter to the Australian Health Practitioner Regulation Agency (**Ahpra**), who investigated whether ACP Van Hoorn had provided adequate clinical care to Bridie in respect of the foreign airway obstruction. On 21 March 2022, Ahpra and the Paramedic Board of Australia determined that no further action would be taken, as ACP Van Hoorn had acknowledged the concerns and accepted that improvements could be made to her practice and she had completed additional relevant education and professional development as well as a period of supervised practice. Ahpra determined that those steps were “appropriate to address the concerns and mitigate any risk of harm to the public”.<sup>72</sup>

[172] The court sought expert opinion in respect of how this missed opportunity may have affected Ms Gilligan’s outcome from Consultant Emergency Physician Dr Sean Rothwell. Dr Rothwell, who is the Director of the Emergency and Trauma Centre at the Royal Brisbane and Women’s Hospital, reviewed the QAS records, Dr Rashford’s report and the autopsy report. He was asked to consider whether “the outcome for Bridie would have differed if the first [QAS] crew had identified and removed the obstruction in Bridie’s airway?”.<sup>73</sup>

[173] Dr Rothwell was unable to provide a definitive answer to that question although he hypothesised that, even in a best-case scenario, Ms Gilligan would likely still have experienced a period of at least 15 minutes without cardiac output. Dr Rothwell noted the following data in respect of the known survival rates for persons who have had a cardiac arrest:

*The survival rate for all out of hospital cardiac arrest in (sic) is less than 10% in most studies. Even with in-hospital cardiac arrest, the probability of survival in a witnessed non-shockable cardiac arrest with 15 minutes of CPR is approximately 5% and for 30 minutes of CPR is close to 0%.*<sup>74</sup> (References omitted).

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<sup>71</sup> Exhibit B4, page 2.

<sup>72</sup> Exhibit B6, pages 6 – 7.

<sup>73</sup> Exhibit H1, page 2.

<sup>74</sup> Exhibit H1, page 3.

[174] Dr Rothwell concluded that whilst there was a “very small chance”<sup>75</sup> of the outcome being different if the first QAS crew had identified and removed the obstruction, the likelihood is that the outcome still would have been the same for Ms Gilligan.

[175] Dr Rashford was given the opportunity to read and respond to Dr Rothwell’s report. In a letter to the court dated 12 August 2024 Dr Rashford advised that he agreed with Dr Rothwell’s opinion.<sup>76</sup>

### *Conclusions*

[176] On the basis of the documentary evidence outlined above it was determined, with the agreement of the parties, that this issue would not be considered further at inquest and, accordingly, no witness evidence was given in respect of this issue.

[177] I find that it is unlikely that the outcome would have been different for Ms Gilligan even if the first QAS crew who attended had identified and removed the obstruction in her airway.

### **Findings required by s 45 of the *Coroners Act 2003***

[178] I make the following findings:

**Identity of the deceased** – Bridie Gilligan, born 23 April 1979.

**How the deceased died** – Ms Gilligan, a 42 year old woman living with disability, was at her home in Venus Battery Close with a disability support worker on the afternoon of 29 April 2021. Ms Gilligan and her support worker had just returned from a trip in the car, and Ms Gilligan’s support worker had purchased each of them a Yumbo burger from Hungry Jacks. When they got home, Ms Gilligan’s support worker was about to cut up Ms Gilligan’s burger into small pieces for Ms Gilligan to eat, when Ms Gilligan grabbed the whole burger and ran outside. Ms Gilligan tried to shove the whole burger into her mouth and began to choke on the food. Her airway was blocked and she lost consciousness. The support worker called an ambulance and Ms Gilligan was taken to hospital but later died.

**Place of death** – Cairns Hospital, 165 The Esplanade, Cairns North, Queensland.

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<sup>75</sup> Exhibit H1, page 3.

<sup>76</sup> Exhibit B4.1.

**Date of death–** 3 May 2021.

**Cause of death –** Ms Gilligan lived with a long-standing intellectual disability associated with Cornelia de Lange Syndrome. Ms Gilligan’s death was caused by a hypoxic brain injury due to choking on food. Her Cornelia de Lange Syndrome is considered to have contributed to her death.

### **Comments and recommendations**

[179] In their written submissions, Ms Gilligan’s family provided references to a number of reviews and systemic studies which have examined choking and food aspiration as a cause of death of people with disability, and found that the rates of death from choking are higher for people with disability than for the rest of the population. As the family have submitted, choking and food aspiration is “a significant risk for people suffering the same conditions as [Ms Gilligan]”,<sup>77</sup> and this risk has been recognised nationally for some time.

[180] I thank the family for this information, and I agree that this is an issue which persists, despite having been the subject of much consideration and comment over the last decade.

[181] The family made no written submissions in support of any particular recommendations in their written submissions, noting that I had invited Endeavour, as a service provider operating within the disability support sector, to provide any practical recommendations they thought appropriate in the circumstances. Ms Gilligan’s family have urged me to carefully consider any proposed recommendations which may address this issue or go some way to preventing from it re-occurring.

[182] In its written submissions, Endeavour has provided some further relevant and useful information about the NDIS sector and suggested the following four recommendations:

#### **Recommendation 1 – *Information Sharing***

The National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission (**QSC**) undertake a review of Support Coordination and the systems and processes under the NDIS for SIL providers to access information about allied health supports and recommendations necessary to properly support NDIS participants. The review should include input from various stakeholders including SIL support providers, support coordinators, and allied health professionals, with a view to identifying suitable communication guidelines or protocols to ensure the timely and coordinated flow of information between providers under a participant’s NDIS Plan.

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<sup>77</sup> Written submissions on behalf of the family, [30] – [32].

## **Recommendation 2 – Complex Case Management**

That consideration be given by the NDIA to designating part of a participant's plan funding for complex case management. Such funding could be allocated to a Support Coordinator or the SIL provider, depending on what best suits the participant's needs. This should not be a decision-making role but rather would function as a coordinator across disability and health supports to ensure those providing day-to-day supports for independent living are aware of the participant's complex health needs as appropriate and health providers have access to accurate and relevant information and collateral from those who support the participant every day. Under such a model, the support provider best known to the participant would be able to take an active role in identifying and planning supports required and escalating requests for referrals and changes to Plan funding for those supports. Family and/or substitute decision makers would maintain their decision-making role and be supported to engage across the multi-disciplinary team.

## **Recommendation 3 – Guidance on managing conflicts between professional recommendations and participant choice**

The NDIA or NDIS QSC provide clear guidance to NDIS providers on managing conflicting professional health and allied-health recommendations and participant's personal choice, including how to record decisions and decision-making processes adopted in managing such conflicts.

## **Recommendation 4 – Funded training by allied health professionals**

The NDIA include appropriate funding in participants' plans to ensure allied health professionals are able to deliver reasonable and appropriate training to providers of SIL supports, under the participant's plan.

[183] I note that the NDIA did not appear, examine witnesses or make submissions at this inquest. Accordingly, I rely on the information provided to me by Endeavour, without input from the NDIA, as to the utility of these recommendations. I accept that Endeavour, as a long-standing, non-for-profit provider which operates in Qld, NSW and Victoria, has the knowledge and expertise to suggest practical recommendations, and particularly recommendations which have arisen from its careful consideration of the issues which have arisen in the course of the investigation into the circumstances of Ms Gilligan's death.

[184] Accordingly, I suspect that NDIA considered the recommendations provided by Endeavour.

[185] In written submissions on behalf of Ms Lowry it was suggested that I consider a further recommendation relating to the RiskMan portal operated by Endeavour: that it be made accessible to all Endeavour staff,

including sub-contractors, and that Endeavour establishes a system that prompts staff to check for new potential entries.

[186] In Ms Gilligan's case, while there was some discussion in the evidence of the fact that sub-contractors could not directly access the RiskMan portal, and evidence that staff who did have access would print out relevant entries for sub-contractors to be able to see, there is no evidence that this system contributed to or caused any Endeavour employee to be unaware of Ms Gilligan's previous incidents of choking and, therefore, unaware of her risk of choking in the future. Accordingly, I make no formal recommendation in relation to the RiskMan system operated by Endeavour.

[187] That said, I agree with the submissions made on behalf of Ms Lowry that "it would be beneficial for all support staff to have access to the RiskMan portal",<sup>78</sup> and I encourage Endeavour to explore ways to ensure that sub-contractors have access to the same information as employed staff.

[188] I close the inquest.

Stephanie Gallagher  
Deputy State Coroner  
CAIRNS

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<sup>78</sup> Submissions made on behalf of Ms Lowry, [67].