STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jordan Leigh Sargent
Hearing dates:	7 April 2014
Date of findings:	7 April 2014
Place of findings:	Nowra Local Court
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – Death in care, supervision of a person with a disability, choking on food
File number:	2013/78347
Representation:	A/Sgt Luke Johnson, Advocate Assisting the Coroner Mr Patrick Rooney of Counsel i/b Ms Voukidis for Life Without Barriers Mr Bill De Mars (Legal Aid NSW) for the Sargent family

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The Coroners Act in s81 (1) requires the findings of an inquest to be recorded in writing. These are the findings of an inquest into the death of Jordan Sargent.

Introduction

When she was a child, Jordan Sargent was diagnosed with Bardet-Biedl Syndrome which caused a number of intellectual developmental and physical disabilities.

After she completed school she began attending a disability and out of home care service, Life Without Barriers (LWB), in her home town of Nowra, to facilitate social contact under a controlled environment with carers trained in dealing with special needs clients.

On 12 March 2013, Jordan was picked up from home by a staff member from LWB. Late that day, she went with the carer and a number of other clients of the service on a trip to the nearby town of Berry.

As the group was returning to Nowra, a lolly the carer had given Jordan became stuck in her throat. The carer tried without success, to dislodge the lolly. Paramedics arrived soon after, and succeeded in clearing her airway but she was already unconscious and going into cardiac arrest. Emergency care was provided on the way to the Nowra Hospital, and spontaneous respiration was restored. However, it became apparent that Jordan had suffered significant hypoxic brain injury and the following day the family decided to turn off her life support. She died soon after. Jordan was 21 years of age at the time of her death.

This inquest has confirmed the identity of the deceased woman, the date, place, medical cause and manner of her death. It has also considered whether the supervision provided by the LWB carer on the day in question was appropriate and whether any changes are needed to the policies and procedures of LWB to reduce the likelihood of similar events occurring in the future.

Social and medical history

Jordan Sargent was born on 25 August 1992 at the Paddington Women's Hospital in Sydney. She is the eldest of four children in the family. At 16 months of age it became apparent Jordan was not developing normally and she was initially diagnosed with autism. When she was 12 years of age, genetic testing established that she suffered from Bardet-Beidel Syndrome which causes rapid deterioration of sight, developmental delays, cerebral palsy, sleep apnoea and various intestinal problems.

Jordan attended special schools throughout her youth and teenage years and continued to live with her family at their home in Nowra.

After Jordan withdrew from school in 2010, she commenced attending Life Without Barriers (LWB). Her mother, Charon Wood, says she sent Jordan there so that she could participate in outings and socialise under a controlled environment. It seems she first attended there in September 2010.

Ms Wood says that Jordan needed constant supervision. She could dress and undress herself; she was mobile and could vocalise but could not prepare her own meals or attend to other complex tasks. She said that Jordan was constantly supervised when eating and did not eat lollies

As part of the process of participating in the programs offered by the service, Ms Wood completed a number of questionnaires providing information about Jordan. In a document headed Lifestyle & Environment Review, dated 24.10.2010 and signed by Ms Wood, it was recorded on page 4 that Jordan was to be "*supervised while eating, choking an issue.*" On page there was recorded the following: "*Eating to be supervised when eating* (sic) *puts to* (sic) *much in…causes serious concerns with choking."* And on the next page: "*Eating to* (sic) *quick, to be watched. Choking a concern."* In a document headed Nutrition and Swallowing Risk Checklist also dated 24.10.2010, in response to the *Question 7. Is the person physically dependent on others in order to eat or drink?* Ms Wood had ticked the box *"Yes*".

For reasons that have not been ascertained that document is not on Jordan's LWB file. There are however a number of other documents that make mention of possible eating difficulties but none outline the problem as nearly as serious as the document quoted above. A Nutrition and Swallowing checklist dated 19 October 2010 only notes in answer to Question 7 the client is dependant on others for eating and drinking and in answer to Question 24 that the person shows distress when eating or drinking. When the document was reviewed a year later, both answers were changed to the negative.

Jordan attended LWB 4 days a week. She would participate in activities such as bowling, music, swimming and going to the library. The activities also included day trips and picnics.

Ms Wood attended meetings with LWB staff every 12-18 months to review Jordan's care. She would advise LWB staff if there were any medical changes to Jordan's condition and they would discuss new goals for Jordan's development.

Ms Wood said that at one of those initial meetings, she had told LWB that Jordan needed constant supervision and that she had a tendency to place inappropriate things in her mouth on account of having oversensitive gums. Apparently she would pick up stones and other things and rub them on her gums for stimulation.

Ms Wood claimed; "*all the staff members knew she had trouble eating, she would put too much into her mouth*".

Ms Wood also said in her statement, that up until Jordan's death; *"I had not had any issues with Life Without Barriers, they were excellent".*

Events preceding the incident

On the day before her death, Jordan was collected from home by a LWB staf member in a bus operated by the service.

It had been arranged that she and two other clients would be going on an outing to Berry, a near-by town as part of what was called a CAFÉ program. The clients were under the care of Fiona Beaven, a casual employee of LWB. Although Ms Beaven was not a full-time employee, she had tertiary qualifications and extensive experience in disability support care. She had interacted with Jordan on a number of previous occasions at the centre, and taken her on external trips to the park and swimming etc. In addition to her qualifications in disability care, she also had a current first aid certificate.

As part of her role at LWB, Ms Beaven had read Jordan's file, and made progress notes on it. In accordance with their procedures, whenever she took clients away from the centre, she took with her an emergency information sheet for each client

At about 11.00am, Ms Beaven took Jordan and two other clients, Laura and Jessica to Berry. The intention was to visit the shops and stop at a café. They travelled there in a 12 seat mini bus. The trip took about 15 minutes.

They walked around some of the specialty shops there and they each had a drink. Jordan drank a chocolate milkshake.

At about 11:50am before boarding the bus to return to the centre, Ms Beaven and the three clients went into a lolly shop to purchase some chocolate. Ms Beaven bought for them some Giant Jaffa lollies and they all got back into the bus.

Once seated, Ms Beaven gave each of the clients one of the lollies. Laura was siting directly behind the driver's seat and Jordan was in a seat behind her. Laura was beside Jordan but in a seat across the aisle that led to the back of the mini-bus.

They then commenced the return journey to Nowra at approximately 12:06pm. After a couple of minutes Ms Beaven heard Jordan cough and then say "*yuk*" and she heard her spit out what she assumed was the lolly. Ms Beaven was told by one of the other two clients what Jordan had done. They told her that Jordan had spat out the lolly and had it in her hand. Ms Beaven passed back a tissue box to Jessica, who was sitting next to Jordan, and asked her to give Jordan a tissue to wrap the lolly up.

Shortly after, Ms Beaven heard Jordan start to cough and she was told by one the other two clients, that she thought Jordan was choking and that she should stop. However, the carer could see Jordan who didn't appear distressed and the other girl didn't seem to be indicating that anything was seriously amiss, so she kept driving. Soon the other client repeated her statement and by this time it was clear to Ms Beaven that she needed to investigate.

The fatal incident

Ms Beaven says she looked for a place to stop. In her interview with police she said that it took about two minutes before she could safely pull over. In court she said it

was less than a minute. At this first opportunity, Fiona pulled the bus over to the side of the road. She got out into the back of the bus and slid into the seat beside Jordan was still coughing and gasping for breath.

She slapped Jordan on the back on a number of occasions in the hope that would dislodge the obstruction. It was unsuccessful. She noticed Jordan had become very pale. She undid her seatbelt and Jordan fell forward. She vomited while Ms Beaven continued to try to dislodge the lolly. Ms Beaven tired to get her to drink some water hoping it would wash the lolly down. Jordan wouldn't or couldn't drink any. Jordan then lost consciousness.

Ms Beaven called 000 and followed the instructions provided by the operator while waiting for the ambulance. That included laying Jordan flat on her back and performing chest compressions.

The ambulance arrived at 12:24pm about 10 minutes after Ms Beaven had first called. Paramedics used suctioning equipment to remove sputum, a laryngoscope to attempt to view the obstruction and Magill's Forceps to attempt to remove it. During the suctioning bits of what can be assumed to be the Jaffa were removed from her airways.

Intra-venous access was gained and Jordan was ventilated with a bag valve and mask. Jordan remained unconscious and she was asystole- that is her heart was not beating.

She was administered Adrenalin and rushed to hospital. En route a heart beat was re-established as was spontaneous respiration.

Hospital care and death

Jordan was taken to the Shoalhaven Hospital and the emergency department was advised en route of her pending arrival. When she arrived she was immediately assessed in the Emergency Department.

It soon became apparent that she had suffered irreversible brain damage. The next morning, her family made the difficult decision to turn off the life support system. Jordan died soon after.

Investigation

Autopsy

An autopsy was conducted on Jordan's by Pathologist Dr McBride. In his report, Dr McBride expressed the view that her death was caused by irreversible hypoxic brain injury as a result of choking.

Police investigation

The death was investigated by Senior Constable Coventon-McKenna of Nowra police. She interviewed family members, carers and other clients of LWB and obtained copies of most relevant records. She concluded the death was accidental.

External review

Circumstances of Jordan's death were reviewed by an independent external consultant, Mr David Bradford of DaV'ange Consulting. In summary, he concluded that there had been no significant breach of LWB policies, and that Ms Beaven had acted appropriately throughout. He did however make some recommendations for improvement which I will detail below.

As part of the review, Mr Bradford examined Jordan's LWB file. Among a detailed profile, was a Nutrition and Swallowing Checklist. The current checklist indicated that Jordan did not have:-

- *Any difficulties in swallowing*
- *Feeding herself*
- *A requirement for supervision whilst eating*
- *Or any episode's of choking or food aspiration*

The checklist had originally been completed in October 2010 when Jordan first commenced attending LWB and was updated on 25 November 2011. When first completed, among many, the following questions were asked and answered:-

> *Question 7:Is the person physically dependent on others in order to eat or drink?*

Initially this was answered, "*Yes*" However when the questionnaire was revised, this answer was struck out and "*No*" was inserted.

Further on in the assessment, the following questions were asked and all were answered in the negative:-

> *Question 17*: *Does the person cough, gag and choke or breathe noisily during or after eating food, drinking or taking medication?*
>
> *Question 18: Does the person vomit or regurgitate on a regular basis?*
>
> *Question 19: Does the person drool or dribble saliva when eating or drinking?*
>
> *Question 20: Does food or drink fall out of the person's mouth during eating or drinking?*
>
> *Question 21: If the person eats independently, do they overfill their mouth or try to eat very quickly?*
>
> *Question 22: Does the person appear to eat without chewing?*
>
> *Question 23: Does the person take a long time to eat their meal?*

There is apparently no other evidence on the file of any advice regarding Jordan having difficulties with eating and swallowing.

Ms Beaven and other staff at the centre indicated that Jordan ate a variety of foods She ate apples and sandwiches without any apparent difficulty. She ate independently and had no trouble swallowing and did not suffer from choking.

Mr Bradford concluded that the activity on the day that Jordan suffered her fatal condition, were carried out in accordance with LWB's current policies and procedures and that appropriate risk management had occurred.

Mr Bradford concluded that first aid had been appropriately undertaken by Ms Beaven.

Mr Bradford acknowledged that preventing the clients of LWB from eating while being driven in a motor vehicle could be seen as discriminatory and could limit their life experiences. However, he also acknowledged that there were risks involved in the practice that made it unwise. Accordingly he recommended the LWB institute a policy of prohibiting it.

He also recommended changes to some of the documenting of assessments used by the service.

Conclusions

Having considered all of the evidence I have come to the conclusion that Jordan died as a result of a tragic accident when she choked on a lolly while being driven between Berry and Nowra.

The difficult question to resolve is whether the disability support worker who gave her that lolly should have foreseen the risk of Jordan choking and refrained from giving it to her.

It is true that there was no necessity for the Jaffa to be given to Jordan and that it was an unfamiliar item that she did not ask for. Conversely, Jordan was attending the program so that she could socialise and be exposed to a wider range of experiences.

There is no doubt that it would have been safer for Jordan to never have undertaken such activities, but her mother recognised that her daughter deserved an opportunity to do as many as she could of the things young people without disabilities enjoy. That inevitably involved some risk.

Jordan's eating difficulties were apparently set out in a document created by Ms Wood soon after Jordan started attending LWB. However, it is not on Jordan's file at the service and the carer who was with her on the day in question had never seen it or any other written reports indicating Jordan was at risk of choking. She had been attending LWB for two and a half years when she died. In that time there was no indication that she was at risk of choking.

I find that the disability support worker who was with Jordan at the time of the fatal incident had no reason to suspect that giving the lolly to Jordan was dangerous or unwise. Further, in doing so the disability support worker did not breach any of the policies or procedures of her employer then in force.

In hindsight the disability support worker could have moved to stop the mini-bus sooner when one of the other clients made a comment about Jordan choking. Although she has explained that she could see Jordan and she didn't seem in distress and nor did the informant sound concerned her decision not investigate further immediately was perhaps unwise.

However, when the driver did realise that intervention was necessary, I do not consider there was any undue delay. She has variously estimated the time between coming to the realisation that she needed to stop and actually doing so as variously two minutes and less than one minute. I accept that retrospectively estimating time is notoriously difficult. I also accept her evidence that she stopped as soon as she could find a safe place to do so.

I find that the disability support worker applied appropriate first aid and that failure of her or the paramedics to save Jordan from suffering unsurvivable injury was not due to any substandard practice.

I offer Jordan's family my sincere condolences for their tragic loss. I also offer my deep sympathy to the staff members of LWB who were no doubt severely distressed by this event.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Jordan Leigh Sargent.

Date of death

Ms Sargent died on 13 March 2013

Place of death

She died in Nowra, New South Wales

Cause of death

The cause of death was hypoxic brain injury due to choking on food. The Bardet-Biedl Syndrome suffered by Jordan is likely to have contributed to the death.

Manner of death

Ms Sargent's death was accidental

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death investigated by inquest.

The independent expert who reviewed the incident made six recommendations. All but one have apparently been accepted and implemented. The outstanding issue concerns clients of the service eating in motor vehicles operated by the service. As I understand it, many of the clients of LWB have no eating difficulties. I am not persuaded they should be denied food in vehicles when on activities away from the centre. I am of the view it is more appropriate that careful and fully informed risk assessments be undertaken so that those who can not do this safely are not exposed to the danger.

I don’t consider there are any other matters connected with this sad death that I have a sufficient basis to make recommendations about.

I close this inquest.

M A Barnes
NSW State Coroner
Nowra
7 April 2014