

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATHS OF RAYMOND LESLIE ROACH AND ANDREAS GEORGOU

[2026] SACC 40

Inquest Findings of his Honour Deputy State Coroner White

24 September 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the deaths of two elderly men in residential aged care facilities after their airways became obstructed. The Inquest explored the manner in which the risks of aspiration and choking were managed by each of the residential facilities involved.

Held:

1. Raymond Leslie Roach, aged 89 years of Myrtle Bank, died at The Lodge Lourdes Valley, Myrtle Bank on 4 April 2019 as a result of aspiration of food material with contributing severe pulmonary emphysema and congestive cardiac failure.
2. Andreas Georgou, aged 87 years of Croydon Park, died at St Basil's Home, Croydon Park on 6 April 2021 as a result of acute upper airway obstruction on a background of dysphagia.
3. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR M KIRBY

Family: MS J ROACH

Counsel: MS L LAROSA - Solicitor: TINDALL GASK BENTLEY LAWYERS

Interested Party: SOUTHERN CROSS CARE (SA, NT & VIC) INC

Counsel: MS H VEALE - Solicitor: WOTTON KEARNEY

Interested Party: ST BASIL'S HOMES (SA)

Counsel: DR R GRAY KC WITH MS K FITZGERALD - Solicitor: GILCHRIST CONNELL

Witness: MR A LUCIDI

Counsel: MS H VEALE - Solicitor: WOTTON KEARNEY

Witness: MS K JOHNS

Counsel: MR S PLUMMER - Solicitor: MERIDIAN LAWYERS

Witness: MS M DUMBRECK

Counsel: MS S GILES - Solicitor: SPARKE HELMORE LAWYERS

Hearing Date/s: 14/01/2025-22/01/2025, 11/02/2025, 13/02/2025 & 17/02/2025

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Introduction

- 1 This Inquest arose out of the deaths of two elderly men who were not known to each other and lived in residential aged care facilities in different areas of Adelaide. They were linked by the fact that each had died as a result of airway obstructions in the context of known issues with swallowing. The Inquest explored the manner in which the risks of such incidents were managed by the aged care facilities involved and whether there are systemic issues. The two cases gave rise to two different aspects of the same condition; food selection and food delivery.

Dysphagia

- 2 Dysphagia is the medical term for the symptom of difficulty in swallowing.¹ It is a descriptive term which does not reveal the underlying cause of the difficulty in swallowing.² It is reasonable to expect that the incidence of deaths from choking on food will increase as the global population ages and the prevalence of neurodegenerative conditions that impair swallowing rises.
- 3 Deaths due to dysphagia are often incorrectly attributed to cardiac issues, as they often involve a sudden episode where the patient clutches their chest.³ Choking and aspiration events in life are often considered to be ‘one-off’ which results in a lack of proper assessment of the underlying neuromuscular condition at play. Dysphagia assessments are therefore very important, particularly in the elderly population. Further, for those of the elderly that need a high level of care, it is imperative.
- 4 To understand the details of dysphagia, it is important to understand the anatomical structures involved. I heard the following evidence:

The trachea is a hollow tube which extends from the larynx where the Adam's Apple is down into the middle of the chest where it divides into the left and right main bronchi, which are the airways supplying the respective left and right lungs.

The oesophagus sits immediately behind the trachea at the back of the throat and down through the chest. It then passes beyond where the trachea branches, passing behind the heart down to the diaphragm, which is the muscular sheet separating the chest and abdominal cavities and immediately after passing through the diaphragm, it joins the stomach. It's the gullet, it's the food passage from the mouth to the stomach. And as I say, the two lie close together and they share a common point of origin at the top.

In the back of the pharynx, the oesophagus opens up behind the larynx and allows food to pass down to the stomach. The larynx is immediately in front of that. The opening to that then becomes the trachea or airway, and when swallowing there is a little flap called the epiglottis which helps to cover the opening to the larynx while swallowing, normally ... The epiglottis protects the inlet to the airway...⁴

¹ Exhibit C11a at [39]

² T97

³ T98

⁴ T59

- 5 Identifying dysphagia involves conducting a swallowing assessment. Swallowing incorporates a number of phases. The first is the oral phase or oral preparation, which involves the cooperation of the teeth, jaw and lips.⁵ The next is the pharyngeal phase. This involves the movement of food from the mouth to the throat and necessitates an assessment of whether there is any food remaining in the mouth indicating that this phase is ineffective.⁶ The final phase is the oesophageal phase. This sees the passage of food down the throat into the stomach and is involuntary.
- 6 Initially, treatable conditions, such as infections, that might impair swallowing need to be excluded.⁷ An oral motor examination will then be conducted. This involves assessment of the physiological structure of the mouth and tongue and the ability to cough.⁸ An oral trial is then conducted with the food samples. This is done using samples of liquids of various viscosity and foods of varying textures that are consumed while a speech pathologist conducts observations and examinations, including listening to the throat sounds with a stethoscope.

Dysphagia management

- 7 I was assisted by evidence from independent expert geriatrician, Professor Joseph Ibrahim. Professor Ibrahim has extensive clinical experience in geriatric medicine and teaches at La Trobe University and Monash University. He has published more than 200 scientific papers. Professor Ibrahim provided important contextual information about the aged care industry.
- 8 Professor Ibrahim explained that the prevalence of dysphagia increased with advancing age, with 10-20% of people over 65 years old expected to have swallowing difficulties.⁹ He said that this figure also increased when combined with other conditions, such as stroke, dementia and Parkinson's disease.
- 9 Professor Ibrahim referred to recent changes to the Aged Care Quality Standards which requires any aged care provider to have procedures in place that support safe swallowing.
- 10 Professor Ibrahim explained that a key strategy in addressing choking and aspiration risks in the older population is to modify the texture of food and the thickness of drinks to make them easier and safer to swallow.¹⁰ I observe that selection of a poorly fitted diet can put patients at risk of an acute incident where the diet is not manageable, but can also put them at a more general risk of not wanting to engage in eating where the diet is not appetising enough, diminishing their overall health. Therefore, there is a balance to be struck and difficult decisions to be made.
- 11 Professor Ibrahim said that the International Dysphagia Diet Standardisation Initiative (IDDSI) brought in new internationally-standardised terminology and definitions to describe food and liquid to minimise the risk of incorrect diets being administered.¹¹ Having standardised terminology and definitions ensures that there is no miscommunication about resident requirements. It allows for recommendations made by

⁵ T520

⁶ T522

⁷ T496

⁸ T517

⁹ Exhibit C11a at [44] and T99

¹⁰ Exhibit C11a at [41]

¹¹ T100

speech pathologists to be well understood by caterers and care staff alike. It allows for consistency to be achieved for a patient's meals. It is commonly used in aged care. The IDDSI framework provides the following levels (with food and drink sharing two levels):¹²



- ¹² The IDDSI framework sets out specific guidance for standard techniques used in the assessment of food and drink to determine the level within which it sits. One example is the 'spoon tilt test' which is used to identify foods within levels 4 and 5. It is an excellent standardisation. I was assisted by evidence from speech pathologist, Kelly Johns, about the manner in which the appropriateness of food can be confirmed. I will discuss her evidence in more detail later.¹³

Mr Roach

Background

- ¹³ Raymond Roach was born in March 1930. He was a family man. He was married to his wife, Lillian, for about 68 years, having five children together.¹⁴ He worked as a brush cutter, doing hard manual labour often in the heat. In about 1989, Mr Roach suffered a stroke and following rehabilitation he returned to his Pooraka home, where he was cared for by his family. He had re-learned how to walk, talk and eat, but continued to suffer from weakness and numbness to the right side of his face, making eating difficult. He was also paralysed in his right arm. He was unable to use his legs properly, and required the aid of a walking stick or a tripod to assist him. When he was at home, he had some capacity to feed himself.¹⁵

¹² www.iddsi.org

¹³ For example, T488-T490

¹⁴ T15

¹⁵ T22

- 14 In addition to the consequences of his stroke, Mr Roach, an ex-smoker, had diagnoses of chronic obstructive pulmonary disorder with a baseline oxygen requirement, atrial fibrillation, peripheral vascular disease and obstructive sleep apnoea.
- 15 In January 2019, Mr Roach developed sepsis from an ulcer on his foot. This was initially investigated at the Royal Adelaide Hospital (RAH), after which he was transferred in February to the St Margaret's Rehabilitation Centre.¹⁶ A medical note from 7 January 2019 records a conversation between a doctor and Mr Roach:

Patient seen in the absence of any family members

Alert and oriented currently

I explained that we still believe infection is likely from his foot and that operative management would be the only thing that would get source control and therefore treating infection

In sound mind he stated both that he wants to live and continue antibiotics but that he does not want to lose his foot stating 'save my foot'

I expressly told him unfortunately both may not be possible but the best people to decide would be the vascular surgeons at the RAH, with the potential only option being amputation. To this he consented to discussing with them but again stated he does not want his foot amputated

When directly asked if it came to his foot or his life, which would he rather save, he avoided the question but later continued to state he wants to save the foot.¹⁷

- 16 On 2 February 2019, Mr Roach was taken to the RAH after he was observed choking on fluids and then developed a cough, hypoxia with oxygen supplementation requirement, and acute confusion. A chest x-ray found bibasal consolidation which resulted in a diagnosis of aspiration pneumonia. He was treated with intravenous antibiotics and his respiratory condition was able to be resolved. He was weaned off oxygen above his usual requirement.¹⁸ While at the RAH, Mr Roach's leg had progressed to gangrene and he continued to have severe pain. He was initially managed conservatively, but then after discussion with his family, an amputation to achieve pain relief was agreed upon. This occurred on 18 February 2019¹⁹ and was successful in relieving the pain. The purpose of the procedure was recorded as 'amputation for palliation'. Following that surgery, Mr Roach entered respite care at The Lodge Lourdes Valley in Myrtle Bank (Lourdes Valley), operated by Southern Cross Care.

Dysphagia

- 17 During his time at the RAH, Mr Roach was assessed by a speech pathologist, Greta Garnett. Ms Garnett wrote a note that was included in Mr Roach's discharge paperwork. It recorded:

13/02/19: INTERIM SPEECH PATHOLOGY (Please refer to medical summary for admission details and previous medical history)

Raymond Roach was referred to Speech Pathology for assessment of swallowing following admission on 02/02/19 with respiratory failure. Initial Speech Pathology assessment on 03/02/19 revealed chronic moderate oropharyngeal dysphagia characterised by extended oral phase, delayed swallow initiation, reduced hyolaryngeal excursion. Smooth Pureed

¹⁶ T16

¹⁷ Exhibit C16 at 108

¹⁸ Exhibit C14 at 153

¹⁹ Exhibit C14 at 156

Diet and Moderately Thickened Fluids were recommended. Swallowing function did not change over the course of the admission. Review of swallowing on 13/02/19 revealed ongoing chronic moderate oropharyngeal dysphagia. It is thought this is Mr Roach's baseline swallow function.

Recommendations at Discharge include:

- Smooth Pureed Diet
- Moderately thickened Fluids
- Not suitable for solid dose oral medications, please consult Pharmacy for alternatives
- Must be upright and alert for all oral intake
- Full assistance with oral intake
- Seek medical advice if clinical indicators of aspiration are observed
- Please arrange Speech Pathology review of swallow function and to provide family with education regarding modifying diet and fluids if Mr Roach is discharged home from respite facility.²⁰

- 18 This note was later provided to Lourdes Valley after Mr Roach was admitted there in early March 2019, initially for respite, with a plan for permanent care upon approval. The Care Awaiting Placement Program run by the Local Health Network produced a handover tool which recorded the following:²¹

Food and Fluids Requirements	Diet: Regular / <u>Smooth Puree</u> / Soft / Minced Moist / Diabetic / High Protein / High Energy	
	Fluids: Thin / Thickened	Consistency: Mild / <u>Moderate</u> / Extreme
	Weight: <u>63 kg</u>	WITH SET UP ASSISTANCE
	Supplements:	

- 19 Mr Roach's discharge from hospital and admission to Lourdes Valley occurred on 4 March 2019. His admission contained an exhaustive list of assessments and considerations to be made within the first 30 days.²²
- 20 The various records created around his admission contained some variations about the specific care he required.
- 21 A Nursing Care Plan completed by Lourdes Valley staff on 4 March 2019 recorded the following requirement for meals:²³

Assistance with meals / drinks	I require supervision / 1 x / no assistance for mobility (circle) <u>Full assist, ensure he is upright & fully alert for oral intake</u>
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- 22 A nursing note on 4 March 2019 recorded:²⁴

Smooth puree diet and moderate thickened fluid, requires sit upright and full alert when having oral intake, requires full assistance for oral intake, on crushed meds.

²⁰ Exhibit C14 at 62

²¹ Exhibit C14 at 150

²² Exhibit C14 at 45-46

²³ Exhibit C14 at 60

²⁴ Exhibit C14 at 87

- 23 An Admission Assessment and Screening Tool completed on 4 March 2019 recorded slightly different advice:²⁵

Nutrition / Hydration

- ☐ client requires a special diet? *Smooth puree diet, moderate thickened fluids*
☐ client requires assistance to eat / food to be cut etc?
 Describe level of assistance: _____
☐ Any swallowing problems? Details: _____
☐ Any allergies to food? Details: _____
☐ History of weight loss or weight gain: _____
☐ Requires referral to appropriate specialist: _____

- 24 An Admission Assessment and Screening Tool completed on 25 March 2019 recorded slightly different advice:²⁶

Nutrition / Hydration

- ☒ Does the resident require a special diet? *Smooth pureed diet, mod thickened fluids.*
☒ Does the customer require assistance to eat / food to be cut etc?
 Describe: *set up assistance.*
☒ Are there any swallowing problems? Details: *1/2 of aspiration pneumonia.*
☐ Are there any allergies to food? Details: _____
☐ History of weight loss or weight gain: *unknown*
☐ Requires referral to appropriate specialist: _____

- 25 According to his family, Mr Roach was fully aware of and compliant with his diet, and in any event relied on staff to feed him.
- 26 In the early hours of 4 April 2019, Mr Roach was observed to be short of breath and with saturations at 81%. A short time later, he was only able to achieve 77% saturation with 3 litres per minute of supplied oxygen.²⁷ Mr Roach was taken to the RAH by ambulance. Lourdes Valley staff supplied the following information with Mr Roach:

Ray has moderate to severe dysphagia. He requires smooth pureed diet and moderately thickened fluids. He requires full physical assistance with meals. Staff to use teaspoon only at all times. He is at risk of aspiration pneumonia. Ensure he is sitting up right during meals. Staff to ensure to leave Ray sitting upright at least 30 minutes after meals.²⁸

- 27 While at the RAH, Mr Roach was diagnosed with fluid overload and community-acquired pneumonia. He was treated with intravenous antibiotics and a diuretic medication, achieving a return to 90% saturation on his usual oxygen supply. He was then discharged to Lourdes Valley later that morning with oral antibiotics.²⁹
- 28 Thus it can be seen that the advice about Mr Roach's diet was consistent over time; namely, he required Level 4 (pureed) food. The advice about the level of support needed varied between set up assistance to full assistance.

Mr Roach's death

- 29 In the lead up to Mr Roach's death, he was administered Mylanta. While he had had episodes of aspiration, there was never any swallowing assessment using instrumentation which might be able to shed more light on whether the difference between thin and thick

²⁵ Exhibit C14 at 119

²⁶ Exhibit C14 at 57

²⁷ Exhibit C14 at 91

²⁸ Exhibit C6 at [5]

²⁹ Exhibit C14 at 90

fluids meaningfully affected his risk of aspiration. I received evidence that Mylanta is more viscous than water, but less than olive oil.³⁰ Given the lack of evidence and the lack of significant difference, I make no finding on this topic, except to observe that it is unlikely that it had any impact on Mr Roach's death.

- 30 According to records and evidence from staff at Lourdes Valley, Mr Roach was alert and orientated and settled back into his room when he returned from hospital. A nurse, Mikayla Dumbreck, attended and received a handover from the paramedics who had transported him back home.³¹ He had not been given his medications at hospital. Therefore Ms Dumbreck obtained and provided them to him. She requested a medical review in order to update his medication orders to align with what the hospital had prescribed. At 11:59 am, Ms Dumbreck recorded a case note in which she uploaded the discharge summary provided by paramedics to Mr Roach's file.³² She then made a subsequent note at 12:23 pm, where she recorded that the following events had occurred at 11:52 am. She said this was based on information other staff had provided her:³³

Mikayla Dumbreck (Care Co-ordinator)

wrote on 04 Apr 2019 12:23 ...

I: Return from hospital

A: Raymond returned to LV @ 1130 via SAAS, diagnosed with fluid overload and CAP given stat dose of IV Frusemide and IVABx whilst in ED. Has returned to LV on X2 oral antibiotics, QID Cefalexin and mane Azithromycin. Mornings medications given @ 1130 as not given while in ED, offered food on return but refused however, accepted a milo. NOK notified of T/F back to LV, attempted to contact Dr Wangel but did not answer phone. RAH have provided an interim medication chart with antibiotic order to use until GP reviews, medication chart faxed to pharmacy.

O: Continue to monitor, awaiting abx delivery (*)

- 31 Ms Dumbreck thought it was a personal care worker, Anthony Lucidi, who advised her that Mr Roach had been given a Milo.³⁴
- 32 Ms Dumbreck also made a retrospective note where she recorded that she administered Mr Roach's usual nebulizer between 11:40 and 11:50 am, during which time Mr Roach was sleeping, but able to be roused when the mask needed to be removed.³⁵
- 33 After this, a physiotherapist, Karla Graham, visited Mr Roach. In a retrospective note, Ms Graham recorded 'Reported that he was feeling fine and would like to do some exercises this afternoon. He seemed bright with nil signs of SOB, continuous O2 was on'.³⁶
- 34 At about 1 pm, Mr Roach was found unresponsive in his room by Mr Lucidi. A nearby Nurse Educator came to assist and identified that Mr Roach had died. She then called

³⁰ T285

³¹ Exhibit C14 at 35-38 and T347

³² Exhibit C14a at 6 and T352

³³ Exhibit C14a at 6 and T354

³⁴ T354-T355

³⁵ Exhibit C14a at 5

³⁶ Exhibit C14a at 2

Ms Dumbreck who came quickly and also agreed that Mr Roach had died.³⁷ No resuscitation was attempted. The general practitioner, Dr Christian Wangel, was present at Lourdes Valley. He attended Mr Roach's room and made a formal declaration of life extinct.³⁸ Mr Roach was 89 years old. Dr Wangel then reported Mr Roach's death to the State Coroner with Ms Dumbreck's assistance.

- 35 Southern Cross Care conducted an internal enquiry into Mr Roach's death. Rather than acting on the conclusions they reached internally, I have preferred to assess the matter myself independently and the findings I have reached are my own. I do not consider it necessary for me to comment upon the adequacy of the internal investigation for the purposes of executing my duty under the *Coroners Act 2003*, as amended (the Act) namely: to ascertain the cause and circumstances of Mr Roach's death and to consider whether any recommendations ought to be made.

Decision not to resuscitate

- 36 I heard evidence from Mr Roach's daughter, Judith, that Mr Roach had a strong will to live. She explained that when he was undergoing the preparation for his leg amputation, she heard him asked about his wishes. She says that he expressed that he wished to live and to have resuscitative measures, if necessary.³⁹ This was recorded in an 'Interim Care Plan' held by the hospital in April 2019.⁴⁰ However, it does not appear to have been formalised into an Advance Care Directive or a formal resuscitation preference form. Judith said that she would have expected his expressed wishes to have transferred to Lourdes Valley.
- 37 The evidence shows that two resuscitation documents were sent to Lourdes Valley⁴¹ and I received a copy of those documents into evidence.⁴² Each forms part of the 7-step pathway documentation required.
- 38 The first is dated 17 February 2019. It records a discussion with Mr Roach and three family members. The following notation was made by a doctor:

After extensive discussion with Raymond and patient's family about resuscitation, unable to reach any consensus about resuscitation plan. They want him considered for full measures, but are understanding that if measures are deemed inappropriate then they will not be offered by medical staff.

- 39 It records that it was determined that this decision should only be valid for that particular admission to hospital and so would have expired by the time of Mr Roach's death.
- 40 The second is dated 4 March 2019. This time, it records a decision that no CPR should be attempted. It records that this was decided in discussion with Mr Roach, with him considered to have the capacity to make that decision. It records that a decision was made that this preference should remain in place until revoked.

³⁷ T358-T359

³⁸ Exhibit C25 at [7] and T270

³⁹ T33

⁴⁰ Exhibit C17 at 7

⁴¹ They are each contained in the notes held by them

⁴² Exhibit C14 at 148 and 157

- 41 In light of this evidence, it is clear that, although Mr Roach had subsequently expressed in the presence of his family a desire to undergo CPR if necessary, he had formalised a different decision earlier. It was the formal decision without expiration date that was sent to Lourdes Valley with the subsequent discussion never formalised. On the basis of the information available to Lourdes Valley at the time he was found unresponsive, it would not have been considered appropriate to conduct any resuscitation efforts. It would therefore be impossible to criticise the fact that this was not attempted. I will return later to the question of whether CPR could have made a difference in any event.

Cause of death

- 42 In reporting Mr Roach's death to the State Coroner, Dr Wangel provided his opinion that the death had occurred because of a myocardial infarction, or heart attack.⁴³ He was asked about the basis for this opinion:

Q. In coming to the consideration or the opinion that there was a myocardial infarction, what did you turn your mind to at the time.

A. The abruptness of his passing.

Q. The abruptness being from what was reported to you.

A. That it wasn't an expected event and that there was no period leading up to his passing where people knew something was not right. So it was sudden, in other words.

Q. Did his medical background also form any part of that consideration, his history.

A. Well, I think his age and multiple morbidities.⁴⁴

- 43 Dr Wangel's approach was therefore akin to an educated conclusion rather than having any special knowledge about the circumstances of Mr Roach's death. He acknowledged that his suggested cause of death might not be established during the coronial investigation and he indicated his deference to the pathologist's opinion on this topic.⁴⁵ He accepted that Mr Roach was at risk of sudden death from food incidents.⁴⁶

- 44 A post-mortem examination was conducted by senior specialist forensic pathologist, Dr John Gilbert.⁴⁷ Dr Gilbert found poorly masticated food in the stomach. The distal oesophagus was occluded by a bolus of meat and there was a column of food material in the oesophagus proximal to the bolus. The trachea and bronchi contained mucoid secretions containing fragments of meat and a fragment of carrot.

- 45 Dr Gilbert found collapsed lungs that were emphysematous and oedematous, but without pneumonic consolidation.⁴⁸ The heart was enlarged with right ventricular hypertrophy. There was old ischaemic fibrosis in the walls of the left ventricle. The aorta had severe atheromatous disease and the origin of the left internal carotid artery was completely occluded.

- 46 Dr Gilbert's opinion was that Mr Roach had eaten a meal of meat and vegetables despite his requirement for smooth pureed food. He gave evidence with the assistance of

⁴³ Exhibit C14 at 134

⁴⁴ T273

⁴⁵ T274

⁴⁶ T287

⁴⁷ Exhibit C8a

⁴⁸ T63

photographs taken during the post-mortem examination. He pointed out portions of carrot that were about 2.5 cm long and fragments of meat of similar size in the stomach.⁴⁹ In the trachea and main bronchi there were smaller fragments of meat and carrot. There was a piece of carrot about 1 cm in length at the entrance to the larynx.⁵⁰ There was a bolus of meat blocking the lower oesophagus.⁵¹ Dr Gilbert explained that there was microscopic food material in the peripheral airways, which suggests that Mr Roach had inhaled the material while he was still alive.

- 47 Dr Gilbert explained that what likely occurred was that after a relatively large meat fragment became lodged in the lower oesophagus, subsequently swallowed food accumulated behind it in the upper oesophagus which has then overflowed into the airways.⁵² This was then poorly tolerated because of the underlying congestive cardiac failure and severe emphysema.
- 48 On that basis, Dr Gilbert concluded that Mr Roach had died as a result of aspiration of food material contributed to by severe pulmonary emphysema and congestive cardiac failure. This became the subject of dispute. It was postulated that Mr Roach might have instead experienced an airway obstruction by food which, instead of wholly inhibiting respiration, placed pressure on his respiratory system only to the extent that it had the effect of bringing on a sudden cardiac collapse which left no specific pathological evidence.
- 49 When Dr Gilbert gave evidence, he expanded on what he had written in his report and explained that along with the food material, there was mucoid fluid that, in combination with the food, had likely played a role in the aspiration. While he did not measure the specific quantity of this fluid, he observed 'I can't really quantify it, but I'd regard that as sufficient to account for an inability to breathe effectively'.⁵³
- 50 There was some criticism of Dr Gilbert for having raised this only during his oral evidence and not explaining it in his written report.⁵⁴ However, in my view, that criticism was unfounded. A post-mortem report contains a summary of the specific findings and the discussion of how it fits together could never be considered comprehensive. It is common for any witness who gives a written report to be examined during oral evidence and in doing so there are additional details underlying their written comments that are revealed. If I were to criticise Dr Gilbert for giving a more detailed explanation in his oral evidence than in his written report, I would have to similarly criticise most witnesses who present to Court to give evidence.
- 51 I observe that Dr Gilbert's post-mortem report contained reference to the mucoid fluid. Therefore, the criticism appeared to be limited to not discussing the interplay between the fluid and the food in his written report. There was no suggestion of any lack of credibility or reliability on Dr Gilbert's behalf and so this submission was, in effect, merely an observation. It is not an observation that causes me to have any doubt about Dr Gilbert's opinion.

⁴⁹ T64

⁵⁰ T65-T66

⁵¹ T67-T68

⁵² Exhibit C8a at 2, T68 and T70

⁵³ T67

⁵⁴ See T871

- 52 I received evidence from Dr Ral Antic, a respiratory physician with experience in the field since 1970.⁵⁵ Dr Antic had reviewed the materials, including the photographs taken during the post-mortem examination, and provided an opinion about Dr Gilbert's conclusion.⁵⁶ Dr Antic accepted that aspiration of food material can lead to death through either the obstruction of respiratory gases or by infection.⁵⁷ Dr Antic placed weight on the fact that the photographs he viewed did not depict objects he considered were significant enough to obstruct the airway. He placed significant weight on Mr Roach's comorbidities. He placed significant weight on the fact that Mr Roach was found sitting up and concluded that this meant that Mr Roach was not struggling when he was found, making it more likely that his death was more gentle than one would expect with choking.⁵⁸
- 53 Dr Antic said that a large volume of fluid would be required to produce a drowning effect and that such quantities of saliva could not be produced. He said that saliva would be more likely to move and less likely to be static. I have difficulty accepting these opinions. I have particular difficulty when Dr Gilbert was quite clear that it was likely the *combination* of food and fluid which prevented respiration. Rather than viewing the process as 'drowning' which implies a filling of the lungs, Dr Gilbert was describing particular points of the airways being occluded by a combination of materials. If a piece of food had already restricted the airway to a significant degree, logically, less fluid would be required to complete the occlusion. In addition to that, I also factor in that Mr Roach had a baseline oxygen deficiency which required 2 litres per minute of supplemental oxygen via nasal specs to achieve his baseline saturations.⁵⁹
- 54 While Dr Antic has pointed to a number of factual matters, I am not satisfied that he has properly combined them in a forensically pathological sense. I must respect the advantage Dr Gilbert had by being the doctor who opened Mr Roach's airway and made direct observations of the manner in which the foreign materials found were composed. I am satisfied that Dr Antic has placed too much weight on his theory of a gentle perimortem scenario. It is simply completely unknown whether there was a struggle or not. I observe that even if there was a sudden cardiac event, that would also carry a likelihood of sudden movements in response. It cannot therefore logically be used as a reliable tool to discriminate between those causes.
- 55 I observe that, on either approach, the mechanical blockage of the airways by food played a definite role, whether it be wholly obstructive or merely limiting gas exchange, triggering a cardiac event. Dr Antic tried to deal with this issue by allowing for the possibility of 'some modest non-obstructive aspiration which was not critical to gas exchange'.⁶⁰ It is unclear to me how he was able to be so confident about the obstruction being modest, except that he did not consider that the photos showed large enough foreign materials. In that respect, I consider that Dr Antic was at a disadvantage by not having been able to inspect the materials in situ.

⁵⁵ T722

⁵⁶ Exhibit C29 and Exhibit C29a

⁵⁷ T723

⁵⁸ T728

⁵⁹ T24

⁶⁰ Exhibit C29 at [22]

- 56 To be clear, I do not accept Dr Gilbert's opinion without scrutiny. I accept it having read it, heard it explained and tested in oral evidence and having heard scrutinising evidence about it. As with all coronial findings, I am required to apply the balance of probabilities. I am required to consider on the basis of all of the available evidence, and in light of the conflicting expert opinions, what conclusion I view as more likely than any other, if I am able to reach such a level of satisfaction at all.
- 57 Given the evidence underlying Dr Gilbert's conclusion and the manner in which he reasoned it, together with the drawbacks with Dr Antic's approach, I am not satisfied that Dr Antic's opinion should be preferred. I accept Dr Gilbert's conclusion as more likely than not and enter a finding regarding the cause of death to that effect.

Mr Roach's last meal

- 58 The post-mortem examination results identified that a meal had obviously been provided to Mr Roach and that it was not in line with his dietary requirements. Mr Lucidi could not recall seeing any food tray in the room when he found Mr Roach.⁶¹ Dr Wangel also could not recall any food tray in the room.⁶²
- 59 At Lourdes Valley, unless an order had been made for 'nurse only feed', all meals were provided under the oversight of personal care workers.⁶³ There was no such order made in relation to Mr Roach. Mr Lucidi gave evidence during the Inquest. At the time of Mr Roach's death, Mr Lucidi was one of the most experienced care workers at Lourdes Valley.⁶⁴ There were five personal care workers on duty in Mr Roach's area at the time of his death.
- 60 Mr Lucidi explained that, notwithstanding Mr Roach having declined a meal at about 11:30 am, he would be offered lunch again when the lunch service was happening.⁶⁵ He said that this involved taking the lunch to the room anyway and then asking whether the resident wanted it, then feeding them if they required assistance.⁶⁶
- 61 He explained that a carer would attend the pantry and tell the staff the name of the resident they were serving and the staff would plate up an appropriate meal. Mr Lucidi would then check this against details contained in a folder kept there. The meal would be covered with a stainless steel dome if it was being transported away from the dining area, such as to the resident's room.⁶⁷ There was no notation on the dome as to what kind of meal was contained inside, having just been checked by two people. Ms Dumbreck gave evidence that the formal responsibility to ensure that the diet provided matched the resident's requirements fell to the carer.⁶⁸
- 62 While Mr Lucidi had no specific memory, his evidence was of his usual practice on the basis that he may have provided Mr Roach a meal. He said he would have conducted a

⁶¹ Exhibit C13 at [51]

⁶² T276

⁶³ T334-T335

⁶⁴ T250 and T345

⁶⁵ T236 and T315

⁶⁶ T317

⁶⁷ T232

⁶⁸ T336 and T376

check on Mr Roach's personal care folder and ensured that he was delivering Mr Roach an appropriate meal.

- 63 Mr Lucidi's credibility was challenged on the basis that he had advised Southern Cross Care internal investigators about 20 months after Mr Roach's death that he could not recall whether he was the person who had found Mr Roach dead, but about five years after the death, when he swore an affidavit with the advice of his lawyer, he indicated that he was the person who found Mr Roach dead. This was in pursuance of a submission that I should not accept Mr Lucidi's more critical evidence, as follows:

I do not recall whether I was assisting residents in the dining room or feeding residents in their rooms on 4 April 2019. Another carer would have fed the residents who were having lunch in their rooms if I was working in the dining room at the time of the lunch service. This wasn't something we wrote down, we would just figure it out on the day. That was different with [a subsequently-introduced computer system] because we record what people eat.

I do not have any recollection of feeding Mr Roach lunch and I can't remember any other carer feeding him lunch on 4 April 2019. If I did feed him lunch, I would have fed him the type of meal specified on his Food and Fluid Preference Form.⁶⁹

- 64 The difficulty with the submission is that the internal investigators' report does record that Mr Lucidi was the person who found Mr Roach.⁷⁰ The evidence therefore falls short of establishing that Mr Lucidi was deliberately trying to conceal that fact. In addition, and more to the point, his affidavit specifically envisages that it might have been Mr Lucidi who provided food to Mr Roach. Further, in his oral evidence, he specifically accepted that he may have provided an inappropriate meal.⁷¹ In his affidavit, he explained that he has no specific recollection, but that 'If I did feed him lunch...' he would have followed processes in place. I accept that as a reasonable approach of a witness being asked about a single meal provided in the course of his work five years earlier. It is true that Mr Roach's death would have attributed heightened significance to the events surrounding it, but not if those events were routine or in line with usual practices. For those reasons, I do not consider that there is any reason to doubt that Mr Lucidi was doing his best to assist the Court with his evidence.

- 65 Mr Lucidi was expressly asked whether he had acted inappropriately and covered it up:

Q. What I want to ask you, it could have been the case that you had fed Mr Roach in his room. Realised that you'd fed him the wrong food, left the room, took away the plate and the feeder, didn't tell anyone and then you went back around about 1 o'clock to check if he was okay.

A. No, if I had fed Mr Roach the wrong food I would have immediately notified the RN.

Q. So, you deny that you would have done that at all.

A. Yes.

Q. I know you have no recollection.

A. Yes.

⁶⁹ Exhibit C13 at [47]-[48]

⁷⁰ Exhibit C14a

⁷¹ T241, T246 and T293

Q. But you deny that if you fed someone the wrong food.

A. Like, I said before, if it was possible that I fed him and I realised he had the wrong food I would have notified the RN immediately.⁷²

66 Mr Lucidi appeared to be genuine in his denial of this being what happened. I accept that he had not acted dishonestly.

67 The result is, however, that I am unable to make any specific findings about the circumstances of the delivery of the meal to Mr Roach. Incidentally, the fact that meals provided are now recorded in the residents' records will serve as a tool to ensure that an appropriate meal is provided, as it will force carers to have the resident's record open when providing meals with the accountability of the record bringing a higher level of discernment to the task. This was not necessarily always present under the former system.⁷³ While I cannot determine how the relevant meal was provided to Mr Roach, who provided it, or whether that involved mistake or carelessness, I am satisfied that it is unlikely to occur again.

68 Mr Lucidi said that if a resident appeared to be struggling with food, he would make sure they were sitting up and tell them to cough up the food and then call a registered nurse to assist.⁷⁴ That appears to be a perfectly reasonable approach for a non-medically trained care worker in an aged care setting. While I accept Mr Lucidi's approach was proper, it may be that additional training would assist to potentially identify signs of choking earlier.

69 Determination of what happened between Mr Roach's return to his room and him being found unresponsive would have been of critical assistance to the determination of the issues arising in this Inquest. However, that has not been possible. There were no witnesses identified during the investigation who were able to shed any light on what happened in the intervening time. I am left therefore to find only what can objectively be inferred from the evidence that exists, including the results of the post-mortem examination.

70 I infer that, at some point, Mr Roach was provided a meal. I cannot say who did this or how he or she did it. I infer that the meal provided was, at least partly, large pieces of chicken schnitzel and vegetables. I infer that Mr Roach was either left to eat it himself, unsupervised, or that he was assisted to eat it in a manner that was not consistent with the speech pathology recommendations. Given his physical limitations, I favour the proposition that he was assisted by a member of staff. I infer that he ate (either by himself or assisted) in an unsafe manner; either too quickly or with too large mouthfuls or both. It appears likely that Mr Roach was simply provided a meal that was not modified for his requirements and it was provided in a manner that was not modified for his requirements. I make a finding to that effect. These events have brought about his death by the mechanism I have discussed above.

⁷² T300

⁷³ T296

⁷⁴ T237

Assessment of the care provided to Mr Roach

- 71 Professor Ibrahim said that once Mr Roach had been found unresponsive with no signs of life, resuscitation was not possible and futile attempts would not have been appropriate.⁷⁵ Given the descriptions of Mr Roach's presentation at that time, I accept that opinion. I find that by the time Mr Roach had been found, there were clear indications that he had died and resuscitation was therefore inappropriate. I have already made observations about the state of the records about Mr Roach's resuscitation preferences. I have found that there is no criticism to be made of the decision not to attempt resuscitation and that even if it was attempted, it would not have been successful.
- 72 Professor Ibrahim provided his opinions in relation to the meal provided to Mr Roach. He cautioned that he is not an expert in culinary affairs, nor speech pathology. However, he was able to observe that the findings at post-mortem examination were not consistent with the diet recommended.⁷⁶ He said that the pieces of food found in Mr Roach's stomach would have been considered Level 7 (regular diet).⁷⁷
- 73 I heard evidence that personal care workers who were responsible for providing meals to residents at Lourdes Valley had training in particular on the issue of how to satisfy themselves of the dietary requirements of each resident when conducting food service.⁷⁸ How this meal came to be selected for Mr Roach is, therefore, another issue that I am unable to resolve.
- 74 Professor Ibrahim agreed with Dr Gilbert that Mr Roach's comorbidities would have meant that he would have struggled to deal with the consequences of the pieces of food he was consuming.⁷⁹ He said there may have been an ineffectual cough or a complaint of a burning feeling and/or shortness of breath.⁸⁰ Mr Roach's face may have become flushed and he may have become sweaty.
- 75 Professor Ibrahim explained that there is no accepted standardised definition of 'supervision' in the aged care sector. He said that there is a distinction drawn between supervision and assistance.⁸¹ He said:
- The frequency and intensity of supervision varies according to factors such as the availability of staff, the stability of the resident's health status and the nature of the hazard that could cause harm.
- 76 Notwithstanding the lack of identifiable standard and that lack of evidence about precisely what happened, Professor Ibrahim considered that the supervision surrounding Mr Roach's meal on 4 April 2019 was inadequate as adequate supervision would have identified an issue. I agree with Professor Ibrahim's logic and I make a finding to that effect.

⁷⁵ T128

⁷⁶ T102

⁷⁷ T121

⁷⁸ T342

⁷⁹ T123-T124

⁸⁰ T125

⁸¹ Exhibit C11a at [73]

Preventability

- 77 In the background of an assessment of Mr Roach's death is the fact that he was on a palliative pathway. However, that is not the end of the story. Those receiving palliative care are entitled to expect that care is delivered in a proper way which preserves their wellbeing for as long as their comfort can be maintained. Therefore, the issue of preventability in this setting must reflect an assessment of the particular circumstances that led to the death and whether it could have been prevented from happening when it did.
- 78 I have already found that resuscitative efforts would not have been successful, even if they had been attempted when Mr Roach was found. I find that after Mr Roach had swallowed the food that brought about his death, there was no opportunity to prevent it.
- 79 Professor Ibrahim's opinion was that Mr Roach's death was preventable, but he could not express that with any great certainty because of the unknown circumstances in the immediate lead up.⁸² He said that if Mr Roach had been fed a meal, then this could have been prevented by detecting the inappropriateness. However, if Mr Roach had been able to source an inappropriate meal and eat it himself, it would not have been able to be prevented. Professor Ibrahim believed that once the meal had been eaten and the obstruction occurred, there was a chance at reversing it, but only a low chance.⁸³
- 80 I have formed a similar view to that expressed by Professor Ibrahim. As I have set out, I am satisfied that Mr Roach's death was a result of the food he had consumed. I consider it unlikely that Mr Roach was able to source an inappropriate meal himself and eat it without any staff assistance. The most likely proposition is that an error was made in the selection of the meal for him. This was potentially contributed to by the fact that he had been absent from the facility while in hospital, so his specific dietary requirements would have been less familiar to staff, than for residents who had been fed in recent days. Given this conclusion, I am satisfied that it is more likely than not that Mr Roach's death could have been prevented, by providing him with the correct diet rather than the incorrect meal he received. I am unable to make an assessment as to whether there were opportunities to prevent his death arising from the pantry staff or in Mr Lucidi's actions, or both or neither. In my view, that inability to be specific does not detract from my satisfaction that whatever went wrong in the meal delivery could have been done differently.

Improvements

- 81 I received evidence about a number of improvements that Southern Cross Care has made at Lourdes Valley which have decreased the likelihood of a similar incident occurring again. These include:
- a. Modifications to dietary requirements being recorded quicker and brought to the attention of staff in a better way;
 - b. Formally adopting and implementing the IDDSI standards;
 - c. Delivering modified diets to residents in a more targeted way, rather than relying on plating of different diets in communal areas, which includes bringing kitchen staff onto the system where dietary requirements are recorded;

⁸² T127

⁸³ T136

- d. Introducing a higher number of qualified staff in dining areas;
 - e. Adopting handheld electronic devices which provide residents' information to staff without having to leave a resident's side.
- 82 These are positive improvements that will reduce the risk of inappropriate meals being provided to future residents.

Mr Georgou

Background

- 83 Andreas Georgou was born in February 1934. He moved to Australia in 1955 from Greece. He was married and had four daughters. During his life, he lost his wife and one of his daughters. His other daughters remained involved with his care and would regularly attend assessments and appointments with him.
- 84 Mr Georgou had a number of health conditions, most significantly including previous myocardial infarction, congestive cardiac failure, high cholesterol and hypertension, ischaemic heart disease, insulin-dependent diabetes, renal failure, obstructive sleep apnoea, osteomyelitis and chronic kidney disease. He had a diagnosis of vascular dementia. He had a below-knee left leg amputation in 2018. He had experienced an untreated stroke, observed incidentally in 2010. Mr Georgou had an episode of choking that led to a cardiac arrest in March 2018.

Dysphagia

- 85 Mr Georgou entered residential care at St Basil's Home in December 2018. A screening form completed on 5 December 2018 recorded:

Upon initial admission, Speech pathology reviewed patient who showed a motility dysphagia. However, he was non-compliant with recommendations for alterations to diet. On 8/3/18 developed cardiac respiratory arrest following choking [sic] episode on solid food bolus which obstructed his airway. Following recovery and discharge from ICU, he was made NBM and placed on NET feeds. As per SP Moderate to Severe Oro-Pharyngeal Dysphagia now on minced and moist diet and thickened fluids.

- 86 He underwent a speech pathology assessment on 8 January 2019. That assessment recorded:

Assessment:

-soft diet – banana, cake + croissant Good oral phase although tendency to overfill
One clearance cough following all food, reflective of pharyngeal build-up.
No overt aspiration or laryngeal penetration
-Thin fluids – orange juice Tolerated without incidence.

Plan: SOFT DIET TRIAL

- Please cut up
- Supervision in dining room
- Give teaspoon to eat with to control amount in mouth

Upgrade to thin fluids.

Medications whole.

Please re-refer as required.⁸⁴

⁸⁴ Exhibit C22p at 1

- 87 A document called Dysphagia Management Recommendations, completed on 26 March 2019 recommended the following:

STRATEGIES TO MAXIMISE SAFE SWALLOWING	
☒ Ensure resident is alert and upright (90°)	☒ Remain upright for <u>30</u> minutes at completion.
☒ Discontinue, if resident fatigues or coughs excessively or fails to swallow	
☐ Assist resident slowly	☒ Encourage resident to ☒ eat ☒ drink slowly
☒ Alternate eating with drinking	☒ Ensure resident clears each mouthful before taking the next
☒ Offer meals with only: ☐ dessert spoon ☐ knife ☒ fork ☒ teaspoon	
☒ Offer drinks with only: ☒ open cup ☐ spouted lid ☐ straw ☐ dessertspoon ☐ teaspoon	
☐ Check and clear for oral residue; complete oral hygiene after meal	

- 88 In June 2019, a swallowing assessment was conducted after a referral for a choking episode on 3 June 2019.⁸⁵ That assessment identified an adequate range of jaw motion rate and strength, no gag reflex or reflexive cough, but a mild delay in reflexive swallow. There was a mildly extended oral preparatory phase with trace oral residue. In the pharyngeal phase there was a mild delay in initiating a swallow with decreased hyolaryngeal excursion, but no signs of airway entry. The oesophageal phase was normal. The assessment identified an impulsive behavioural choke potential with harder-textured solids. The diet recommendation was for both soft and bite-sized as well as minced and moist, together with thin fluids. A suggestion for supervised intake with verbal cues to slow down was made.
- 89 An executive at St Basil's, Konstantinos Psaromatis, gave evidence about Mr Georgou. He was asked whether Mr Georgou expressed any view about his diet. He said:
- A. Well, very relevant to this coronial inquiry. He certainly didn't like thickened fluids and he certainly didn't like pureed based foods. That was, I could say he detested them. He really did not like them.
- Q. Can I just ask you to pause there. What led you to believe that he detested or didn't like them, do you have a recollection of what he may have said to you.
- A. Perhaps not something, well he may have said to me but certainly with the family advocating, in his presence they would suggest that he did not like thickened fluid and that he did not like a pureed based food, I should say. He liked to get back to a solid base diet and to thin fluids. In fact, there was a special provision if he had to go to a thickened fluid, that the only way he could actually have it would be to have a special makeup of the fluid refrigerated.⁸⁶
- 90 Focused on his quality of life, Mr Georgou requested an upgrade in his diet in July 2019. A further swallowing assessment was conducted on 18 July 2019 which identified much the same as the earlier assessment, but with a slightly reduced jaw strength than before.⁸⁷ It was concluded that the dysphagia present was as a result of general and neurological decline. It reaffirmed that there was a behavioural component and that the choking potential with harder textured solids remained. The diet recommendation was for minced and moist only, together with thin fluids. Once again, supervision with verbal cues to slow down were suggested.

⁸⁵ Exhibit C22p at 4-5

⁸⁶ T655

⁸⁷ Exhibit C22p at 8-9

- 91 During a visit to The Queen Elizabeth Hospital in August 2019, a speech pathologist recorded:

Speech Pathology has noted that a palliative approach acknowledging Mr Georgou's high risk of aspiration and the family's concern with poor QoL with modified diet was discussed by The Respiratory Team with plans for continuing normal diet with acceptance of aspiration risk.

Speech Pathology is concerned about Mr Georgou's airway obstruction risk with 'normal diet' solids based on his history of columnating [sic] his oesophagus and choking on soft diet in ICU as well as his Modified Barium Swallow results and would recommend Minced Diet be considered the upper limit for choking hazard management in the context of palliative care.⁸⁸

- 92 In August, Mr Georgou's family again requested a re-review of the situation. This was conducted on 23 August 2019.⁸⁹ The document generated for this review recorded that a diet of soft and bite-sized was to be administered at the request of Mr Georgou's family, against the Speech Pathology recommendation of minced and moist only. The recommendations about supervision remained unchanged.
- 93 On 30 July 2020, a routine review was conducted following two choking episodes. The oral preparatory phase continued to be prolonged, now with lateral chewing motion and a decreased lingual elevation and post-swallow oral residue found. The pharyngeal phase continued to have delay with decreased hyolaryngeal excursion, now also with decreased breathing and swallow coordination. This was noted to increase the existing risk of aspiration and choking. The speech pathologist recommended vegetables and desserts be served at Level 6 (soft and bite-sized), but that meats be served at Level 5 (minced and moist).⁹⁰ The level of supervision recommended had progressed by this time to physical assistance being required. One of the strategies recommended was for complete oral hygiene to be conducted after eating and for administration of food by teaspoon only.
- 94 Mr Georgou's speech pathology assessments were thereafter provided by Kelly Johns. Ms Johns has been a qualified speech pathologist since 2014, working in the aged care sector since 2017. She provided speech pathology services to residents at St Basil's through a private company, AvantiCare.⁹¹ Ms Johns explained that conducting a speech pathology assessment involved reviewing medical notes and speaking to staff to gain relevant background information.⁹² The resident's preferences are ascertained through discussion. Ms Johns explained that these individual preferences are important, as a diet provided against the resident's desires may well be refused which impacts on their overall health. Ms Johns said that she would then conduct an oral trial which involved the resident eating different foods and fluids while their eating and drinking mechanisms are observed, felt and listened to. Recommendations are then made which results in a review of the diet specified in the resident's records and care plan. Ms Johns then engages with the staff to get a feel for the appropriateness of the approach.⁹³

⁸⁸ Exhibit C16 at 1995

⁸⁹ Exhibit C22p at 10-1

⁹⁰ Exhibit C22a at 7 and Exhibit C22p at 15-17

⁹¹ T495

⁹² T496

⁹³ T498

95 Ms Johns first assessed Mr Georgou on 19 January 2021. Ms Johns had been asked to conduct the assessment because Mr Georgou's family had requested that his diet be upgraded from a soft diet, in particular because he wished to be permitted to eat toast.⁹⁴ After reviewing Mr Georgou's medical records, Ms Johns conducted a comprehensive swallowing assessment. She detected some lack of self-awareness in that Mr Georgou was taking large mouthfuls and filling his mouth again without giving himself sufficient time to swallow.⁹⁵ She identified some mild issues with his mechanisms, but said 'it wasn't significant enough to, sort of, throw off alarm bells'. He was able to clear his mouth between exercises without residue.

96 Ms Johns concluded that there was mild oropharyngeal dysphagia based on mild issues with the mechanisms of eating which were compounded by his behavioural approach to eating. Oropharyngeal indicates issues with both the oral phase and the pharyngeal phase of eating.⁹⁶ She recommended Level 0 for fluids with an open cup and Level 6 for all food. This represented a shift from the previous recommendation which had been split between vegetables and dessert, and meats. In effect, it brought uniformity, with all food now being recommended at the higher level. Ms Johns explained:

So he has a good reflexive cough, he's got good dentition, so he's able to chew and masticate those more higher textures, he - yes, he might have been a little bit fast of rate, but that was something that was manageable. Aside from that, he ate foods that needed extra chewing, like whole grapes and bread, he did okay. In my experience he was - the risk was minimal.⁹⁷

97 She recorded a specific note to emphasise that 1.5 cm sized pieces were required.⁹⁸ She recorded that he responded well to prompts to slow down and that he also exhibited lingual fishing for residue which suggested awareness of residue in the mouth. She made a recommendation that toast be permitted, but cut into bite-sized pieces. This was to address his specific request. Instead of full assistance with meals, she recommended close supervision at all times, with prompting to eat slowly and to take small mouthfuls. She explained that she did not consider that Mr Georgou needed someone to pick up food and put it in his mouth, he merely needed someone to monitor and prompt him to do that himself safely.⁹⁹ In her evidence, she was asked to describe what she intended to convey by 'close supervision'. She said:

So 'close supervision' is a term that implies - it's a bit interchangeable between standby, so it means you're not sitting next to them and you're not giving them full assistance but you are close, so within one or two to three, you know, steps away at all times again. So 'close' determines proximity. 'Supervision' is what we're wanting is them to be watched over and monitored. 'Prompt to eat slow and take smaller bites and mouthfuls', so make sure that he doesn't overfill by taking more than one bite, and watching.¹⁰⁰

98 She explained that there are also concepts of distant supervision and full assistance at each end of the spectrum with close supervision sitting between them.

⁹⁴ T515

⁹⁵ T521

⁹⁶ T523

⁹⁷ T534

⁹⁸ T525

⁹⁹ T535

¹⁰⁰ T527

99 On 23 February 2021, Ms Johns assessed Mr Georgou again after he was discharged from hospital following an aspiration event. While in hospital, in light of the recent aspiration, Mr Georgou had been placed on a Level 4 (pureed) diet. She was unable to conduct her full assessment because Mr Georgou was not well enough to participate. She nevertheless noted some concerning signs about his ability to swallow and made a recommendation of Level 4 food to be provided by teaspoon with full assistance. This was, effectively, a complete upgrade to the most cautious approach to Mr Georgou's feeding. Ms Johns explained that she did not want to change the diet, but would conduct a review when there were signs of improvement.¹⁰¹

100 Ms Johns assessed Mr Georgou again on 10 March 2021, this time being able to conduct a full assessment. The purpose of the review was to consider an upgrade in diet classification. Once again, Ms Johns observed mild oropharyngeal dysphagia with physical weakness compounded by impulsive eating behaviours, however she described him as being 'much improved' since his previous assessment.¹⁰² Ms Johns then recorded:

[Mr Georgou] will benefit from a modified diet for ease of intake and oral safety. NOK has agreed to the following recommendations.

RECOMMENDATIONS:

FLUID: Think fluid (level 0) open cup

DIET: Soft and Bite-sized diet (level 6)

Medications: Crushed with puree

*add moisture

*Toast only OK with no crust cut up into BITE-SIZED pieces with moist toppings

CLOSE supervision, provide setup

PROMPT to eat slowly or take meal out of reach if overfilling and full assist

Avoid distractions while eating/drinking

Cease if fatigued, SOB, pocketing

ENSure mouth is clear at end of meal

2x Daily Oral care

Watch for signs of aspiration e.g wet gurgly voice and prompt to cough and break

Remove item if issues arise and req R?V ¹⁰³

101 Ms Johns explained that she did not consider it would be appropriate to put a meal in front of Mr Georgou and walk away, but acknowledged that close supervision is necessarily less than one-to-one supervision.¹⁰⁴

102 On 12 March 2021, Mr Georgou's care plan was updated, including the nutrition and hydration care plan, with Ms Johns' updated recommendations being incorporated. That care plan re-stated Ms Johns' recommendations and recorded:

I require

A special set up due to physical impairment, staff to remind him of approaching meal times and toileting prior to meal times

I require his drinks to be poured

For 1:1 physical assistance I require food to be cut up

¹⁰¹ T545

¹⁰² T551

¹⁰³ Exhibit C22a at 1

¹⁰⁴ T559

My readiness to eat assistance details:

Andreas needs to be positioned at the dining table by staff as he needs assistance to mobilise with wheel chair

Staff are to ensure that he is sitting upright for all meals.

For 1:1 physical assistance I require placing or guiding food into my mouth for most of the meal

My eating assistance details:

Ensure resident is alert and upright.

Remain upright for 30-45 minutes at completion.

Andreas requires physical assistance to start, continue and finish his meals due to high risk of choking, high risk of aspiration, staff to ensure that he drinks throughout the meal to ensure that clears his mouth.

Andreas has a history of choking and coughing with meals as well as placing too much food in his mouth at one time.

Assist & encourage Andreas to eat slowly. If Andrea's non compliant move food out of reach until mouth is cleared of food then place back in front of Andrea's (as per family and Speech Pathology recommendation's)¹⁰⁵

103 A Catering Form dated 18 March 2021 then re-stated Ms Johns' recommendations to those preparing Mr Georgou's meals.¹⁰⁶

104 On 31 March 2021, Ms Johns assessed Mr Georgou again.¹⁰⁷ She received background information from staff that he had not had any issues with eating since she had recently changed his diet classification. The purpose of this review was to determine whether Mr Georgou could take medications whole. Ms Johns conducted a swallowing assessment using a placebo pill and thin fluids. While Mr Georgou had a strong volitional cough after swallowing the tablet, he did not regurgitate it and was able to manage it with his usual swallowing mechanism being effective for the tablet. Ms Johns determined that Mr Georgou was suitable for whole medications, but with strategies of moistening the oral cavity beforehand, breaking any larger tablets in half, administering one at a time with thin fluid from an open cup. In respect of his diet, Mr Georgou remained on the plan Ms Johns had recommended on 10 March 2021. She explained that she considered Mr Georgou's presentation on this day backed up what she had previously determined as appropriate and that he was showing signs of continuing improvement in eating ability.¹⁰⁸

Mr Georgou's last meal

105 As far as it related to Mr Georgou, the Inquest focused on the circumstances surrounding Mr Georgou's last meal and the supervision provided. The findings that I make now are based on the evidence I heard together with my own viewing of the CCTV footage.

106 Nurse Fei Chen gave evidence during the Inquest. She was in the dining room on her first day working at St Basil's having been a Registered Nurse for 7-8 months prior.¹⁰⁹ I was also assisted by the evidence of carer Sunil Vijaya. Mr Vijaya had worked at St Basil's for about a year and was familiar with Mr Georgou. Mr Vijaya explained that Mr Georgou strongly preferred to feed himself and that he would eat quickly. Mr Vijaya

¹⁰⁵ Exhibit C22q Bundle 3 at 231

¹⁰⁶ Exhibit C22e at 13

¹⁰⁷ Exhibit C22a at 3

¹⁰⁸ T558-T559

¹⁰⁹ Exhibit C12a at [2]

would tell him ‘sigá sigá’, Greek for ‘slowly slowly’.¹¹⁰ Mr Vijaya said that because he was aware that Mr Georgou usually ate his meals very quickly he would often ask him if he was alright, with Mr Georgou usually nodding back.¹¹¹ Mr Vijaya said that following a recent return from hospital, Mr Georgou was having minced food. He said that on this day, he noticed that Mr Georgou was back on solid food again.¹¹²

- 107 Notwithstanding the speech pathology recommendations and the catering documents, Mr Georgou was provided his lunch and fed himself without staff assisting or in the immediate vicinity supervising him. Records from St Basil's indicate that the meal provided to Mr Georgou was soup followed by a lamb fricassee which was accompanied by rice. He ate the soup and then began eating the lamb fricassee.
- 108 Mr Vijaya said that he assisted Mr Georgou by pushing him to the dining room in his wheelchair shortly after noon on 6 April 2021. There were about six other residents in that room.¹¹³ There was another carer working in the room, Con Tsourtos. There was a lifestyle volunteer who had the role of observing the residents eat. By my count, that is four people overseeing the delivery of meals to seven residents. Mr Vijaya said that there was a policy that while residents were eating, a carer would be present with them at all times.¹¹⁴
- 109 Nurse Chen was responsible for administering residents’ medications. She said that, after he had arrived in the dining room, she administered insulin to Mr Georgou. At that time, she spoke to Mr Georgou and he was responsive to her.¹¹⁵ He was then provided his meal. Mr Vijaya explained that he would move around the room and while doing so, he would be watching and listening for any signs that someone might need assistance.¹¹⁶
- 110 The other carer, Mr Tsourtos, took on the task of feeding a resident that needed full assistance.¹¹⁷ Mr Vijaya then sat down with another resident that needed full assistance and began feeding that resident.¹¹⁸ At the time, Mr Vijaya was facing Mr Georgou. He said that he was checking on the other residents in between providing mouthfuls to the resident he was directly assisting.¹¹⁹
- 111 Mr Vijaya observed on the CCTV footage that Mr Georgou shrugged. He explained that on occasions when he told Mr Georgou sigá sigá, sometimes Mr Georgou would shrug in response.¹²⁰ It is likely therefore, that Mr Vijaya had reminded Mr Georgou to eat slowly. Mr Georgou was provided with and drank water during his meal.¹²¹ At one point, after he coughed, Mr Vijaya asked Mr Georgou if he was okay and he motioned back with his

¹¹⁰ T599

¹¹¹ Exhibit C28 at [8]

¹¹² Exhibit C28 at [14]

¹¹³ Exhibit C28 at [4]

¹¹⁴ T604

¹¹⁵ T184

¹¹⁶ T606

¹¹⁷ T611

¹¹⁸ T612

¹¹⁹ T612

¹²⁰ T616

¹²¹ T619

arm that he was.¹²² He then continued to cough. Once again, Mr Vijaya asked if Mr Georgou was alright and he nodded and drank some water.¹²³

- 112 Mr Vijaya then approached Mr Georgou with a spoon that he intended to use to clear his mouth.¹²⁴ However, Mr Georgou would not open his mouth.
- 113 Nurse Chen said that while she was doing her duties, Mr Vijaya drew her attention to Mr Georgou, reporting that he did not look well. Mr Vijaya said that by this time Mr Georgou ‘didn’t look right’ and was losing a bit of colour.¹²⁵ The footage shows that Nurse Chen stopped what she was doing and came over very promptly.¹²⁶ Nurse Chen turned and saw Mr Georgou was chewing, but was ‘not that alert’ with sluggish eyes, so she spoke to him. He did not respond to her. She initially did not consider that he was choking as he was still chewing which was inconsistent with her expectation that choking would be accompanied by coughing or efforts to expel the food.¹²⁷ She asked him to spit the food out into paper towel that she raised to his face, and he could not. She then extracted food from his mouth, but was not able to get all of it, because as she described it was quite mashed. Nurse Chen explained that she then delivered back blows to Mr Georgou.¹²⁸ She observed that he was not improving, with his face turning pale and blue, so she asked the carer to get the duty nurse. The footage shows that it took 19 seconds for the duty nurse to arrive.¹²⁹ The duty nurse also delivered further quite forceful back blows.¹³⁰ Ms Chen assisted by delivering further back blows as well. The duty nurse administered chest thrusts.
- 114 More staff attended and an oxygen bottle was brought in with a suction attachment, but ultimately Mr Georgou became entirely unresponsive. He was put on the floor and CPR was commenced while staff still continued to try to clear his airway.
- 115 An ambulance had been called earlier and paramedics attended, arriving at about 12:36 pm. They took over the CPR effort. They conducted a laryngoscopy and found extensive soiling of the airway with meat chunks and pureed food around the vocal cords and flowing from the trachea. They were able to remove numerous pieces of meat from the airway using suctioning and forceps. Notwithstanding that, they were not able to achieve ventilation. Mr Georgou was not able to be revived and paramedics made a declaration of life extinct at 1:10 pm. Mr Georgou was 87 years old.

Cause of death

- 116 A pathology review of the documentation available was conducted by Dr Jane Alderman under supervision of senior specialist forensic pathologist, Dr Cheryl Charlwood. Dr Alderman reviewed the CCTV footage and the paramedic records, finding them to be consistent. She considered that Mr Georgou had died as a result of choking on a

¹²² T621

¹²³ T622-T623

¹²⁴ T625

¹²⁵ Exhibit C28 at [9]

¹²⁶ Exhibit C5b, File 2 at 6 minutes and 11 seconds

¹²⁷ T200

¹²⁸ T182 and T185

¹²⁹ Exhibit C5b, file 2, request shown at 7 minutes and 7 seconds, support arriving at 7 minutes and 26 seconds

¹³⁰ T187 and T644

background of ischaemic heart disease, chronic obesity hypoventilation syndrome, cerebrovascular disease, vascular dementia and dysphagia.

- 117 Dr Gilbert had been asked about the ability to distinguish between choking and a sudden cardiac event. He agreed that, without post-mortem examination, this was a distinction that would come down to a matter of probabilities, not certainties.¹³¹ He agreed that where death occurs during eating, the probability of choking being the mechanism is higher.
- 118 Dr Charlwood gave evidence. She explained that there are difficulties in distinguishing whether a person is choking or aspirating.¹³² She said that there is a great range of responses a person might demonstrate when experiencing either of those events, modified by physiological individualities. Dr Charlwood explained:

Q. Can you explain what the relevance is of the meat chunks that have been removed from the trachea.

A. Yes, so, again, concordant with a potential choking, there were pieces of meat, I presume larger pieces of distinct, identifiable food within the airway around the cords. The puree, I don't know what they mean by that. It could be foodstuffs, it could be secretions mixed with pulmonary oedema, the fluid from the lungs. But, at this stage, as well as potential material still in his mouth when he collapsed, we don't know what's happening in terms of regurgitation, whether he had an oesophagus because of his swallowing difficulties, whether there was food in his oesophagus that would come up, and also the resuscitation attempts will complicate matters as well. If we use any sort of forceful resuscitation, it can actually increase the risk of food coming out the stomach.

Q. And so, is the presence of meat chunks in the trachea, does that lead one way or any other towards aspiration versus choking.

A. It would lead me more to choking because the pieces are larger and you're less likely to get larger pieces going down the smaller airways. The airways are like a tree branching, so they get smaller and smaller, and in my experience, choking is virtually always meat, actually, yeah. So, virtually always; it doesn't exclude other things, but, yeah, meat is one of the biggest culprits that I've come across.

Q. Why is that, because of its rough texture and density.

A. Yeah, it's dense. It doesn't tend to be able to be chewed as easily and it can - even though it can mould itself to the shape of, like, the trachea and things like that, it is quite tough and doesn't break up easily in the mouth, and could I just say that, obviously, the complicating factors here with the resuscitation and the large build and then his coughing and his dysphagia, it's all very difficult to say whether it's aspiration, whether it's both, but there's been some occlusion of the airways by foodstuffs, complicated by all of those factors. But why we probably went with choking in the first place on that initial - from the medical history is that he was sat upright and he immediately had an event that caused him to rapidly decline. Aspiration is more difficult because it's quite a spectrum and you could get massive aspiration, I'm not saying you can't acutely decline from aspiration, but aspiration tends to be smaller particles and when you talk about aspiration, you quite often get later sequelae down the line, you get aspiration pneumonitis or you get aspiration

¹³¹ T82

¹³² T703-T704

pneumonia, if I'm making myself clear. So, that's why we leant more to a choking episode rather than an aspiration, but I'm not saying there's not aspiration as well.¹³³

- 119 Dr Charlwood agreed that she could not 'completely exclude' a cardiac arrest 'which was unrelated to the fact that they were eating at the time', but pointed to the fact of some cardiac rhythm as a contradictory factor.¹³⁴ I consider this alternative scenario is simply not established and is unlikely.
- 120 I am satisfied that there is sufficient evidence to make a positive finding about the cause of Mr Georgou's death. I accept Dr Alderman's comprehensive assessment of the factors leading to Mr Georgou's death and I accept Dr Charlwood's further explanations. I find that the particular circumstances point towards choking as distinct from other mechanisms explored during the Inquest. I find that the choking as explained by Dr Charlwood is established on the balance of probabilities and I enter a finding to that effect as set out in paragraph 116.

Assessment of the care provided to Mr Georgou

Professor Ibrahim

- 121 I was also assisted by evidence from Professor Ibrahim in relation to Mr Georgou. Professor Ibrahim said that the risk to Mr Georgou was able to be minimised, but it could not have been eliminated.¹³⁵ He said that it was commendable that those caring for Mr Georgou permitted him to live life the way he wanted, with meals he wanted to eat, notwithstanding that doing so came with risk. However, he said when doing so, they had to approach it in a way that was consistent with the recommendations made.
- 122 In relation to the meal, Professor Ibrahim cautioned that a photograph I received into evidence lacked the features that would be required to form reliable conclusions about the meal provided to Mr Georgou. In particular, it was without any scale reference that would allow for a determination of the size of the chunks of meat. Notwithstanding those cautions, Professor Ibrahim did express that the meal, viewed generally, was likely not in line with the recommended Level 6 (soft and bite-sized). He explained that, even when allowing for meat to shrink when cooked, the pieces were too large.¹³⁶
- 123 Professor Ibrahim explained that he viewed the selection of Level 6 (soft and bite-sized) to be a reflection more of Mr Georgou's preference rather than the specific recommendation of Ms Johns.¹³⁷ This was the subject of substantial questioning as Professor Ibrahim gave evidence that the diet selected was against Ms Johns' advice. After his evidence was finished, he reviewed all of the materials again and advised the Court that he had formed an impression that was not factually correct.¹³⁸ He agreed that the diet recommended was the diet formally selected by Ms Johns. I sincerely appreciate Professor Ibrahim's candour and utmost professionalism in his approach to this issue. However, I am not satisfied that this issue actually does boil down to a binary proposition that it was either Mr Georgou's preference or Ms Johns' preference. In my view, from

¹³³ T711

¹³⁴ T714

¹³⁵ T116

¹³⁶ T162

¹³⁷ T161

¹³⁸ Exhibit C11b

the records and the evidence I heard, while Ms Johns made the recommendation, it was not absent the context of what Mr Georgou wanted.

- 124 The issue was really whether there is a difference between a recommendation made by a health professional being pushed in a particular direction by their patient, and a recommendation made without any preference expressed. In my view, Professor Ibrahim's observation of this issue appears relevant. Ms Johns had conducted multiple assessments of Mr Georgou, each really aimed at trying to reduce the modification of his diet. Viewed in this way, it can be observed that Mr Georgou appeared to be more open to risk than other patients might have been. I have observed that a diet that does not resonate with an elderly patient can have a negative effect on their wellbeing. The task of Ms Johns, in light of Mr Georgou's preferences, was therefore to try to accommodate the least modified diet she could with whatever safeguards were necessary to achieve that. I do not consider this to be an unreasonable approach or for Professor Ibrahim's observation about this tension to be inapt. In my view, this reflects the realities of the work of a speech pathologist in the aged care sector. Of course, Ms Johns was required to approach the matter professionally and only recommend a diet that could be provided reasonably safely. In my view, she did just that. In particular, I refer to the occasion on 23 February 2021 when she was requested to upgrade the diet, but declined to do so where she perceived a high risk. She was clearly willing to make recommendations that were against Mr Georgou's wishes where that was necessary.
- 125 Professor Ibrahim considered that the supervision of Mr Georgou while he ate his meal on 6 April 2021 was inadequate.¹³⁹ He explained his reasoning that the placement of two courses within Mr Georgou's reach at the same time was inconsistent with the recommendation to spread his meals out over time and that separate presentations would have been preferable.¹⁴⁰ He left it to those with expertise in meal delivery to comment on how long the break should have been.¹⁴¹ He said that he was not able to discern from the CCTV footage who was actually responsible for closely supervising him.¹⁴² The footage also revealed that there was a division of attention between residents. Professor Ibrahim allowed for the possibility that the care provided was 'close supervision', although he expressed why that might not be so.¹⁴³ He particularly pointed out that in the aged care setting, a recommendation for supervision is usually intended to encourage independence, without intervention unless necessary.¹⁴⁴ He said that if the requirement for supervision was recommended at one-to-one, that would likely not have been feasible in any event, given the level of aged care funding available. Mr Psaromatis gave evidence about how close supervision would be applied at St Basil's in practice. He said:

...we knew that there is a distinction between supervision and assistance. We know that quite clearly. Assistance would happen in the unfortunate case where a resident could not help themselves to eat and physical assistance would be required. Close supervision on the other hand would be about monitoring and specifically for Mr Georgou the primary reason for close supervision was to stop the impulsive eating, to stop the rapid rate of mouthfuls which personally I had seen myself from Mr Georgou. I had seen him eating mouthful after mouthful without delay and on those occasions I do know that staff did prompt Mr Georgou

¹³⁹ Exhibit C11a at [83]

¹⁴⁰ T107

¹⁴¹ T156

¹⁴² T111 and T163

¹⁴³ Exhibit C11a at [87] and T115

¹⁴⁴ T108

to slow down and on those occasions it did end up the staff actually removing the meal from Mr Georgou. Mr Georgou wasn't too happy about the removal of that but on those occasions the staff were able to speak to Mr Georgou and return the food and encourage him to finish the meal at a slow rate. So in regards to close supervision particularly for Mr Georgou it was significantly about slowing down the rate of the mouthfuls and if you want me to go - I'll leave it at that.¹⁴⁵

- 126 In relation to the efforts after Mr Georgou began choking, Professor Ibrahim said that it is not possible to determine from CCTV footage whether the back blows administered were done with sufficient force,¹⁴⁶ but agreed that there is no specific requirement.¹⁴⁷ He accepted that trying to clear the blockage was a reasonable first step.¹⁴⁸ He said that the ideal response is back blows and chest thrusts while emergency help is being arranged. This was what happened. Another intervention would be to bend the patient forward, however Mr Georgou was heavy set and wheelchair bound. This would have been very difficult to practically achieve.¹⁴⁹
- 127 Professor Ibrahim said that even if everything had been done in a safer way, Mr Georgou may still have died while eating.¹⁵⁰ His final position was that there was a likelihood that the death could have been prevented, but that likelihood was small.

My assessment

- 128 Mr Georgou was assessed by a speech pathologist 11 times while he was at St Basil's. This is a very high level of care addressed to the issue of his dysphagia risks. I received evidence that St Basil's staff had IDDSI framework and dysphagia training in 2019 with the IDDSI teachings implemented at the time of Mr Georgou's death. His death therefore does not appear to reflect any systemic issue with the approach of St Basil's to the care of its residents.
- 129 In relation to the dysphagia assessments, in my view, it is only necessary to review the work of Ms Johns, as she performed the assessments in 2021 leading up to Mr Georgou's death. While these would no doubt have been influenced by earlier assessments, they were nevertheless separate and independent assessments and need to be considered on their individual merits.
- 130 Ms Johns demonstrated a quite reasonable approach to Mr Georgou. She was dealing with requests for more enjoyable meals to be given. She had to balance that against the risks presenting themselves through negative incidents. When she saw particularly concerning signs in February 2021, she ordered a pureed diet, taking a cautious approach. When she saw signs of improvement, she relaxed that approach. She put in place measures to mitigate the risks while allowing more enjoyable meals to be provided. I am satisfied that Ms Johns' approach to Mr Georgou was appropriate and reasonable. I accept the submission that her role was to make recommendations and to leave it to care staff to

¹⁴⁵ T669

¹⁴⁶ T112

¹⁴⁷ T150

¹⁴⁸ T146 and T151

¹⁴⁹ T112-T113

¹⁵⁰ T164-T166

determine the manner in which those recommendations should be implemented.¹⁵¹ She was not under any obligation to provide total specificity on all eating issues.

- 131 Turning to the implementation of Ms Johns' recommendations, and specifically the meal provided, namely lamb fricassee with rice, I find on the balance of probabilities that the meal was prepared in accordance with the IDDSI diet recommended by Ms Johns. This finding is made notwithstanding Professor Ibrahim's reservations.
- 132 In my view, Ms Johns' recommendation for close supervision needs to be viewed in the context of the content of that supervision. In relation to Mr Georgou, there was a need for monitoring of the speed of consumption and verbal prompting on that topic. Therefore, in the context of his case, close supervision had to involve supervision for a duration and from a distance where those things could be properly monitored. I am satisfied that this occurred. As multiple witnesses explained, the requirement for close supervision must also be contrasted to a more onerous obligation, such as constant supervision or constant observation. I accept that the attention of the nurse and carers was divided among other patients, but it remains that there were a high number of staff supervising a relatively small number of people.
- 133 I find that Mr Georgou's consumption of food in an inappropriate manner was not a consequence of any failure to provide close supervision as was recommended. A higher level of supervision had not been recommended and the need for it had not demonstrated itself.
- 134 In relation to the care provided following Mr Georgou's unresponsiveness, Nurse Chen gave evidence that the entire incident occurred very quickly, within minutes.¹⁵² In assessing the actions of those involved, I must allow for the natural human reactions involved in stressful scenarios. In particular, I recognise that it will take people some moments to identify what is happening and make decisions about how to respond. While these are trained and qualified individuals, I do not overlook that there remains a reasonable time for skilled people to properly approach events like these. I also observe that they would equally be open for criticism if they were required to rush to act without properly assessing the situation, as they might administer an inappropriate intervention that worsens the situation. Professor Ibrahim explained that there can be hesitation in striking an elderly person too hard for fear of hurting them and that it is not possible to determine whether blows were applied with proper force or not. Hindsight bias must be avoided in my assessment as demanded by The Australasian Coroner's Manual.¹⁵³
- 135 The footage reveals a delay of about a minute from the identification of potential choking to the delivery of back blows. In the context of the factors discussed above and the lack of evidence that there would have been any meaningful impact of earlier blows, I am satisfied that there should be no criticism of this brief delay.
- 136 Having administered multiple back blows and having tried to clear Mr Georgou's airways, he remained unresponsive. An ambulance was called. Mechanical suction was used to try to further clear the airways. Chest thrusts were conducted. These are all reasonable and appropriate measures that were, sadly, unsuccessful. I do not find any

¹⁵¹ T593

¹⁵² Exhibit C12a at [11], T183 and T198

¹⁵³ At pp 10-11

criticism in the reaction to, and the manner in which it occurred, this episode of unresponsiveness.

- 137 The efforts by paramedics were comprehensive and reasonable. Like St Basil's staff, they were not able to remove all of the blockage to achieve ventilation, even with forceps. I find that their efforts were reasonable and that there were likely no greater measures available that would have made a meaningful difference.

Preventability

- 138 I am satisfied that the fact that Mr Georgou had begun choking was identified reasonably quickly. However, by the time it was identified, his airway was blocked in a manner that was not able to be wholly reversed, or even reversed to a degree that permitted sufficient ventilation. That was, no doubt, contributed to by Mr Georgou's rapid approach to eating.
- 139 While Mr Georgou was required to be guided to slow his eating, I am not satisfied that doing so here would have prevented his airway becoming blocked. In making this assessment, I particularly rely on my own observations of Mr Georgou's eating as recorded on the CCTV footage. His pace appears fairly steady. I am not able to be satisfied then that telling him to eat more slowly would have had any actual impact on what happened.
- 140 In relation to the meal presented, I must reflect on and pay due regard to the decisions made in the lead up to the incident. There were concerted efforts to have Mr Georgou fed meals that he found more enjoyable. That was his, and his family's, right to request. His dysphagia, while worsening, was not to a degree that he was entirely unable to eat more solid meals. On the balance of probabilities therefore, I am not prepared to reach the conclusion that it was unreasonable to allow Mr Georgou's preferences to be persuasive and I am not satisfied that the diet recommended was inappropriate in all of the circumstances. There are always risks involved in pushing against medical advice, but those risks are often taken on for good reason. It is not my role to make an assessment of whether Mr Georgou and his family's requests for more solid food were wise. They were simply a reflection of his preferences and his weighing of competing factors and in that sense could never be inappropriate.
- 141 I am satisfied that after the choking was identified, that appropriate care was provided. Back blows were administered with manual attempts at clearing the airway. There was then suctioning applied without success. Paramedics were able to remove food lodged deeper, using forceps, but this was still not successful. The CPR efforts as described were all reasonable interventions and the best that could have been provided in the circumstances. After commencing choking, there were no interventions available in the aged care setting that could have prevented Mr Georgou's death.

- 142 For those reasons, I am unable to conclude that Mr Georgou's death could have been prevented.

Improvements

- 143 I heard evidence that St Basil's policies and procedures are subject to routine review and updating. An example of an update that was drawn to my attention was the enhancement of advice given to staff who observe signs of choking about what steps to take. I heard

that a mock choking scenario was conducted as part of a staff training drill in 2022.¹⁵⁴ Annual dysphagia training has been mandated for qualified care staff. These are positive improvements that will assist to prevent a similar event happening again.

Recommendations

144 I am required to consider whether there are any recommendations I consider appropriate to make that would reduce or prevent circumstances such as those that arose in Mr Roach and Mr Georgou's cases from happening again, or that would otherwise improve public health and safety.

145 I am satisfied that an improvement in the knowledge of care workers administering meals about the signs of choking might assist in bringing attention to residents who begin to struggle slightly earlier. I do not wish to limit my recommendation to the two facilities involved, as such an improvement should be considered by all aged care facilities. In accordance with s 25(2) of the *Coroners Act 2003* (SA) and s 341(1) of the *Aged Care Act 2024* (Cth), I make the following recommendation to the Department of Health, Disability and Ageing and the Commonwealth Minister for Aged Care and Seniors:

One That a communique be made to all aged care facilities formally encouraging them to provide training to personal care workers who may be involved in the provision of meals to residents about dysphagia and how to identify the early signs that a resident might be struggling with swallowing.

146 I was particularly impressed by the international protocols developed which govern advice about diets. The standardisation of language on that topic carries significant safety benefits. I am satisfied that a similar improvement could have similar benefits in relation to the language used around supervision. For example, if there was a clear stratification of the types of supervision required for patients with dysphagia, this would provide clear guidance and understanding for aged care facilities and could be used in the planning of resources required for meal delivery. The peak body for speech pathologists is Speech Pathology Australia. While they are not responsible for the governance of speech pathology services, they appear to be an appropriate body to spearhead a standardisation effort. I therefore make the following recommendation to Speech Pathology Australia:

Two That a project be undertaken to consider the benefits of publishing a standardised set of supervision levels that speech pathologists can use to clearly explain what supervision of a particular patient with dysphagia should encompass. The adoption of standardised language could be achieved in a similar manner to the IDDSI framework.

147 I was asked to make a recommendation mandating a post-mortem examination in circumstances such as Mr Georgou's. This would do nothing to prevent the same circumstances that led to Mr Georgou's death from happening again and could only, of course, tangentially improve public health and safety through having a clearer result at Inquest. The decision to order a post-mortem examination is the solemn duty of the State Coroner of South Australia. It is never a decision taken lightly, or without many difficult considerations being weighed. I am satisfied that it is inappropriate to recommend that the discretion of the State Coroner or other individual Coroners be curtailed to achieve

¹⁵⁴ Exhibit C9 at [129]

certainty, particularly here where I have found that there is sufficient evidence to establish a cause of death on the balance of probabilities without a post-mortem examination having been conducted. I refrain from making the recommendation sought.

Condolences

- 148 While the families of Mr Roach and Mr Georgou will no doubt be grateful that each lived a long and happy life, it is nonetheless difficult to accept the loss of a loved one in such sudden and traumatic circumstances as these occurred.
- 149 I express my sincere condolences to the family of Mr Roach and the family of Mr Georgou.

Keywords: Dysphagia Management; Speech Pathology; Swallowing Assessments