IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 3139 / 2009

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Gregory Donald Cole

Delivered On:	8 May 2015
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	13 March 2012, 14 March 2012 and 29 March 2012
Findings of:	PETER WHITE, CORONER
Representation:	Ms J Mizzi, sister of Mr Cole Mr R Stanley appeared on behalf of Babtcare Mr Peter Darmos, on behalf of Australian Commercial Catering
Police Coronial Support Unit	Leading Senior Constable Amanda Maybury

I, PETER WHITE, Coroner having investigated the death of GREGORY DONALD COLE

AND having held an inquest in relation to this death on 13, 14 and 29 March 2012

at Melbourne

find that the identity of the deceased was Gregory Donald Cole

born on 5 February 1959

and the death occurred on 25 June 2009

at Wyndham Lodge, 120 Synott Street, Werribee, Victoria

from:

1 (a) CEREBRAL HYPOXIA AND BRONCHOPNEUMONIA POST EPISODE OF CHOKING (FROM CLINICAL HISTORY)

CONTRIBUTING FACTORS

2 CARDIOMEGALY, MYOCARDIAL FIBROSIS AND ISCHAEMIC CORONARY ARTERY DISEASE

in the following circumstances:

1. Gregory Donald Cole was a 50- year- old man who, at the time of his death was a resident of Wyndham Lodge in Werribee Victoria. He had suffered a stroke and had one leg amputated from below the knee. He also only had use of his left arm and ambulated with the use of a motorised wheelchair.

2. Mr Cole passed away on 25 June 2009 after a choking incident on 23 June 2009. The choking incident was the subject of my inquest in to Mr Cole's death. He was taken to the Sunshine Hospital Emergency Hospital where he was diagnosed with severe hypoxic brain injury and the decision was made to return Mr Cole to Wyndham Lodge for palliation. He subsequently passed away on 25 June 2009.

3. Dr Malcolm Dodd of the Victorian Institute of Forensic Medicine performed a post mortem medical examination. Dr Dodd provided a report of his findings at autopsy. He noted that the immediate cause of Mr Cole's death appeared to be cerebral hypoxia and bronchopneumonia after an episode of choking. Dr Dodd commented that the examination disclosed histological evidence of both acute and remote episodes of hypoxia as well as bronchopneumonia. Significant ischaemic coronary artery disease was identified. Mr Cole's cause of death was not in issue and I adopt Dr Dodd's findings in relation to the medical cause of death.

Investigation and Inquest

4. During the course of my coronial investigation, I received an application from Janine Mizzi, Mr Cole's sister, requesting that an inquest be held in relation to her brother's death. From the material available to me prior to inquest, it appeared that there was discrepancies in the circumstances surrounding Mr Cole ultimately choking on a food bolus on the evening of 23 June 2009. I therefore granted that application and determined to hold an inquest under section 52 (1) of the *Coroners Act 2008*.

5. At inquest I heard testimony from the following witnesses:

    a. Angela Tararas, Speech Pathologist

    b. Cheryl Matthewman, employee of Australian Commercial Catering (ACC)

    c. Lisa Lynch, Personal Care Assistant

    d. Jennifer King, Register Nurse Division 1

    e. Michael Mizzi, brother in law of Mr Cole

    f. Victor Madeira, Chef Manager at the time,

    g. Jade Roether, Trainee Division 2 Nurse

    h. Leanne Mackey, Director of Nursing

6. I note that this finding is based on the totality of the material the product of the coronial investigation into Mr Cole's death. This material includes the inquest brief prepared by Constable Lee Kendrick, Wyndham Lodges' records relating to Mr Cole, the testimony of the witnesses called and final submissions by the interested parties. This finding does not propose to summarise all the evidence but will refer to it in only such detail as is warranted by its forensic significance and its interest in narrative clarity.

Background Circumstances

7. Mr Cole resided in room 9 of the high care area at Wyndham Lodge.[1] Catering for the facility was provided independently by Australian Commercial Catering Pty Ltd.

8. Mr Cole was admitted to Wyndham Lodge on 19 January 2009. He had moved to this facility from Corpus Christi Community Home in Greenvale in order to be closer to his family. His sister Ms Mizzi, was his primary carer and visited him a number of times during the week.

[1] After Mr Cole's death, Wyndham Lodge was taken over by Baptcare in August 2011.

9. Upon admission, he was assessed by the Director of Nursing, Ms Leanne Mackey. The Dietary Advice/Request form signed by Ms Mackey notes that Mr Cole was to receive a normal diet but that staff were to cut up his food as he only had use of his left arm.[2]

10. Mr Cole was then assessed on 29 January 2009 by speech therapist Ms Angela Tararas. Ms Tararas completed a Dietary Advice Alteration[3] form noting that Mr Cole presented with a 'moderate predominantly oral stage dysphagia and therefore requires a modified diet'. Ms Tararas made four recommended alterations. The recommendations were:

    a. That Mr Cole commence a soft (texture A) cut up diet including cut up meats (soft) and increased gravies and sauces.

    b. Continue thin free fluids as these were tolerated safely

    c. Sandwiches with soft fillings/spreads may be offered cut up in small fingers.

    d. Discontinue dry/crumbly goods including rice dishes, pastries and biscuits.

11. Ms Tararas's assessment was also written up in Mr Cole's progress notes and a note made in his Care Plan.

12. Ms Tararas again reviewed Mr Cole on 11 March 2009 and completed another Dietary Advice Alteration[4] form. Ms Tararas again recommended that an alteration to his diet be made as he presented with mild-moderate predominately oral stage dysphagia. She recommended that he commence a finely chopped diet including finely chopped meats and '++ gravies/sauces to moisten'. He was to continue with thin free fluids as were tolerated safely. These changes were again noted in the progress notes and the care plan.

13. On 2 June 2009, Mr Cole was referred to Ms Tararas for a further assessment of his swallow function. Ms Tararas completed a Change of Food/Fluid Consistency Form. Ms Tararas emphasised on the form that Mr Cole's meals needed to be finely chopped, as it had been reported that meals were being cut up but not finely chopped.[5] These changes were communicated to nursing staff and kitchen staff as evidence by the signatures on the form.

14. Arrangements were made for Mr Cole to eat his meals at a table behind the nurses station as he liked to have a private space to eat but he also needed supervision.

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[2] See Exhibit 9B.

[3] See Exhibit 1D.

[4] See Exhibit 1E.

[5] See Exhibit 1A.

Events of 23 June 2009

15. On 23 June 2009, Mr Cole's brother in law Mr Mizzi and his son, visited him at approximately 5.20 pm.[6] Mr Mizzi attended the inquest to give evidence. He stated that he and his son remained at Wyndham Lodge in Mr Cole's room for approximately 20 to 25 minutes.[7] Five minutes before he and his son left, he testified that a female delivered Mr Cole's evening meal and left the room.[8] The meal was covered up and he did not see the contents of the meal.[9] He testified that he left at approximately 5.45pm.[10] He did not recognise any of the nursing staff on duty that night that were present in the Court when he gave evidence.[11] The person who attended was wearing an apron and he had the impression that this person was one of the kitchen staff, by the way they were dressed.[12]

16. At sometime before 5.35 pm (see footnote 10), Registered Nurse Division 1, Jennifer King, was attending to another resident in room 14, when she exited the room, and observed Mr Cole at the door of room 14 in his wheel chair, cyanotic and dyspnoeic. Ms King called for the assistance of Jade Roether and they immediately removed Mr Cole from the chair and placed him in the left lateral position. Ms King then suctioned Mr Cole's airways but only removed blood. It is her evidence that Mr Cole took at least two breaths on his own but then his heart rate and respirations ceased. They commenced Cardio Pulmonary Resuscitation (CPR). The Director of Nursing Called 000.

17. The Ambulance Victoria electronic Patient Care Report notes that the call was received at 5.39 pm, the ambulance crew were dispatched at 5.40 pm and arrived on the scene at 5.53 pm. Two ambulance crews were in attendance.

18. Paramedic Paul Furniss provided at statement[13] to the Court. Mr Furniss reported that

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[6] T 201.

[7] T201:20-25

[8] T197:18-20

[9] T196:18-20

[10] T198:11-16. It is not in dispute that Mr Mizzi and his son in fact left the facility before the incident occurred. Allowing for the evidence from Ambulance Victoria that they were first notified at 5.39pm I draw the inference that Mr Mizzi and son in fact must have left the facility at or around 5.35 pm.

[11] T205

[12] T198:27-31

[13] See Exhibit 15.

[a]t approximately 17.54 hrs performed a laryngoscopy on the pt and found his airway to be obstructed by a foreign body and began to attempt to remove it with Magill's forceps. The obstruction was quite soft and kept braking [sic] requiring 3 attempts to remove what could be reached. It seems to have the consistency of a soggy sausage roll.[14]

19. Paramedics Christopher Jewell and Leanore Tucker also provided statements noting that the food bolus removed appeared to be a sausage roll. Ms Tucker further reported that '*someone at the scene stated that someone had bought them in as a treat*'.[15] The Director of Nursing, Leanne Mackay was in attendance and stated that she saw the paramedic pull something out of Mr Cole's throat that looked like a sausage roll.[16] The Wyndham Lodge staff in attendance could not confirm what Mr Cole had consumed. As mentioned above, Mr Cole was then transported to Sunshine Hospital.

Practices at Wyndham Lodge for food service in June 2009

20. During the course of the inquest, I heard much evidence relating to the preparation of food, the service of meals and responsibilities of kitchen and nursing staff. It seems that there was a level of inconsistency of understanding in relation to whose responsibility it was to ensure that Mr Cole's food was finely chopped.

21. After the incident, Ms Mackey met with all the staff present at the time of the incident. No staff member recalled having given Mr Cole his meal that night. Staff were aware of the requirement that his meal was to be finely chopped however, after three days of inquest, there is no evidence about whether his meal was finely chopped or not on 23 June 2009.

22. In addition, Victor Madeira, Chef Manager at the time, gave evidence that he could not remember what food was prepared for the evening meal that day.[17] If sausage rolls had been on the menu (and it remains unclear if they were), given Mr Cole's requirements of which he was aware, he would have made the sausage rolls with filo pastry and then taken the pastry off and covered the meat portion with gravy. Therefore it would have been served to

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[14] Ibid

[15] I note the fact that Mrs Tucker's statement on this matter came some 3 years after the event. It is also relevant that the (alleged) fact that the food had been offered or distributed in this manner on 23 June 2009, was not supported by the direct evidence of any one else who was present, this despite the immediate interest within the facility, which had focused on the source of the food in question.

[16] T353

[17] See the evidence of Ms Mathewman at T82-83 as to the inexact nature of the starting date for the June 2009, menu which I note did include an evening meal incorporating sausage rolls.

Greg '*like chopped mince with gravy on top*'.[18] The sausage roll in this form would be served to Mr Cole despite the note from Ms Tararas that Mr Cole not consume pastries. Mr Madeira testified that he never changed the menu except in exceptional circumstances and he could only recall having to do this twice.

23. Mr Madeira stated that the meals were placed on trays and on to a trolley with a docket placed on top with their name and what they had to eat. The trolley was then pushed out to the nurses station between 4.30 and 5pm. Mr Madeira never took meals to individual residents. He stated that '*the food was put on the trolley for Greg the way he should eat it*'.[19]

24. Providing a differing version of practises at that time, Ms Jade Roether, a Trainee Division 2 nurse, who was on duty at the time of Mr Cole's choking incident, appeared at the inquest to give evidence. Ms Roether understood that part of her role included cutting up meals for residents but she could not specifically recall preparing Greg's meal.[20] She relied on verbal handovers for residents and their eating requirements.[21] Mr Cole needed supervision while eating, '*just to check*' and that was the reason why he ate near the nurses' station.[22] At the time of the incident, she was physically feeding another resident.[23]

25. Ms Roether had seen kitchen staff and visiting family members distribute meals to residents. They began feeding residents at about 5pm and it '*took a good half hour to distribute meals*'.[24] Ms Roether commented that it was possible that he received his meal late because his family were visiting.[25]

26. Ms Lisa Lynch, a Personal Care Assistant at Wyndham Lodge was at work on the afternoon of 23 June 2009. She was aware that Mr Cole needed a normal diet cut up small[26] but she had no recollection of who took Mr Cole his meal, on that night.[27] It was her recollection

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[18] T241

[19] T253

[20] T277

[21] T280

[22] T292

[23] T282

[24] T283

[25] T292

[26] T107:28-30

[27] T108:28-31

that sometimes, nursing staff would hand out food to the residents and sometimes cut it up.[28] I note here that this is also in contrast to Mr Madeira's evidence that kitchen staff did themselves undertake the chopping of food on behalf of Mr Cole.

27. Ms Lynch stated that now, nursing staff are the only ones who can hand out meals and the staffing ratios have been increased during meals to facilitate this.[29] In addition to these changes, Ms King testified that residents no longer eat in their rooms unless they are sick and need to be isolated.[30]

28. Ms Lynch gave evidence that when Mr Cole was first admitted, he had difficulty adjusting to his change of life.[31] Mr Cole who only had use of his left hand, had to be reminded to slow down when eating.[32] She had heard from other staff that he would sometimes leave the facility and return with chocolates.[33]

29. Cheryl Matthewman, a food services assistant at Wyndham Lodge, was working on the night of 23 June 2009. She had worked back in order to cover a shift of a colleague who was unwell. Ms Matthewman attended the inquest to give evidence in relation to kitchen practices at the time and now. She stated that kitchen staff knew of the resident's dietary requirements.[34] All high care residents received the same meal but in different consistencies according to their requirements.[35] The Change in Food Fluids Consistency Form was written in to a diary for kitchen staff to read.[36]

30. Ms Mathewman informed that the hot food plates were served on trays and under a food warming cover.[37] It was her understanding that back in June 2009, the kitchen staff did not alter the food.[38] For a finely chopped meal, it would come out of the kitchen in whole form

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[28] T110:7-10

[29] T127, T134

[30] T193

[31] T125:3-5

[32] T140

[33] T125

[34] T65:15

[35] T67-68

[36] T69:11-31

[37] T 63. I note here that Mr Mizzi informed that the food delivered to his brother in law, was covered by a plate cover.

[38] T78:18-21

and would be mashed up with a fork by nursing staff.[39] She agreed that it would be hard for the nurses without a food processor to make the food in to the consistency required, and that that is why the recent changes have been implemented.[40] Ms Mathewman who made her statement in September 2010, was unable to recall much concerning the events of June 23 2009.

31. In addition, there have now been changes to the labelling of food and meals are categorised according to the Australian Standards. Cards are placed on each resident's meal with colour coded stickers alerting staff to diet requirements.[41] The kitchen also has a poster on display that shows the different consistencies of food.[42]

32. During the course of my investigation, I was also provided with a statement from Ms Kirago Mugo, employed by Baptcare as the Director of Nursing and Manager of Baptcare Wyndham Lodge. I did not hear oral testimony from Ms Mugo. Her statement addresses current practices in relation to food preparation and food service.

FINDINGS

33. Having considered the totality of the evidence and submissions from the interested parties, I make the following findings in relation to Mr Cole's death.

34. On 23 June 2009, Mr Cole's meal was served to him by an unknown female wearing an apron, in his room at Wyndham Lodge. It was left on a moveable bench right in front of him, sitting within his battery-powered wheel chair in his room.

35. This occurred at a few minutes before 5.39 pm, (the time of the 000 call). It is common ground that Mr Mizzi and his son departed the facility a few minutes after the tray was delivered, but before Mr Cole started eating. Mr Mizzi who had another appointment to consider stated that his length of visit was between 20 to 25 minutes. I accept this evidence. I further find that Mr Cole started eating soon after Mr Mizzi's departure.

36. I also observe that Mr Cole was discovered in difficulty, at some few minutes before the 000 call at 5.39 pm, while still in his wheel chair, which he had caused to move from room 9, to a position near the door to room 14.

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[39] T79:18-31

[40] T81:17-23

[41] T90

[42] T76:14-24

37. I also note that the delivery of food to his room, on the evidence of Mr Mizzi, was not made by a member of nursing staff, as was usually the case, and that its delivery in this manner was contrary to the practice that had been put in place for him to eat his meal near the nurse's station.

38. I also accept the evidence of Mr Mizzi that he saw the food brought in on a tray, [43] and on a round plate with a cover [44], plus a smaller bowl with a, *'dessert or something in it.'*

39. I additionally note that during his visit Mr Mizzi testified that he saw no evidence of other food remaining, brought in, or otherwise left in the room.[45] The person, who served the meal, immediately left the room without assisting Mr Cole.

40. I am unable to conclude from the evidence whether the meal left for Mr Cole had been finely chopped, as the meal was covered when it arrived. I am therefore unable to say whether the meal did in fact include a sausage roll, but I accept the evidence of the paramedics that the food bolus removed from Mr Cole was sausage roll like in consistency.

41. I have additionally considered evidence in relation to the possibility of Mr Cole accessing a sausage roll by leaving Wyndham Lodge. There is no evidence that Mr Cole left Wyndham Lodge that day or that he would normally purchase savoury like food.

42. I have also considered the suggestion that food had been brought in to the facility and provided as a *'treat'* by a visitor.[46] Again, there was no evidence that this actually occurred and I was unable to identify a person that could clarify if that was indeed the case.[47] In the result I determine that I should not attach weight to this evidence

43. As a result of my consideration of all of the evidence and the submissions received, I find myself satisfied that Mr Cole ate food from the plate, which had been delivered to him in the circumstances observed by Mr Mizzi,-upon which he later choked and that it is more probable than not that the food in question was inadvertently supplied by a female person, who was a member of staff.

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[43] T197

[44] T 138 19-21

[45] Transcript page 197

[46] T 305-09. This was of course hearsay evidence and it is also the case that the alleged fact concerning this matter or the fact that these words were overheard, was not corroborated by other witnesses despite what I find was the considerable staff focus on the source of the food, taken by Mr Cole, immediately before his demise.

[47] See also discussion at paragraph 19 above.

44. It was in these circumstances that Mr Cole was able to access a food bolus and consume it in a manner that lead to him choking and I additionally find that practices put in place for supervising Mr Cole's consumption of his meal, were not followed on the evening of 23 June 2009.

45. I am further satisfied that appropriate measures have now been put in place to clarify for both kitchen and nursing staff who is responsible for the preparation and service of the meals, in order to prevent a similar circumstance from occurring again.

I direct that a copy of this finding be provided to the following:

Mr Cole's family
Baptcare Pty Ltd
Australian Commercial Catering
Constable Lee Kendrick
Leading Senior Constable Amanda Maybury

Signature:

PETER WHITE
CORONER
Date: **8 May 2015**