Review of the South Australian Coroner's Report into the death of Christopher Lens

Christopher Lens aged 63 years, died in Brighton, South Australia on the 5th day of March 2019 as a result of hypoxic ischaemic encephalopathy and its complications following cardiac arrest due to upper airway obstruction. Mr Lens who suffered from schizophrenia was under the care of the Minda Nursing Home. The Coroner's Report was not published until 22 December 2023.

Despite some findings concerning miscommunication about feeding and observation after eating, which are matters for the facility; Mr Lens choked on a peanut butter sandwich given to him by staff. It is unclear from the report the exact sequence of events that transpired that resulted in the death of Mr Lens. A statement made by a Ms Cousins simply states in **Paragraph 4.22**:

"Later Mr Lens came from his room. He was choking and CPR was started before he was taken to hospital."

This statement provided no detail of the process undertaken to recognise choking, or any first aid steps taken before Mr. Lens became "unconscious" (as one can only presume that CPR was not commenced on a conscious standing adult). Nor does this testimony provide any indication of how long this process took before the arrival of assistance. A Ms Hurst testified **she "thought that it was three to five minutes later that Mr Lens came to the staff choking."** i.e. Mr Lens was still ambulant and conscious at the time he sought staff assistance. This would indicate that with the appropriate and effective intervention, Mr Lens was "saveable" at this time.

In **Paragraph 4.24** the evidence states that **"South Australian Ambulance Service (SAAS) members were in attendance at Minda regarding other matters when Mr Lens had the choking episode. They provided urgent first aid assistance and also called for additional assistance before conveying Mr Lens to the FMC."**

The report does describe SAAS staff as removing a large piece of un-chewed bread from Mr Lens' airway as well as **'3 large pieces food removed'**, another member describing those three pieces **as '3 large chunks chewed food removed - suction'.** The report does not indicate if these obstructions were removed by manual finger sweeps or oral "suction" and suggested. However, it would seem that even in this most ideal of scenarios i.e. minimal response delay, these measures failed to relieve the severe upper airway obstruction before the patient suffered a cardiac arrest, even when applied by trained professionals. It should also be noted that focused "suction" (probably using a Yankeur suction catheter designed for liquids in the oro-pharynx) was referred to as a method used during initial treatment by SAAS staff and that suction is the primary mechanism of suction airway clearance devices e.g. LifeVac™.

4.28. Mr Lens developed aspiration pneumonia and was thought to have a brain injury as a result of the choking incident, despite not being evident on the scans taken. However clinical indicators were noted. Mr Lens did not improve and continued to suffer pneumonia and was continually at risk of aspiration. He was treated with antibiotics for pneumonia with good success, but his condition never improved. He remained drowsy, agitated, and with impaired cognition.

It is evident from this testimony that the prime cause of the resultant death of Mr Lens was the brain injury caused by extended hypoxia resulting from the time taken to relieve the upper airway

obstruction. Given that, there were no foreign bodies still present on radiology examination and the complication of aspirational pneumonia was successfully treated with antibiotics.

Other than the recommendation for a **"complete review of all detention orders be undertaken by South Australian Civil and Administrative Tribunal (SACAT) and other relevant bodies to ensure compliance with relevant acts for the protection and care of vulnerable persons subject to an order."** there were no recommendations made by the coroner in this matter.

Given the brevity and superficial investigation and inquest into the death of Mr Lens, it is not surprising that in this case, the coroner assumed that everything that could have been done was and Mr. Lens was just "unlucky" that one minute he was conscious and choking requiring assistance and the next he was unconscious and receiving CPR despite all first aid measures. These details should have been appropriately investigated in a proper inquest.

The evidence in Mr Lens' case is that even full compliance with locally produced first aid measures makes no difference in cases of severe obstructions. LifeVac™ is used around the world after even the best first aid has failed and has never caused harm. All these case reports are part of an international multi-institutional study and usage is monitored by the regulators (in Australia the TGA) for failure or harm. It is highly probable, considering the nature of the obstruction, its removal with suction and the window of consciousness before this caused severe hypoxia (leading to brain injury); that if the LifeVac airway clearance device had been available to staff (even prior to the response of on-scene SAAS staff attending another patient, Mr. Len's would have survived the incident without brain injury. Again, in this case, the SA coroner has missed a significant opportunity to change the future outcome of severe choking in facilities, like residential care facilities and mental health institutions where there is a higher risk of choking. Schizophrenia patients have a 30 times higher risk of choking and this was not recognised as a foreseeable risk that may have required the availability of additional emergency equipment e.g. LifeVac; by the facility or the coroner in his cursory investigation. The coroner in the case of Mr Lens has done nothing to prevent a reoccurrence in this high-risk patient group/facility type and has presented another case of the failed argument that doing the same thing again in the same circumstances will probably work, sometimes.

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