FINDINGS and COMMENTS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Kenneth Francis Dunster

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Kenneth Francis Dunster with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

29 October 2018 at Hobart in Tasmania

Representation

Ms E Avery Counsel Assisting the Coroner

Ms G Chen for the Tasmanian Health Service

Introduction

1. Mr Kenneth Francis Dunster was born in Hobart on 16 January 1963. He grew up as part of a close family in the suburb of Warrane and was educated locally. A champion boxer and talented athlete, after finishing school he joined the Australian Regular Army where he served as a gunner in the Royal Regiment of Australian Artillery (RAA) for three years

2. After his discharge from the RAA, in about 1985, Mr Dunster returned to Tasmania. His brother, Allen, said that after the discharge Mr Dunster had trouble with the police for what he described as “stupid stuff”, like fighting. It is apparent that during this time Mr Dunster was struggling with mental health and seemingly never participated in full-time employment again. Allen describes him as suffering from massive mood swings during this time. As Mr Dunster’s mental health continued to

worsen so did his physical health. Mr Dunster spent some time in prison in his 30s during the late 1990s.

3. Allen said that his brother would spend time in Tasmania, return to Queensland and then return back to Tasmania fairly regularly. During this time Mr Dunster fathered a child with whom he had contact in the latter part of his life.[1]

4. From about 2007 Mr Dunster's mental health deteriorated to such an extent that he required treatment as an inpatient in mental health facilities both in Queensland and Tasmania. The evidence was that he was diagnosed as suffering from chronic schizophrenia and presented with declining cognitive function, paranoia, disordered thoughts and hallucinations. In addition to his mental health issues he had a documented history of heart disease and obesity.

5. At the time of his death Mr Dunster was the subject of a treatment order, made on 14 November 2014 pursuant to section 39 of the *Mental Health Act* 2013.[2] That order was renewed by the Mental Health Tribunal on 5 May 2015 and was expressed to remain in force until 12 November 2015. Mr Dunster was subject to that order at the time of his death. Amongst other things, the order authorised Mr Dunster's detention for treatment at the Millbrook Rise Centre as an inpatient. It also mandated his use of antipsychotic and other medication.

6. Mr Dunster was also the subject, at the time of his death, to an order made on 13 March 2015 under the terms of the *Guardianship and Administration Act* 1995.

7. As the order under the *Mental Health Act* 2013 was current at the time of Mr Dunster's death, he was consequently a person "held in care" in terms of section 3 of the *Coroners Act* 1995 (the 'Act") at the time of his death. As such, an inquest into his death was mandatory and I am

[1] Exhibit C8 affidavit of Allen James Dunster sworn 31 August 2015.
[2] Exhibit C24.

obliged to report on the care, supervision or treatment of Mr Dunster while he was held in care.[3]

8. Mr Dunster had spent a significant period of the last 10 years of his life in and out of the Millbrook Rise Centre. He was well known to the staff. He was what might be described as a 'creature of habit'. Mr Dunster was a regular smoker and had a particular chair in the lounge room where he would return to meals to watch television.[4] At times demanding, occasionally intimidating and sometimes verbally and physically aggressive towards other residents and staff[5], Mr Dunster's mental and physical health deteriorated significantly in the six months leading up to his death. Staff described his personal hygiene as poor and it was apparent to many that his memory was declining.

The Role of the Coroner

9. However, before an analysis of the circumstances surrounding Mr Dunster's death is undertaken, it is important to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. In this case, because Mr Dunster died in care as has already been noted, the *Act* makes an inquest mandatory.[6] An inquest is a public hearing.

10. When investigating any death, whether or not an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Act* asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the

[3] See section 28(5).
[4] Exhibit C10a affidavit of Graham Frank Vessey sworn 3 July 2015.
[5] Exhibit C15 affidavit of Vicki Anne Plummer sworn 2 July 2015.
[6] Section 24(1) (ea).

death.[7] A coroner is required to make findings of fact from which others may draw conclusions.[8] A coroner is also able, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

11. A coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of a crime or offence.[9] I should make it very clear that in this case there is no reason to think, at all, that anyone has committed any crime or offence in relation to Mr Dunster's death.

12. As was noted above, one matter that the *Act* requires is finding how the death occurred.[10] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[11] Any coronial inquiry necessarily involves a consideration of the circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1) (b) upon the coroner.

13. The standard of proof in coronial inquests is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquiry reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw.*[12] That case is authority for the proposition, that the task of deciding whether a serious allegation is proved should be approached with great caution.

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[7] See *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7.
[8] See *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76.
[9] Section 28(4) of the Act.
[10] Section 28(1)(b) of the Act
[11] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[12] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

Circumstances of Death

14. The evidence was that on the morning of 1 July 2015 Mr Dunster arose as normal and went about his normal activities in Tyenna Green Ward. Tyenna Green Ward is one of three sections of the Millbrook Rise Rehabilitation Centre. The evidence was that the Centre was a 27 bed unit consisting of three sections. One, Tyenna Blue, was a six bed closed section. Another - Tyenna Green, where Mr Dunster was housed - was described as an open section containing 11 beds. The other unit – the Clyde Unit – was a 10 bed rehabilitation section housing patients who had been flagged as likely to be discharged to the community.

15. Mid-morning Mr Dunster was seen having a cup of tea (his preferred hot beverage) in his usual chair in the lounge area of his ward. As usual, he was seen to go outside several times in the course of the morning for cigarettes. All staff who gave evidence about his behaviour on 1 July 2015 said there was nothing unusual about his behaviour.

16. As normal, lunch was served in Tyenna Green from 11.55am. The practice was that all residents were required to eat their meals in the communal dining area. The evidence was that Mr Dunster normally sat at the same table in the same seat. That table and seat was closest to the lounge room and faced towards the sink in the communal dining area. On 1 July 2015 lunch was chicken cacciatore with mashed potato and vegetables. Ms Angela Berry, a ward aide, said that Mr Dunster was served with his meal and started to eat the food in his usual way at his usual table.

17. Ms Berry's responsibility was to serve meals from the kitchen. She did so on 1 July 2015 but did not actively supervise the patients. In evidence at the inquest she said she remembered serving Mr Dunster his meal and noticing him eating. However, she conceded that she paid no particular attention to Mr Dunster occupied as she was with her duties in the kitchen.

18. Mr Mark Steward, a registered nurse, was rostered on in Tyenna Green on 1 July 2015. He said in his evidence that he administered medication to two of the residents of the ward between 11.55am and 12.05pm, and then moved on to assist with the supervision of lunch. He said that, as at 1 July 2015, Tyenna Green ward accommodated 11 patients and that only he and Ms Berry were on duty at lunch. His evidence was that three members of staff were rostered on for the day, however, one staff member was not present, having returned home for their lunch. Apparently this practice of staff absenting themselves at lunch was common.

19. Mr Steward said that at about 12.10pm to 12.15pm as he was collecting cutlery and plates from a dining table he was alerted by a patient that Mr Dunster was on the floor.[13] Mr Steward saw Mr Dunster lying face down on the floor of the lounge room about 6 metres away from where he was in the dining area. Mr Steward went straight to Mr Dunster. He found him unresponsive. He called out to Ms Berry for assistance and one or other of them (it was unclear whom and nothing turns on it) activated a duress alarm. Mr Dunster was rolled onto his side into the recovery position. Neither Mr Steward nor Ms Berry noticed any movement on his part or breathing. Mr Dunster's airway was checked by Mr Steward and it was found to be obstructed by food. Mr Steward also noted a bruise on Mr Dunster's forehead which had not been present earlier. Ms Berry also saw the bruise.

20. As this was happening Dr Graham Vessey, a psychiatric registrar at the Centre, entered Tyenna Green unit to return some dishes after lunch. He saw Mr Dunster on the floor in the lounge room. He described seeing blood to his forehead and either food or vomit next to him. Dr Vessey said he noticed a coffee table in the area of Mr Dunster that was at an odd angle and concluded that Mr Dunster had hit his head on the coffee table.

[13] Exhibit C12 affidavit of Mark Steward sworn 7 September 2015.

21. Dr Vessey said Mr Dunster was unresponsive. He described him as appearing to be grey or blue. Dr Vessey inspected Mr Dunster's airways and noticed a small amount of blood which he thought might have been from Mr Dunster biting his tongue. He also noticed food particles in Mr Dunster's mouth.

22. Attempts at resuscitation were commenced immediately. By now, Glen Archer, another ward aide, had responded to the alarm activation and assisted with resuscitation attempts. A defibrillator and an oxygen mask were brought to the scene by other staff members. An ambulance was called and dispatched at 12.22pm.[14] The Ambulance Tasmania records indicate that an ambulance with an intensive care paramedic and two volunteer ambulance officers arrived at the Millbrook Rise Centre at 12.27pm. The paramedic and ambulance officers took over attempts at resuscitation. They found Mr Dunster's airway to be completely blocked by food. The paramedic and ambulance officers noted Mr Dunster to be asystole. Mr Dunster was also difficult to ventilate.[15]

23. At about 12.35pm with no signs of life present, after the use of the defibrillator and following consultation between the Intensive Care paramedic, Dr Vessey and Dr Vessey's supervisor, Dr MacArthur, resuscitation efforts ceased.

24. The evidence at inquest satisfies me that staff responded appropriately (with one exception which I will deal with later in these findings) and were appropriately trained in relation to emergency first-aid.

Investigation

25. The fact of Mr Dunster's death was reported to police by the attending Intensive Care Paramedic at 12.40pm. Within a short time police attended the scene. The scene was carefully examined and comprehensively photographed. Mr Dunster's body was photographed

[14] Exhibit C7 Ambulance Tasmania electronic dispatch records.
[15] Exhibit C16 affidavit of Bruce Robert Connor sworn 18 July 2015.

where he died and after formal identification[16] transported to the mortuary at the Royal Hobart Hospital.

26. Attending police, who included detectives from the Criminal Investigation Branch, uniform officers, and an officer from Forensic Services, found nothing at the scene of Mr Dunster's death giving rise to any suspicion that death occurred in any way other than as described by staff at the inquest.

27. I am satisfied that there were no suspicious circumstances associated with Mr Dunster's death, that no other person played a role in it, and that it occurred in the manner described above.

28. Dr Donald McGillivray Ritchey, a very experienced forensic pathologist, carried out an autopsy on Mr Dunster's body the next day. Dr Ritchey expressed the opinion, that the cause of Mr Dunster's death was asphyxia due to choking on food.[17] He noted significant contributing factors were schizophrenia and advanced atherosclerotic cardiovascular disease. He recovered a 50g chunk of poorly chewed white meat that appeared to be chicken from Mr Dunster's throat. I note that the evidence was that chicken had been Mr Dunster's last meal.[18]

29. I accept Dr Ritchey's opinion as to the cause of Mr Dunster's death.

Choking Risk and Response

30. The investigation in relation to the circumstances surrounding Mr Dunster's death involved, amongst other things, a review of his records at the Centre. Those records were tended at the inquest.[19] A factor that emerged from the records was that it was recognised by many staff, and

[16] Exhibit C3 affidavit identification Constable Bradley Coulson sworn 1 July 2015.
[17] Exhibit C5 affidavit of Donald McGillivray Ritchey sworn 25 November 2015.
[18] Exhibit C13 – Affidavit of Angela Berry sworn 6 August 2015.
[19] Exhibit C27.

carefully recorded, that Mr Dunster was at risk of choking because of the manner in which he consumed his food.

31. His brother Allen gave evidence at the inquest to the effect that, for as long as he could remember, Mr Dunster had always “guzzled his meals”.

32. Many Centre staff members who knew Mr Dunster made similar comments in their evidence relating to the manner in which he ate. Ms Plummer said in her evidence that she would “almost say he gorged his meals.” She said she and others would often have to tell him to slow down.[20] Other staff said much the same thing.[21]

33. It is clear, and I am so satisfied, that most, if not all, staff members at the Centre were well aware of the risk that Mr Dunster ran of choking on his food. This was true during his final admission to the Centre as well as during earlier admissions.

34. Mr Dunster, like all other patients at the Centre, had what was described in evidence as an Individual Service Plan. That document was included in the medical records tendered at the inquest. Although not designed to identify risks, the reality was that the document did deal with risks. The Plan expressly identified Mr Dunster as a choking risk. Hand written entries on 16 May 2015 make this clear. A strategy to address his choking risk was noted to be a need to observe him and remind him to slow down and chew his food when eating.

35. A number of other entries deal expressly with the risk of him choking (see for example entries 28/29 May 2015, 16 June 2015, 21 June 2015 and 24 June 2015).

36. I do note that there is no evidence that at any time prior to Mr Dunster’s death he had in fact choked on his food, and certainly not whilst a resident at the Centre.

[20] Exhibit C15 affidavit of Vicki Ann Plummer sworn 2 July 2015.
[21] See for example Exhibit C12 - Affidavit of Mark Steward 17 September 2015 and exhibit C13 affidavit of Angela Berry sworn 6 August 2015.

37. Although the medical records are replete with references to Mr Dunster's risk of choking the reality seems to have been that the management of him as a choking risk was, in real terms, non-existent. A good deal of the evidence at the inquest focused upon how staff at the Centre managed (or did not manage) the choking risk that had been so clearly identified in Mr Dunster's case. What emerged from the evidence at the inquest was that there was no formal process in place to manage Mr Dunster's risk of choking. Further the informal steps that were taken seem to have been singularly unsuccessful.

38. Mr Glen Archer (who had known Mr Dunster for four years) said in his evidence at the inquest that Mr Dunster was a difficult person to persuade to do anything and, moreover, that his cognitive impairment meant that his ability to comply with requests was, at best, variable. Mr Dunster often presented as agitated and although initially compliant with any request to slow down eating his food, he would quickly speed up again within moments. Mr Archer's evidence was to the effect that verbal efforts to attempt to have Mr Dunster slow down when eating his food were not successful.

39. Mr Steward (who had known Mr Dunster for eight years) also gave evidence about efforts to manage Mr Dunster's access to food. He expressed the opinion that reducing or limiting Mr Dunster's access to food would have adversely impacted upon his quality of life. Mr Steward had never seen Mr Dunster choke previously and was unaware of any prior similar incidents. Like Mr Archer, Mr Steward said in his evidence at the inquest that he did not believe Mr Dunster would listen to any request to slow down when eating.

40. Dr Vessey described Mr Dunster as a person not especially amenable to suggestion who had difficulty managing daily activities and had little capacity to engage socially. Dr Vessey said that he believed that attempts to manage Mr Dunster's choking risk (by telling him to slow down) would not have been effective and were likely to have been met with hostility and aggression.

41. Dr Milford MacArthur, the psychiatrist in charge of the Centre, swore an affidavit that was tendered after the inquest.[22] The affidavit comprehensively addressed the issues surrounding the choking risk to Mr Dunster from the Centre's perspective.

42. Dr MacArthur said that, like all patients at the Centre, Mr Dunster was at an increased risk of choking and aspiration. In Mr Dunster's case this was as a consequence of suffering from schizophrenia. He said that the risk of choking from a patient with schizophrenia was 15 per hundred thousand per year compared to 1.9 per hundred thousand per year in the general population.

43. Dr MacArthur said that by reason of the profile of the patients at the Centre staff were acutely aware of choking risks.

44. His affidavit dealt with the particular risk associated with Mr Dunster and what was done to address it. Dr MacArthur said that Mr Dunster was reviewed regularly regarding his mental and physical health. He noted that several weeks prior to his death, Mr Dunster was seen to have some motor side-effects, although not specifically swallowing difficulties, as a result of medication. The team responsible for his treatment and care therefore made a decision to reduce his medication, which Dr MacArthur thought "would have reduced any motor side-effects, including any swallowing difficulties that may have been present."

45. Dr MacArthur also said that as Mr Dunster was prescribed clozapine and some other antipsychotic medication those drugs may have affected his swallowing mechanism. He said that "regular blood testing showed, however, that his serum level was in the therapeutic range [and] he was not over sedated".

46. Dr MacArthur said at paragraph 21 of his affidavit:

> "*In 2015 we introduced a regular dental care plan for all [centre] patients who would agree to see the dentist. One consequence*

[22] Exhibit C30.

of good dental hygiene has been reported to be a reduction in the risk of choking. This is because poor missing teeth can result in poor chewing and larger boluses. Prior to 2015 patients were only seen by dentist because of complaints or symptoms."

47. Commendable as this approach is, there is no evidence Mr Dunster saw the dentist nor even that the program was in place before Mr Dunster's death.

48. Dr MacArthur said that there had been a change to the eating arrangements for patients at the Centre since Mr Dunster's death. He said that patients now must eat their meals in the dining area which is supervised by three members of staff at all times. One staff member is specifically tasked with observing patients eating while the other two staff members attend the administration of medication and the like within the dining area. That procedure appears to have been implemented in late March 2018. Dr MacArthur annexed to his affidavit an email from the Nurse Unit Manager, Mr Tom O'Brien, addressing that issue. The email indicates that "there is a need to have maximum numbers of staff around the midday meal time". It is noteworthy that on the day of Mr Dunster's death the maximum number of staff were not present as one staff member was absent on his or her meal break.

49. Relevantly, Dr MacArthur's affidavit made other points that I consider important in the context of the inquest. First is that reports from staff present at the time of Mr Dunster's death do not indicate that he exhibited characteristic behaviour patterns of people who are choking, such as pointing to his throat. He opines, not unreasonably in my view, that this may have resulted in the assumption that Mr Dunster was experiencing a cardiac event (something that he had experienced in the past and something that staff members were aware of).

50. Second, Dr MacArthur at paragraph 26 of his affidavit says that there are now "regular meetings at the [Centre] between the cook, nursing management and medical staff in an effort to ensure healthy and 'safe'

food is presented to the patients". The meetings are held every three months and matters such as portion size and calorie intake are considered.

51. Finally, I also note that subsequent to Mr Dunster's death a chart entitled "Foreign Body Airway Obstruction (Choking)" has been displayed in all units at the Centre. The chart provides an easily understood and quick overview of the appropriate first-aid response to a patient choking.

Formal Findings

52. On the basis of the evidence at the inquest, I find, pursuant to Section 28(1) of the *Act,* that:

    a. The identity of the deceased is Kenneth Francis Dunster;

    b. Mr Dunster died in the circumstances set out in this finding;

    c. The cause of Mr Dunster's death was asphyxia due to choking on food; and

    d. Mr Dunster died on 1 July 2015 at the Millbrook Rise Rehabilitation Centre, New Norfolk in Tasmania.

Report on Care, Supervision or Treatment

53. As indicated earlier in these findings it is necessary for me to comment upon the care, supervision and treatment of Mr Dunster whilst he was a person held in care at the Millbrook Rise Rehabilitation Centre.

54. Some confusion attended the evidence in relation to the nature of the "code" that was called. This seemed on the evidence to be a perception that it mattered not whether a code blue or a code black was called, with staff saying that the important thing was that there would be a general response to the incident. With respect I cannot agree that the nature of the emergency did not matter. The obvious point, or so it seems to me, is that a medical emergency calls for a completely different response than the threat or actuality of an assault or an attack upon staff or

another patient. Part of the difference in response is the fact that medical response equipment (oxygen, defibrillator and the like) will need to be taken to a medical emergency but is completely unnecessary at a code black. In this regard I comment that the response to Mr Dunster's collapse may have been improved.

55. It is clear on the evidence that none of the staff members recognised immediately that Mr Dunster was choking. Not unreasonably in my view, in light of his cardiac history, the focus was upon him suffering a cardiac event. This there is no basis to criticise staff collectively or individually for their response to Mr Dunster discovered collapsed on the floor.

56. I turn to the issue of supervision. As Ms Chen, counsel for the State of Tasmania, submitted in her helpful written submissions, the evidence was that on the day of Mr Dunster's death only two members of staff were on duty in the dining room to supervise residents taking their lunch. The third staff member was not present as she or he had gone home for lunch. I have already noted that staffing levels in the dining room have since been addressed and have touched upon the rationale for that which was amongst other things to "provide assistance with lunchtime meals and mitigate related incidents".[23] Although it may be true, as Ms Chen submits, that I cannot be satisfied that increased levels of supervision would have prevented Mr Dunster's death, the fact is that it may have had that effect and certainly appropriate levels of supervision may prevent further similar deaths.[24] As such, I comment that on the day of Mr Dunster's death the level of supervision afforded to him (and for that matter other residents) was lower than was necessary to ensure the safety of the patients on the ward.

57. The final area of comment in relation to Mr Dunster's care, supervision or treatment relates to what response, if any, beyond existing efforts staff could employ to attempt to have him slow down eating. In light of all of the evidence in relation to Mr Dunster's eating habits, that is to say,

[23] Annexure A to affidavit of Dr Milford MacArthur sworn 7 November 2018.
[24] See section 28(2) of the Act.

his lifelong habit of “bolting” down his food and the nature of his illness (meaning he was not amenable to advice or suggestion and that he was at increased risk of choking), it is difficult to see what else could have been done at an individual level so far as Mr Dunster was concerned.

58. The circumstances of Mr Dunster’s death and the evidence received at inquest in relation to various changes made at the Centre, including the introduction of enhanced dental services, ensuring maximum numbers of staff are available to supervise meals and the focus on first-aid response to choking deaths do not require me to make any comments or recommendations other than those set out above.

Conclusion

59. I express my thanks to Ms Avery and Ms Chen counsel at the inquest for their assistance.

60. In conclusion, I offer my sincere and respectful condolences to Mr Dunster’s family on their loss.

Dated: 11 January 2019

Simon Cooper
Coroner