CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 2nd and 3rd days of August 2005 and the 15th day of November 2005, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Dimitra Damianou.

The said Court finds that Dimitra Damianou aged 79 years, late of 75 George Street, Thebarton, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 16th day of April 2003 as a result of asphyxiation, due to aspiration of food. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Mrs Dimitra Damianou, aged 79 years, died on 16 April 2003. She had been a patient in the Royal Adelaide Hospital (RAH) since her admission on 7 April 2003. On or about 7 April 2003 she had suffered a stroke which had badly affected her speech and her ability to swallow food safely without choking.

1.2. Patients who had a compromised ability to swallow food safely could be placed on special consistency diets. Depending upon the circumstances of an individual patient, the patient might be placed on a vitamised, minced or soft diet. The individual's diet would be determined by a speech pathologist who has skill in managing swallowing disorders, known as dysphagia.

1.3. On 10 April 2003 it had been determined that the deceased should have a vitamised diet.

1.4. On 15 April 2003 the deceased was transferred from a general ward to a specialised stroke unit in Ward R7 of the RAH.

1.5. In the light of the deceased's improvement since her admission, on 15 April 2003 a speech pathologist decided that the deceased should be trialed on what is called a soft diet for the lunchtime meal on the following day. Unlike a vitamised diet where the food is essentially fully mashed, and is much like baby food, a soft diet involves meals which although solid, are prepared so that the food can be broken easily in the mouth without a large amount of chewing. A vitamised diet for obvious reasons presented less danger to the patient than a soft diet in terms of the potential for choking or the aspiration of food into the lungs. The soft diet trial on 16 April 2003 was unsuccessful. An instruction was then given by the speech pathologist that the deceased should be placed on a minced diet which also has a consistency less solid than a soft diet.

1.6. For the next meal on 16 April 2003, the deceased was provided with a soft diet meal which was contrary to the intentions of the speech pathologist. In the course of the deceased's consumption of that meal, she choked on the food and aspirated some of it into her airways. Although this was quickly detected, efforts to clear the deceased's lungs and airways of the aspirated food were unsuccessful and she died.

1.7. In this Inquest I examined whether those at the RAH responsible for catering had been accurately informed of the deceased's dietary requirements on the day of her death, and in any event, how it had transpired that the deceased had been provided with the wrong consistency meal.

2. The events of 16 April 2003

2.1. On 16 April 2003, the deceased's dietary issues were being managed by a speech pathologist by the name of Ms Megan Herbert. Ms Herbert gave evidence in the Inquest. I also received in evidence a record of interview between Ms Herbert and Senior Constable Paul Gross of the Coronial Investigation Section, that had taken place on 16 July 2004 (Exhibit C7). It was Ms Herbert who had originally determined that the deceased should be placed on a vitamised diet. Speech pathologists, like medical practitioners and nursing staff, noted their examinations and recommendations on the patient's Inpatient Progress Notes. The deceased's progress notes were received in evidence (Exhibit C8). On 10 April 2003, Ms Herbert had noted, inter alia, that the deceased should commence a vitamised diet with close nursing staff supervision. Quite apart from this specific instruction, there was in existence at the time an RAH dysphagia management protocol that formed part of the

Clinical Practice Manual (dated September 2002, Exhibit C12d). This general document also sets out various requirements in relation to the management of a dysphagic patient's meal consumption. I return to this document in due course.

2.2. On 16 April 2003, Ms Herbert attended at Ward R7 to conduct the soft diet trial. She attended at lunchtime. The trial was conducted, after which Ms Herbert made an entry in the deceased's progress notes. The time of the notation was 1:20 pm which is important because that meant that both the trial and the entry into the notes occurred before the afternoon changeover of the nursing shift. The soft diet trial was unsuccessful and Ms Herbert listed her concerns in the notes which included reference to the deceased piling large amounts of food onto her fork or spoon, query occasional intermittent laryngeal penetration with nil evidence of aspiration, mild pocketing of food in the right cheek and mild oropharyngeal dysphagia.

2.3. Ms Herbert then wrote the following instruction into the notes:

'P/
- *continue minced diet (as kitchen unable to provide appropriate soft consistency diet ĉ minced meat*
- *Thin (normal) fluids*
- *Please check for pocketing in R) cheek post meals*
- *R/V $^{1}/_{7}$*'

The reference to *"pocketing"* in the right cheek is a reference to the deceased's tendency to store food in, and failure to swallow food from, the side of the mouth that was affected by paralysis, in her case the right side.

2.4. Ms Herbert told me that although the deceased's ability to manipulate and swallow food had improved from her previous assessment, it had not improved sufficiently for her to tolerate the soft diet. Accordingly, she wrote the instruction to have the deceased placed on a minced diet, which would have the consistency of say, spaghetti bolognese.

2.5. It is worthy of note that this written instruction, as with Ms Herbert's other written instructions, were prefaced by a plainly seen purple sticker which depicts the words *'SPEECH PATHOLOGY'*. The fact that notations about a patient's dietary issues are placed in the patient's progress notes, together with the fact that there was in existence a dysphagia protocol is reflective of the inescapable conclusion that the management of a stroke patient's diet is an important and integral part of the patient's overall management. The note that Ms Herbert made, and her instruction that the

deceased be placed on a certain diet, was clearly intended to be taken on board by the clinical staff responsible for her management.

2.6. Ms Herbert also told me that she would also have verbally advised the nursing staff of the dietary change. If that did occur in this instance, the communication would have been with a member of the nursing staff shift that had been completed by the time the deceased received her next meal. Ms Herbert also said that she spoke to the kitchen about the deceased's dietary requirements. She also believed that she had placed a card in the vicinity of the deceased's bed that bore some information about those requirements.

2.7. The next nursing shift commenced at 2:30 pm and it was during that shift that the deceased received her next meal which is the meal that led to the deceased's difficulties. That meal was served in the late afternoon and it consisted of a soft diet meal, namely chicken and carrots. The provision of that meal would, on the face of Ms Herbert's evidence, have been contrary to Ms Herbert's written instruction and verbal communication with the kitchen.

2.8. Ms Herbert was not going to be present at the deceased's evening meal. She described her expectations as to the input nursing staff should have had as far as the supervision of the deceased's consumption of that meal was concerned. She was asked at T24-25:

> 'Q. Having made the note that you did at 1320 on the 16th, where you have written 'Continue minced diet'. What would your expectation have been of the nursing staff in relation to when they came to supervise her next meal.
>
> A. With the mince diet, when I would have requested the mince diet, I would have also spoken to the nursing staff and requested they change that on the meal list, because that was our procedure as well. Then they would have just had to give her distance - what I would call distant supervision which is just keeping a – they wouldn't have to set with her at a meal, because she wouldn't be in danger of aspirating with the mince meal so much, but it would just be a matter of saying to them after she's finished her meal, can you just check for pocketing. The fact that she'd been managing her vitamised diet up until that point.
>
> Q. Would you have expected them to check to see whether or not she received a minced diet meal before it was actually consumed by her.
>
> A. I'm not sure that they checked that was the procedure that - it's not something that I would have expected them necessarily to have checked for, before she'd started eating her meal. Because normally the kitchen would just bring up the meal and that would be appropriate to that bed. But if she was having trouble when the nursing

staff had noted, then they would then check to see whether she was supposed to be on that consistency.'

She also stated at T26:

'A. Yes, I would just expect them to keep a distant observation and just to occasionally just check on her and see how she was managing, and then to check for pocketing when she'd completed the meal. Because people are always going to pocket some food in their mouth during a meal, so it would be more after she'd completed her meal.'

2.9. Ms Herbert's expectations are to be examined against the relevant requirements of the dysphagia protocol, which included:

'**4 Nurses role within the multidisciplinary team approach**

- Ensure that the texture, consistency and type of food and fluid is provided as ordered'

5 Considerations before feeding

- Check the patient's ability to communicate swallowing difficulty when feeding

7 Items to avoid when assisting the dysphagic patient with oral intake

NOTE: Diets should be ordered by the speech pathologist and dietician and should be strictly adhered to for inpatients.

8 Feeding Techniques

- If patient has unilateral paralysis, place food in the unaffected side of the mouth
- Check the mouth for pocketing of food

10 Interventions to reduce the risk of aspiration

- Follow strictly the recommendations made by speech pathology concerning diets
- Never leave the patient alone with food or fluids'

2.10. In the event, the following is an account of what actually transpired when the deceased received her evening meal.

2.11. I heard evidence given by two of the nursing staff who were on duty at the time the deceased received and attempted to consume her evening meal. They were Shaun Michael Buchheister, a registered nurse, and Judith Van Kessel, an enrolled nurse. In addition, I received into evidence a record of interview conducted between Mr Buchheister and a member of South Australia Police (Exhibit C9a). I also received typed statements that both nurses had provided to the police. (Exhibits C9 and C10 respectively). Neither nurse had any involvement with the deceased prior to

that shift. They had both commenced duty at 2:30 pm which was the normal commencement time for the afternoon nursing shift. Therefore, they were not on duty when Ms Herbert had conducted her soft diet trial of the deceased and there is no suggestion that either of them had received any verbal instruction from Ms Herbert concerning the deceased's dietary requirements during their shift, and in particular for the evening meal. Ward R7 consisted of two divisions, A and B. Mr Buchheister was working within one of those divisions. He had about ten patients, including the deceased, in his care. Ms Van Kessel was a nurse whose duties *'floated'* between the two divisions of the ward. She would work where required and did not have any particular patient or patients allocated to her.

2.12. The deceased was served her evening meal at about 5:30 pm. An unidentified member of the kitchen staff had been responsible for the delivery of the meal. The meal consisted of chicken and carrots. This was a soft diet meal. Ms Van Kessel told me in evidence that she did not see the meal actually being delivered, but had noticed it for the first time on a table by the deceased's bed. The deceased was still lying down at that stage so Ms Van Kessel assisted by sitting her up. Evidently the deceased then attempted to feed herself but Ms Van Kessel could see that she was having difficulty. Ms Van Kessel told me that she cut the chicken off the bone into bite-size pieces so that all the deceased had to do was pick it up with the fork and feed herself. Ms Van Kessel told me that the deceased appeared to cope with this. Ms Van Kessel then left the deceased, I take it alone, to perform other duties.

2.13. When Mr Buchheister walked past her room, he noticed that the deceased was vomiting and having difficulty swallowing her food. This may have been some minutes after Ms Van Kessel had left her. Mr Buchheister then called Ms Van Kessel into the room to assist. He attempted to get the deceased to cough up *'the material she had been choking on'*. It was at about this time that it was observed that the deceased was not breathing. Resuscitation measures, including suction to clear the airway, were unsuccessful.

2.14. Mr Buchheister and Ms Van Kessel both said that they had no knowledge at the time as to whether the soft diet meal that had been provided was the correct meal. I have no reason to doubt those assertions.

2.15. As seen earlier, Ms Herbert had envisaged nursing staff exercising *'distant supervision'* over the taking of this meal. The dysphagia protocol to which I have

referred was produced in evidence through a Ms Susan Gayko-Hombsch who was in April 2004 the acting clinical nurse consultant for the ward. She told me in evidence at T139:

> '… All our staff were familiar with the feeding, the type of feeding techniques that are used specifically for stroke patients and/or neurological patients. When someone first comes into a stroke unit they may have unilateral paralysis depending on what side they have had their stroke on. As they proceed in their stage of admission it has been the case for someone to have say a right-sided deficit, but for them to actually be able to safely feed themselves independently with close or distant supervision. That is usually guided by the pathologist's recommendations.'

Of course, any recommendations made by the speech pathologist would have been based on the premise that the deceased was intended to receive a minced diet meal. She received a soft diet meal, contrary to those expectations. But it would seem in any event, whatever consistency meal was delivered, that certain of the dysphagia protocol requirements set out above were not adhered to. The deceased had been left alone with food to feed herself. By the time she was seen again she was in difficulty with choking. As well, the deceased had unilateral paralysis and the protocol called for food to be placed in the unaffected side of the mouth. It is difficult to see how that requirement could be met without the presence of some person to assist her in that regard.

2.16. The protocol also called for strict adherence to the patient's ordered diet and for staff on the ward to ensure that the type of food provided was as ordered. Those requirements were also not met in the deceased's case. I return to this issue later.

3. The cause of the deceased's death

3.1. No post-mortem examination was conducted in relation to the body of the deceased. The rescusitative measures adopted were managed by a Dr Vida Hamilton, the Senior Registrar in Intensive Care at the RAH. When she arrived on the scene, the deceased was in cardio-respiratory arrest. Manual ventilation was unsuccessfully attempted. The insertion of a guedel airway was also unsuccessful in terms of attempts at ventilation. When suction was applied, some solid white material was moved from the airway. However, cardio output was not able to be restored and further resuscitative measures were considered futile. Mrs Damianou was declared deceased at 6:15 pm.

3.2. On the basis of that description of events, and on the basis of the factual accounts given by Mr Buchheister and Ms Van Kessel, I have no doubt that the deceased's

cardio-respiratory arrest was occasioned by the aspiration of part of the meal she had been served and was endeavouring to consume.

3.3. The original certified cause of death referred to asphyxiation and aspiration of food, and as well bore reference to the deceased's stroke and atrial fibrillation of five year's duration. My view is that for the purposes of these findings the cause of death can be described as cardio-respiratory arrest consequent upon the aspiration of food. I so find.

4. Possible reasons for the provision of the incorrect diet

4.1. Having heard the evidence it is plain to me that there was on 16 April 2003 a breakdown in communication as far as the provision of the deceased's evening meal was concerned, although it has not been possible to determine where exactly in the chain of communication the breakdown occurred. I heard extensive evidence about existing procedures in April 2003 that were designed to ensure that a patient received the correct consistency meal.

4.2. It seems to me that in this particular instance the breakdown in communication could have occurred at any one or more of three levels, namely the speech pathologist, kitchen staff and the nursing staff at Ward R7.

4.3. The speech pathologist, Ms Herbert told me that she had personally given the instruction to the kitchen staff that the deceased was to be provided with a soft diet meal for the trial on 16 April 2003. Her expectation would have been that the deceased would have been provided with both a soft diet and her normal vitamised diet in case the trial was unsuccessful. She could not specifically recall whether a vitamised diet was delivered as well on this occasion. Ms Herbert has consistently noted in the progress notes that this meal was intended as a trial, so I think the probabilities are that she did her best to make it plain to the kitchen that the provision of a soft diet meal for lunch on 16 April 2003 was on a trial basis only. This instruction was delivered verbally on the telephone. The possibility remains that kitchen staff mistook her instruction to mean that the deceased's diet was to be thereafter altered to soft, not just on a trial basis. The person to whom Ms Herbert gave this instruction remains unidentified. There is some evidence that kitchen staff altered the deceased's diet on a substantive basis. A document known as a Meal List that was generated by the kitchen on a ward by ward basis and which listed the dietary requirements of each patient on the ward, was examined after these events and was

said to refer to the deceased being on a soft diet. This document has not been produced in evidence, but I am satisfied by the evidence of three witnesses, namely Ms Van Kessel, Ms Gayko-Hombsch and a Ms Karen Polley, who was the then Director of Nutrition and Food Services at the RAH, that it did refer to the deceased as being on a soft diet. I return to the significance of this document later as even if the information about the deceased's diet was incorrect, there was a procedure of sorts in place whereby the document should have been corrected in time for the deceased's evening meal of 16 April 2003.

4.4. In any event, it is known that Ms Herbert had a further communication with the kitchen after the unsuccessful lunchtime trial. Ms Herbert's note, timed at 1:20 pm, makes specific reference to her having had a communication with the kitchen. She noted that her request was for a minced diet, for the reason that the kitchen was unable to provide an appropriate soft consistency diet with minced meat. What she had in mind here was the possibility of the kitchen providing, as it were, a hybrid meal of soft vegetables but with minced meat. The evidence was divergent as to whether the kitchen would have given Ms Herbert the response that she noted. All I can say is that I find that Ms Herbert honestly believed that she had, on the telephone, made her request for a minced diet clear to kitchen staff and honestly believed that the kitchen staff had indicated to her that the hybrid diet would not be provided. The member of the kitchen staff to whom Ms Herbert spoke on this occasion also remains unidentified.

4.5. Either something was lost in the translation of Ms Herbert's instruction or it simply wasn't actioned, as we know that the Meal List provided by the kitchen to the ward later that afternoon referred to a soft diet and the deceased was in fact provided with a soft diet meal.

4.6. Apart from telephoning the kitchen and placing the instruction in the patient's progress notes, Ms Herbert said that she also would have given a verbal instruction about the deceased's dietary requirements to a nurse of that shift and placed a card or sign near the bed to the effect that the deceased was on a modified diet. The evidence was vague about whether there was any formal procedure in place in April 2003 that enabled, allowed for or mandated a sign relating to a patient's dietary requirements to be placed near the bed. There is such a procedure in place now. Mr Buchheister could not remember whether there was any card (T50). Ms Van Kessel said that there was no card above the bed. I am not satisfied that there had been any such card

placed in the vicinity of the deceased's bed that may have alerted staff as to the dietary requirements of the deceased. It is possible that there was such a card, but the evidence about this lacks cogency.

4.7. The nursing staff were also meant to have an input in relation to a dysphagic patient's dietary concerns. As seen earlier, a change of nursing shift had occurred between Ms Herbert's entry into the deceased's progress notes, and her verbal communication about the deceased's diet with a member of the nursing staff, and the provision of the evening meal.

4.8. I was told of a handover procedure that occurred at nursing shift changes which was meant to ensure that important information about a patient's management within the ward was passed on to members of the following shift. Clearly in this instance, the speech pathologist's instructions concerning the deceased's dietary requirements could be so characterised, especially when it is considered that the specific instruction was to have almost immediate impact. The evidence revealed that the handover was conducted verbally, but with the aid of a "handover board". There were two phases to the handover. Firstly, there was a general handover conducted by a member of the previous shift at which relevant information about the ward's patients would be verbally imparted to the members of the on-coming shift. Such information should have included that pertaining to the patient's dietary requirements and changes to the same. Secondly, there was then a bed-to-bed handover which took place at the bedside of the individual patient and which involved the verbal transfer of information relating to that individual. Again, the information imparted would include reference to diet, including changes to diet. The handover board contained information about the patients' requirements in respect of each division of the ward, and it was on the basis of the information contained in it that the handover took place. I did not see the handover board for the change of shift on the afternoon of 16 April 2003 as they are discarded, but Ms Van Kessel told me that she examined it after these events, and in the deceased's case, it referred to her being on a soft diet. I accept that evidence. If the handover board was meant to reflect information gathered and recorded during the previous shift, it was seriously defective, in so far as it did not reflect the fact that the soft diet was for trial purposes only and did not reflect Ms Herbert's instruction that the deceased be placed on a minced diet. As far as the kitchen was concerned and indeed as far as nursing staff were concerned, that instruction seems to have disappeared into the ether.

4.9. There was also a practice in existence whereby, during the afternoon shift, the kitchen would deliver the Meal List to the ward for the purposes of confirmation. I was told that before the evening meal was delivered, a member of the kitchen staff would telephone the ward to check whether the information about the patient's dietary requirements as set out in the document was correct or not. This call could have been answered by anyone in the ward, that is to say a nurse or other person who did not necessarily have personal knowledge of the patient's dietary requirements. But the person receiving the call was meant to confirm that the information contained in the Meal List reflected the information available in the ward. Such information could conceivably have been within the head of the nurse to whom an individual patient's care was allocated, contained in the handover board or in the progress notes. The information imparted to the kitchen during this call was only as good as the information available in the ward and, indeed, only as good as ward staff's familiarity with that information. Ms Gayko-Hombsch was asked about the steps that would be taken to ensure that by the time of the call the Meal List was accurate. She was asked at T116:

'Q. What would you then expect to happen after that meal has just been delivered.
A. I would expect all the nursing staff to check through the meal list.
CORONER: Is that then or now?
MR BONIG: April 2003 we're talking about, yes.
A. I would still expect that, yes.
Q. Expect them to check through.
A. Yes, it was practice for nursing staff to check through their allocated patients that they were on the meal list as having the right type of meal and generally indicated as correct through a tick at the side of their bed number and name on the meal list.
Q. So I'm a registered nurse at the A end and I've been allocated 10 patients or thereabouts, eight to 10 patients at the beginning of a shift. Are you expecting me in April 2003 at some stage look at that meal list for all of my eight to 10 patients.
A. Yes.
Q. And if I see something that's not correct on the meal list what do I do.
A. Change it accordingly.
Q. By.
A. Striking through the incorrect meal or patient name and placing a tick next to the name.'

This check would have to involve both divisions of the ward. Whether that procedure was adhered to in this case will remain undetermined. All I can say with any confidence is that the Meal List stated soft diet and the probabilities are that when and if the call from the kitchen occurred, a soft diet meal for the deceased's next meal was confirmed. In my view, the procedures described above were fraught with

imprecision. Their effectiveness depended upon a number of events that in the nature of things may or may not have happened. It depended upon:

(a) the handover board accurately reflecting the dietary requirements of the patient and in particular, dietary changes;

(b) the accurate imparting of information regarding dietary requirements or dietary changes from one shift to the next, be it verbal or by reference to the handover board;

(c) whether the kitchen did in fact telephone the ward to check the Meal List;

(d) whether the Meal List was distributed to both divisions of the ward;

(e) whether the individual nurses accurately checked the Meal List, either against the handover board or against their own memories of the dietary requirements of the patients within their care;

(f) whether the person in the ward taking the call from the kitchen accurately imparted the information contained on the Meal List to kitchen staff.

4.10. Undoubtedly the most accurate piece of information within Ward R7 that afternoon was the entry made in the deceased's progress notes by Ms Herbert. The evidence demonstrated that there is a widespread perception among the nursing staff in this ward that there is no need to consult the progress notes at the commencement of a shift, but rather to rely on the verbal handover and the handover board. Lack of time and opportunity was one reason advanced in justification of this attitude. The notion expressed in this Inquest that perhaps nursing staff should actually read the progress notes at the beginning of a new shift was treated almost as if the suggestion bordered on the heretical. I was not impressed by this attitude. Whether nursing staff should read each and every page of a clinical record that involves a long admission would obviously depend on the circumstances, but I struggle to think of any valid reason why it should not be read at least as far as the previous nursing shift notes are concerned. The proposition that nursing staff should read the entries in the progress notes from the previous shift can be tested against the fact that in this case a perusal of the same would likely have prevented the deceased receiving an inappropriate meal, assuming all other necessary procedures were adhered to. In my opinion, the risks associated with an inappropriate diet being imposed upon a dysphagic patient were such that a perusal of the originating dietary instruction was imperative. Those risks

were more than adequately recognised in the dysphagia protocol which makes a number of references to the use of progress notes in the management of such a patient.

4.11. The protocol also called for vigilance at the time of the delivery and consumption of a meal served to the dysphagic patient. Nursing staff were meant to ensure that the texture, consistency and type of food and fluid provided was as ordered. To my mind this requirement referred to the time of delivery. The nursing staff were essentially the last line of defence against error. This was not a situation where the deceased received a meal that was merely not to her taste. Her diet was as much a part of her management as anything else, and her level of nursing care should have reflected that fact.

5. Improvements to procedures since April 2003

5.1. In the Inquest I heard some evidence in this regard. Measures that have been taken since 2003 have included the following:

(a) the provision of bed cards stylised to ensure that the correct dietary requirements are displayed prominently near the patient's bed. I observe that the 2002 dysphagia protocol referred to the use of bed-cards, but the evidence about their use in April 2003 did not inspire confidence about their effectiveness. Ms Gayko-Hombsch told me that she could not recall the use of bed cards as a standard practice within the ward.

(b) the reinforcement of the nursing staff's responsibility to cross-check a meal delivered against the patient's documented dietary requirements.

(c) the proposed promulgation of a supplementary dysphagia protocol. Ms Gayko-Hombsch produced a copy of this. It says little about dietary issues over and above the existing 2002 protocol.

(d) the possible use of electronic, computerised meal lists whereby instructions concerning a patient's dietary requirements are entered into a computer in the ward and are then accessible by a computer in the kitchen, so as to ensure that the information existing in the ward about those requirements is matched in the kitchen. I was told in the Inquest that such a system exists in the East Wing of the RAH but not in the wing which accommodates stroke patients. There were some reservations expressed concerning the further implementation of such a system. The perception is that such a system should not be regarded as the

panacea for all of the ills that were identified in the Inquest and others that for the moment cannot be foreseen. On the whole I tend to agree with this observation, but I return to this aspect of the matter in my recommendations.

6. Conclusions

6.1. The deceased, Dimitra Damianou died on 16 April 2003 after she had aspirated food provided to her that was not in accordance with dietary requirements that had been clearly documented within her ward by a qualified and experienced speech pathologist.

6.2. The provision of a meal that was not in accordance with her stipulated dietary requirements had a direct association with the deceased's aspiration of food and her consequent death.

6.3. The cause of the deceased's death was cardio-respiratory arrest consequent upon the aspiration of food.

6.4. It is not possible to identify with precision the source or sources of error which led to the provision of a meal with the incorrect consistency. None of the following possibilities have to my mind been eliminated:

A. the failure of kitchen staff to fully comprehend the verbal telephone instruction given by Ms Herbert that the lunchtime soft diet meal was to be provided on a trial basis only;

B. the failure of kitchen staff to fully comprehend Ms Herbert's later verbal telephone instruction that the deceased should be provided with a minced diet;

C. the failure of kitchen staff to take the necessary action to ensure that the deceased was provided with a meal of minced consistency;

D. the failure of staff of Ward R7 to accurately reproduce the written instruction made by Ms Herbert in the deceased's progress notes onto the handover board;

E. the failure of members of the oncoming shift to read the deceased's progress notes from the previous shift;

F. the failure within Ward R7 to check with precision the accuracy of the Meal List distributed during the afternoon of 16 April 2003, and a consequent failure to identify and correct the error relating to the deceased's diet.

7. Recommendations

7.1. By virtue of Section 25(2) of the Coroners Act, 2003 the Court may make recommendations that might in the opinion of the Court prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of the Inquest.

7.2. The original source of information relating to the deceased's dietary requirements for the next meal was Ms Herbert's entry in the progress notes. The next entry in the progress notes after that is that relating to the tragic incident and the deceased's death. There is no evidence that anyone looked at the progress notes in the intervening period. I would have thought that such a straight forward instruction should be compulsory reading for ward nurses, both on the shift on which the original instruction is made and the next shift. I recommend that the RAH ensure that nursing staff are made aware of the importance of having regard to the original source of information about a patient's dietary requirements and that, accordingly, they be required to read a patient's progress notes or clinical record at the commencement of a shift for this purpose.

7.3. I recommend that all documentation created in order to facilitate the transfer of information from the members of one nursing shift to the next be checked by a person in authority so as to ensure that the information contained in handover documentation accurately reflects instructions recorded in the clinical record or progress notes pertaining to a particular patient.

7.4. I recommend that the RAH, through whatever means are considered to be appropriate, reinforce the necessity for nursing staff to be vigilant to ensure that dysphagic patients receive meals of the correct consistency.

7.5. I recommend that the RAH, by whatever means are considered appropriate, clarify the duties and responsibilities of nursing staff in relation to the actual feeding of dysphagic patients.

7.6. I recommend that the RAH ensure that nursing staff, who are caring for patients with swallowing disorders, fully understand the risk factors associated with the individual patients in their care so as to enable them to more readily identify situations in which a patient has been provided with a meal of inappropriate consistency.

7.7. As far as the introduction of computerised communications between the ward and the kitchen is concerned, I agree that this should not be regarded as the total solution. For example, it would be wrong for complacency to arise simply because computerisation

has taken place. However, the potential for verbal communication between ward staff and the kitchen to be misinterpreted and/or poorly recorded seems to me to be very real. There is a possibility that poor verbal communication between the ward and the kitchen was at least one factor in what transpired here. I recommend that the RAH give further consideration to the introduction of computerised communication between wards and the kitchen, especially involving wards caring for dysphagic patients.

Key Words: Choking (Food); Dysphagia; Hospital treatment;

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 15th day of November, 2005.

Deputy State Coroner