CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 6th and 22nd days of December 2023, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Christoper Lens.

The said Court finds that Christopher Lens aged 63 years, late of Minda Inc, 12 King George Avenue, Brighton, South Australia died at 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. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Mr Lens was born on 28 April 1955. He died aged 64 on 5 March 2019 at the Minda Nursing Home.[1]

2. Legal orders concerning Mr Lens

2.1. In 1981 Mr Lens was diagnosed with schizophrenia complicated by medication noncompliance, illicit drug use and violence.

2.2. In 1981 the first orders of the Guardianship Board were made in relation to Mr Lens.

2.3. Between 1981 and the closure of the Guardianship Board in 2015, 62 orders were issued in relation to Mr Lens, being a combination of community treatment orders and detention orders.

[1] Minda

2.4. On 28 July 1999 a full administration order was granted appointing the Public Trustee as administrator. The order was reviewed seven times and continued under the South Australian Civil and Administrative Tribunal[2] when SACAT commenced in March 2015.

2.5. Ms Dona Attard, Deputy Registrar Community Stream, SACAT provided a signed affidavit which was tendered to the Court.[3]

2.6. She detailed the extensive history that Mr Lens had with SACAT and the Guardianship Board.

2.7. Mr Lens was under a full administration order dated 8 January 2016 naming the Public Trustee as the full administrator. This order was still in effect at the time of his death.[4]

2.8. Ms Attard detailed that Mr Lens was subject to a Level 2 community treatment order from 25 May 2018.[5] The order was listed to expire 24 May 2019.

2.9. On 24 June 2016 there was an application for guardianship with special powers of residence, treatment and care.

2.10. On 9 August 2016 the Public Advocate was appointed full guardian and special powers order for residence and detention made.

2.11. In 2016 Mr Lens moved into high care residential placement at the Older Person's Mental Health Services in Oakden.

2.12. Mr Lens had a long admission to the Lyell McEwin Hospital[6] between September 2017 and May 2018 for severe treatment-resistant schizophrenia.

2.13. Mr Lens had been residing at Minda from 2 May 2018 until 29 January 2019 when he choked on food and was admitted to the Flinders Medical Centre.[7] His recovery and prognosis from this event was poor. In consultation with the Guardianship Board, active treatments were removed and he was returned to Minda on 27 February 2019 for palliative care.

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[2] SACAT
[3] Exhibit C8
[4] Order 2012/SC9117735
[5] Order 2018/SC00182221
[6] LMH
[7] FMC

3. Cause of death and reason for Inquest

3.1. His cause of death, determined by a pathology review conducted by Forensic Science SA,[8] was hypoxic-ischaemic encephalopathy and its complications following cardiac arrest due to upper airway obstruction.[9]

3.2. Mr Lens was subject to an administration order, guardianship order with special powers and a level 2 community treatment order.

3.3. Due to being under a guardianship order with special powers at the time of his death, and that his cause of death included an upper airway obstruction which is not a natural cause, this was a mandatory Inquest pursuant to Section 21 of the Coroners Act 2003.

4. Mr Lens' admission to Minda Nursing Home

4.1. As noted previously, on 2 May 2018 Mr Lens moved to Minda to reside.

4.2. Dr Alice Wilson was the general practitioner responsible for the medical care of Mr Lens from 2018.[10] Dr Wilson helped facilitate the regular blood tests that Mr Lens required which were associated with the medications he was taking. Dr Wilson described Mr Lens as cognitively slow and physically inactive.

4.3. Linh Mai Truong is a registered nurse who at the time of this investigation was the Residential Services Manager at the Pat Kaufmann Centre[11] at Minda, where Mr Lens was residing.[12]

4.4. Ms Truong detailed that early on during his time in the PKC, an assessment was made by speech pathologist Denita James. This stated that after a swallowing assessment a regular diet with harder foods cut up and thin fluids could be given to him.

4.5. In her statement, Ms Truong explained that:

> 'The speech pathologist's recommendation was that he sits upright during meals for twenty minutes afterwards, and for staff to monitor and report any alteration in his oral intake or any difficulties to the RN or EN on duty. However, with two staff to look after nine

[8] FSSA
[9] Exhibit C1a
[10] Exhibit C6
[11] PKC
[12] Exhibit C4

> residents, remaining with Chris and monitoring for twenty minutes after he'd eaten each time was not practical but staff always remained present while he ate.'

4.6. Ms Truong also stated:

> 'It was normal for Chris to have his meals in his own room and this happened now and then, that's his choice. We encouraged Chris to eat in the dining room with other residents for close monitoring.'

4.7. Ms Denita James was the speech pathologist who was employed by Minda to make assessments of residents and recommend eating and care plans. She has provided an affidavit in regards to Mr Lens.[13]

4.8. Ms James wrote a speech pathology report dated 27 June 2018[14] for Mr Lens. Ms James thought that Mr Lens had one tooth, although other staff say that he had no teeth at all. Ms James assessed Mr Lens as being suitable to be given solid foods, stating that he demonstrated that he was able to swallow adequately. She did recommend that his foods be cut into manageable pieces by staff.

4.9. In her plan, Ms James recommended that his oral intake be supervised which she defined as meaning that a staff member needed to be close by to observe and report any difficulties. It did not mean that someone needed to be present with him. If that were the case she would recommend one-on-one supervision. Supervision could be in the setting of the dining room where a staff member would be close by. She also recommended that he sit upright when eating and drinking and reman upright for at least 20 minutes after oral intake.

4.10. Ms James was not aware that Mr Lens was eating in his room. If she had been, she would have recommended one-on-one supervision believing that there would be no other choice in that situation.

4.11. Minda provided files concerning Mr Lens.[15] Those files included a nutrition and hydration support plan dated 17 May 2018 which highlighted the following:

- Food consistency normal;
- Add extra gravies and sauces/custards to moisten food;
- That Mr Lens was considered a choking risk;

[13] Exhibit C7 - I note this is unsigned as Ms James passed away prior to this occurring
[14] Exhibit C10, MD1
[15] Exhibit C11

- That his meals should be cut with a knife and fork into bite size pieces;
- To maintain adequate nutrition/hydration;
- He needed to sit upright during meals and 20 minutes post meals;
- Monitor and report alteration in oral intake to the on-duty nurse;
- Report any swallowing difficulties to the on-duty nurse.

4.12. The files made it clear that staff were aware of what was required of them in relation to Mr Lens' meals based on the advice of the speech pathologist.

4.13. Ms Alison Cousins is a qualified aged care and disability support worker with a long history in care work.[16] Ms Cousins stated that she has known Mr Lens since he moved to the centre and had a good rapport with him. She stated that Mr Lens' bedroom was his sanctuary and that he spent most of his time on his bed but would leave his room to watch television if it were quiet or if he was up before everyone else.

4.14. Ms Cousins described Mr Lens as gorging or rushing his food when he ate. She stated that Mr Lens sometimes ate meals in his room, as did other residents. The day he choked he had a peanut butter sandwich in his room.

4.15. Ms Cousin was on duty on the day of Mr Lens' choking incident. The other carer on duty with her, Ms Kay Hirst, made the sandwich and took it to Mr Lens in his room.

4.16. Ms Cousins explained that she did go to his room after he had been provided breakfast. She saw Ms Hirst return to the kitchen with an empty plate before she had gone to his room. Ms Cousins said that later she went into his room. Mr Lens was standing at the toilet. He told her that he was okay and so she continued with her work. Later Mr Lens came from his room. He was choking and CPR was started before he was taken to hospital.

4.17. Ms Cousins was aware of the speech pathology report for Mr Lens. She understood the recommendation to mean that when he was eating, he was to be watched and that after eating he was to be watched for a further 20 minutes. She felt this was an unrealistic expectation as there are only two carers and eight residents that needed to be fed.

[16] Exhibit C2

4.18. Ms Kay Hirst was the second care worker on duty the morning that Mr Lens had the choking episode.[17]

4.19. Ms Hirst had also known Mr Lens since he moved to the facility and had a good relationship with him. She stated that Mr Lens needed a lot of assistance with his daily living.

4.20. She was on duty when Mr Lens had the choking episode. She could not remember when Mr Lens had breakfast but thought it between 8am and 8:15am. She made him a peanut butter sandwich using bread from the fridge, making the sandwich and cutting it into pieces as he ate quickly. His '*food card*' said his food should be cut into pieces.

4.21. Ms Hirst explained that Mr Lens normally chewed his food to a point that there was '*never any trouble, he had no difficulty in swallowing his food*'. Ms Hirst took the sandwich to Mr Lens in his room. He was laying on his bed. She got him to sit up. She held the plate and gave him the sandwich. It was cut into about six to nine pieces in squares. Ms Hirst stated that she made Mr Lens sit up while he ate the sandwich and then stayed with Mr Lens and ensured he continued to sit up for a couple of minutes.

4.22. When Ms Hirst left him, she did not think he had sandwich still in his mouth. She had asked him to open his mouth which she thought was clear. She could not say if there was anything in the sides of his mouth. Ms Hirst thought that it was three to five minutes later that Mr Lens came to the staff choking.

4.23. Ms Hirst was of the opinion that if staff were to stay with Mr Lens while he ate and then be physically present for 20 minutes after eating, it was an:

> '… impossibility (sic) in that house where everyone is so ambulant and there can be behaviour issues. Even when I knew I had to stay with him it was his choice for me to leave. When Christopher said, "you can go miss", you go.'

4.24. South Australian Ambulance Service[18] notes[19] showed that 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.

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[17] Exhibit C3
[18] SAAS
[19] Exhibit C10b

4.25. SAAS described 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*'.

4.26. Mr Lens was conveyed to the FMC by ambulance on 29 January 2019. He remained there until he returned to Minda for palliative care on 27 February 2019.

4.27. Dr Yogesh Sharma is a consultant physician in general medicine. At the time of Mr Lens' choking incident he was working at the FMC.[20]

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.

4.29. He made no improvement. Dr Sharma participated in talks about moving toward palliation. After consultation with his guardian, comfort care measures were adopted. On 27 February 2019 Mr Lens was returned to Minda for palliative care.

4.30. On 5 March 2019 he passed away.

5. Coronial investigation

5.1. I observe comments made by the SAPOL investigating officer in his report[21] about the fact that there was clearly a lack of supervision of the type envisaged or prescribed by the speech pathologist at the time Mr Lens choked that ultimately resulted in his death.

5.2. I note that all Minda staff members spoken to suggested it was impractical to continue supervision for a further 20 minutes after eating while other residents may be in need of assistance. The investigating officer also noted that it was apparent in conversations that other residents also chose to eat in their rooms and that residents are empowered to make choices about their daily living.

[20] Exhibit C5
[21] Exhibit C10

5.3. In addition, I observe the comments made by the investigating officer that the guardianship order with special powers appeared to be in breach of Section 57 of the Guardianship and Administration Act 1993, having never been reviewed following its application in August of 2016. It had a recommend review date of 8 August 2019 which was inconsistent with Section 32 of the Guardianship and Administration Act 1993 which required a new order for special powers of detention to have a review date at a maximum of six months from the date the order is made. Ms Attard stated that this inconsistency was not identified and there was no further action on this file until SACAT was notified of Mr Lens' death by the Coroner's Office.

6. Conclusions

6.1. I confirm that the cause of death is as stated in the pathology review set out in paragraph 3.1 above, namely hypoxic-ischaemic encephalopathy and its complications following cardiac arrest due to upper airway obstruction.

6.2. I find the quality of care for Mr Lens by Minda in general was good. Unfortunately, the staffing issues concerning supervising of eating for Mr Lens, as identified by Ms Truong, and to a lesser extent by Ms Hirst, cannot be divorced from the circumstances of Mr Lens' death.

6.3. I find that the failure to review the guardianship order with special powers order did not invalidate it, nor did it contribute in any way to Mr Lens' death.

7. Recommendations

7.1. I support the recommendation of the investigating officer in this matter and recommend that a complete review of all detention orders be undertaken by SACAT and other relevant bodies to ensure compliance with relevant acts for the protection and care of vulnerable persons subject to an order.

Key Words: Death in Custody; Section 32 Orders; Choking episode

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 22nd day of December, 2023.

Deputy State Coroner