LOCAL COURT OF NEW SOUTH WALES

CORONIAL JURISDICTION

Inquest:	**INQUEST INTO THE DEATH OF LESLIE ARMSTRONG**
File number:	0396/10
Hearing dates:	18-20 FEBRUARY, 3 MARCH 2014
Date of findings:	2 MAY 2014
Place of findings:	STATE CORONER'S COURT, GLEBE
Findings of:	DEPUTY STATE CORONER C. FORBES
Findings:	MR LESLIE ARMSTRONG DIED ON 15 FEBRUARY 2010 AT GLEBE, NSW, AS A RESULT OF BLUNT FORCE INJURIES HE SUSTAINED WHEN HE FELL FROM A BALCONY.
Recommendations:	*To the NSW Minister for Planning* I recommend that the Minister consider implementing a process whereby Aged Care Facilities operating within NSW are required to provide Safety Certificates on an ongoing basis in relation to the structural integrity of their balconies & balustrades. Any such requirement should be at least every 3 years and should contain

reference to any deficiencies identified in the safety of those balustrades and the time period required to rectify such deficiencies. I also recommend that if this recommendation is implemented that the Minister's office inform in writing the Commonwealth Minister of Social Services and the Aged Care Quality Agency of any such requirement.

To Commonwealth Minister for Social Services

I recommend that the Australian Aged Care Quality Agency require Aged Care Providers to provide evidence of the compliance with Recommendation 1 at the time of reaccreditation if such recommendation is implemented by the NSW Ministry for Planning.

Representation:

Mr S KELLY (ADVOCATE ASSISTING)

Ms K STERN SC FOR AUSTRALIAN AGED CARE QUALITY AGENCY INSTRUCTED BY CLAYTON UTZ LAWYERS

Ms S BECKETT FOR WESLEY MISSUION INSTRUCTED BY MS T HOPPER

Mr A SINGH FOR CITY OF SYDNEY COUNCIL

REASONS FOR FINDINGS

Introduction

1. On 15 February 2009 Mr Armstrong fell from his 2nd floor balcony at the RJW Lodge, 274 Glebe Point Road Glebe (The Lodge). He had been a resident at the Lodge since March 1996. Mr Armstrong was 84 years of age at the time of his death.

2. The Lodge was a multi storey aged care facility that operated as a residential aged care facility for financially vulnerable and disadvantaged persons. It was run by Wesley Mission, which is a Parish Mission of the Uniting Church.

3. The Lodge was originally built in 1970 as a motel for American Servicemen. It was converted in 1974 to an aged care facility. In 2009 there were 72 allocated places and 64 residents living at the site of which 16 were considered to be high care.

4. The building was constructed of double brick walls and concrete floor slabs with a concrete roof. It consisted of communal indoor areas and an internal courtyard for residents to sit. All rooms were single with ensuites and most had individual balconies. The facility also had a large main dining room and a smaller one, a large activity room on the top floor with an external terrace, lounge rooms on two of the lower floors and an internal courtyard. There were four levels of units and the ground level of the building contained parking and a storage area.

5. According to staff at the Lodge Mr Armstrong preferred to keep to himself and rarely socialised with other residents or attended organised activities. He tended not to attend the dining room for meals. He was described as courteous and polite.

6. In the last few months before his death, staff would take his meals to his room because he appeared a little 'shaky'. It is documented in his medical notes that he had limited mobility and in 2008 was admitted to RPA as a result of an unwitnessed fall. In January 2008 a letter sent to his GP from his Pharmacist noted that Mr Armstrong was at increase risk of falls from the medication Persantin as it was known to cause 'orthostatic hypotension, and therefore recommended that Mr Armstrong's 'blood pressure, be reviewed whilst on the medication'.

7. According to Ms Hagar Lesianawai, the Manager at the Lodge, Mr Armstrong occasionally would still attend the dining room to have his meals although it depended on how he felt.

8. His care plan indicted he had a history of alcohol abuse, depression and that he was hearing impaired and dysphasic, which was believed to be as a result of an earlier stroke. It is not believed that Mr Armstrong had any children or relatives who visited him.

9. He was regularly visited by a volunteer, Ms Sandra Trowbridge, who would attend the Lodge to take him to local coffee shops. She said she would visit Mr Armstrong on average once a fortnight and if he was well enough she would take him for a drive and they would have coffee together, usually in Balmain or Leichardt. She last saw Mr Armstrong the week before he died and at the time she said he was looking forward to seeing her the following week.

10. Ms Rose Tarlington (who was employed at the Lodge) was the last person to see Mr Armstrong. Sometime after 11.45am on the 15th February 2009 she took up his lunch. She noticed that his front door was closed and locked. She said he was sitting on his bed and he asked her what day of the week it was. She told him it was "Monday' but Mr Armstrong did not respond. She told him that his lunch was there and asked if wanted his door open to which he

responded that he did. In her statement she gave to police she described him as ‘cheerful’ when she saw him on that day.

11. Some time shortly after this but before 1pm Ms Kwong, who also worked at the Lodge, was walking to the basement when she saw a person lying on the ground at the side of the building. She immediately ran to tell Ms Lesianawai.

12. Mr Fred Metusela, one of the maintenance officers, heard screaming and went to the basement. He obtained a blanket, which he placed over Mr Armstrong. When he looked up at Mr Armstrong’s balcony he noticed that the railing was missing. He saw one railing near Mr Armstrong’s body. A short time later he went up to Mr Armstrong’s room on level 2, he saw the balcony door was open and that both timber railings were missing. He noticed that the other railing and an orange steel chair from the balcony were on the ground on the other side of a neighbour’s fence. The police and ambulance were called and arrived shortly thereafter.

13. Mr Armstrong’s death was also reported to the State Coroner’s Office and Dr Irvine conducted a Post Mortem on the 16 Feb 2010. She recorded the cause of death as ‘Multiple Blunt Force Injuries. A toxicology report found that he had 0.006g/100mL of alcohol and 0.7 mg/L of Venlafaxine in his blood.

14. Police responded to the call at about 12.50pm. They attended Mr Armstrong’s room and noticed that his lunch was still sitting on the table which appeared to have been untouched

15. Police recorded the timber railings that were found on the ground. They noted a length of brown painted timber approximately 3 metres long lying next to Mr Armstrong. One side of the timber was rotted with no evidence of bolt holes. The other end was not painted and where the bracket was seated he says the bolt holes had elongated and broken through the end of the timber. He also described a slight amount of rotting around these bolt holes. There was also an unpainted area centrally located along the timber and within this

unpainted area there was a single bolt hole with the rusted remnants of the bolt inside.

16. They also attended the rear yard of the neighbours property at 1-5 Pendrill Street Glebe and observed a chair, piece of timber from the boundary fence and brown painted timber rail. Sergeant Power noted that the bolt holes at either end had elongated and broken through the end of the timber. There appeared to be a slight amount of rotting around these bolt holes. Within the centre of the timber he saw two boltholes with the rusted remnants of the bolts inside. The remainder of the timber appeared to be in good condition.

17. Crime Scene Officer Power attended Mr Armstrong's room 205 and made an examination of the balcony. He described the balcony as about 3.1metres wide and 0.9 metres deep. It was constructed with a concrete base and brick sidewalls. The railing consisted of a four-course brick wall to a height of 0.37 m and two timber rails above (which were both missing). These missing rails had been attached to each side wall via L brackets and attached to a central metal post. All four brackets and their associated bolts and nuts were still attached to the walls. All four bolts appeared to be rusted with small amounts of timber attached. The top L bracket in the southwest wall was slightly hanging out from the wall. The central metal post had four dome nuts attached to the internal side of the post (2 nuts for the top rail and 1 nut for the bottom rail). Sgt Power noticed remnants of the associated bolts on the external side of the post, which appeared to be heavily rusted. The height from the top of the brick wall to the side pathway (where the deceased) was located was 11.1 metres.

18. Police notified the City of Sydney Council. Mr John Gilmore, Senior Building Surveyor attended with Mr Andrew Venios (Building Surveyor) at the request of the police.

19. Mr Gilmore provided a statement in which he said that the balustrade to room F2.5 was observed to have failed catastrophically. Both timber horizontal

barrier boards were not seen to be in place. Metal brackets to the North Eastern (side) were observed to still have mechanical connectors (bolts and nuts) in place. The bracket to the SW side also still had connectors in place, however it was observed that the bracket had also been dislodged a small amount from the wall. He also said that the failure occurred where the timber joined the steel bracket. This was primarily due to the failure of the timber at the point of contact with the mechanical fixture. He says *that 'observations made on other balconies would suggest that wood rot had weakened the timber at the support, allowing the timber to slide over the mechanical fixture when a lateral load was applied.* He also made similar observations at other balconies and on one of the balconies observed a cable tie had been used to repair a balustrade at the central support.

20. He also conducted an inspection to the balustrade located adjacent to Eglinton Lane which was the main walkway leading to the front of the resident's rooms. This balustrade was of steel construction with a timber handrail. The steel had corroded in numerous locations, at some places resulting in a significant reduction in ability to carry load. In some locations he observed it to have no positive connection. Of significance, he also observed that where the balustrade was connected to the masonry walls, the point of connection had *'failed'* and it appeared to him there was evidence of earlier repair attempts. He also observed *'spalling'* on the concrete walkway however he was not able to determine what impact if any this had on the stability of the *'steel balustrade'*.

21. Mr Gilmore also recorded the height of Mr Armstrong's balustrade to be approximately 950mm, (which was below the minimum height requirements of the Building Code of Australia as of 2010 for handrails, which was 1000mm). At the time of construction the building requirement for the construction of balconies was governed by Ordinance 71, which in 1972 was amended to insert a prescriptive requirement that handrails be a minimum of 865mm.

22. At the time of Mr Armstrong's death there was no requirement to upgrade to the current standard unless an owner submitted a new DA to upgrade the structure or Council had reason to issue an order pursuant to s121B of the EPA.

23. On the 15 Feb 2010, Mr Gilmore issued an Emergency Order on the building under s 121B of the EPA by City of Sydney Council. The order stated that the Lodge had to:

- Isolate the balconies to the SE side of the premises by locking the doors
- Provide signage to the NW balustrades and verbally inform all occupants to keep clear and not lean against the balustrade
- Provide full height scaffolding to the NW side of the premises to provide a safety barrier
- Submit to council a work method statement and plan to facilitate the removal and replacement of the compromised balustrades and any associated concrete / masonry spalling.

24. In the order it was stated that the balustrades to the NW and SE sides of the building were so dilapidated as to be prejudicial to it's occupants or to persons or property in the neighbourhood.

25. On the 17 Feb 2010 a decision was made by Wesley Mission to temporarily relocate 21 residents who lived in the NW Wing to other Wesley Mission Services.

26. On the 12th March 2010 the Lodge received a modified order from the Council to:

> "*submit a work method statement and plan prepared by a suitably qualified person outlining the method that will be employed to facilitate the removal and replacement of the compromised 'building' element (being the balustrades and any associated concrete /masonry spalling).*

2. Once the proposed works have been reviewed and agreed by Council, to remove the failed 'building' element and reinstate a suitable and compliant balustrades as outlined in Term 1"

27. As a result of this amended order a decision was made by Wesley Mission to close the facility permanently, which it did on the 31st August 2010.

28. The Coroner requested a brief of evidence on 16 February 2010.

29. After reviewing the brief, an inquest was dispensed with by Deputy State Coroner Magistrate MacPherson on 18 February 2011. In his Honour's reasons he stated that

'there are no suspicious circumstances / no care and treatment concerns. The identity of the deceased, the time, date place and cause of the deceased death are sufficiently disclosed. There are no issues for Inquest. Died after falling from balcony of premises he was staying because of a failure of the safety railing'.

30. On the 22 June 2011 the Court received a letter from Mr Rodney Cook who had undertaken some maintenance work at the Lodge shortly before Mr Armstrong's death. Mr Cook informed the Court that he had raised the issues relating to the safety and condition of the balconies with the management of Wesley Mission prior to Mr Armstrong falling and they had not acted.

31. The State Coroner re opened the investigation.

32. The matter was set down for Inquest to determine issues as to the manner of death and whether any recommendations should be made relating to public health and safety.

33. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* is to make findings as to:

(a) the identity of the deceased;

(b) the date and place of the person's death;

(c) the physical or medical cause of death; and

(d) the manner of death, in other words, the circumstances surrounding the death.

34. Section 82 of the Act also allows a Coroner to make any recommendations with particular emphasis on issues relating to public health and safety.

35. It should always be borne in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. Rather, the focus is how and why a person died and whether there are things that can be done in the future to prevent a similar death.

Manner of death

36. On the 1st February 2012 Mr Scott Graham, the Wesley Mission's in house counsel sent an affidavit to this Court that he believed Mr Armstrong's death was an *'apparent suicide'*.

37. Mr Graham's sworn assertion that Mr Armstrong's death was self inflicted was based on an internal Wesley Mission document from Mr Amor, Group Manager to Ms Orr, General Manager four days after the death. That document stated that, *"Staff believe that there is a strong chance that Les intentionally fell to his death as he had repeatedly complained about the lack of purpose for his life and compared his fragile 80 year old self to his young years as a bouncer in Kings Cross'*. Mr Amor was unable to say with any certainty who provided that information to him although he believed it may have come from Ms Lesianawai.

38. Ms Lesianawai said staff had advised her that Mr Armstrong had in the past said *'I wish I could end it'* however at the time of his death she had not heard

that he had recently made such comments and that he did not typically say that sort of thing.

39. Ms Sandra Trowbridge, the volunteer that visited the Mr Armstrong once a fortnight told one of the police that she had last seen the Mr Armstrong the previous Tuesday and that he was a bit depressed and that he had previously made threats of self-harm to her but this was approximately 5 years prior to his death. In a statement dated 7 Feb 2014 she said she had seen him the week before his death and he was looking forward to seeing her the following week.

40. The Aged Care Complaints Investigation Scheme also investigated Mr Armstrong's death. In a report dated 2nd March 2010 the department reviewed his progress notes from 22 Dec 09 -15 Feb 2010 and noted there was no evidence of any identified change in his normal behaviours as noted in his Care Plan and there was no record or any expressed intent of self harm.

41. Suicide cannot be presumed. There must be "clear cogent and exact" evidence before a finding of suicide can be made. [Briganshaw v Briganshaw (1938) 60 CLR 336].

42. Although Mr Armstrong had in the past made comments about self-harm, he had not done so of recent times and according to Ms Lesianawai and Ms Trowbrigde it is most unlikely that Mr Armstrong would have intentionally taken his own life.

43. An available explanation to his death is that he applied a lateral load to the railings on his balcony causing them to give way. Such an application of force could have been applied for a number of reasons, eg he may have leant against them, fell against them etc.

44. The location of the chair from his balcony in the adjoining property has not been properly explained. It is possible that Mr Armstrong may have attempted to physically grab hold of the nearest object to support him at the time the

timber railings had given way. If the chair had been used to intentionally take his life, it is difficult to speculate how the chair could have ended up in the adjoining property if it was used as a means to assist in climbing over the timber rails.

46. There is insufficient evidence to support a finding that his death was intentional.

Public health and safety Issues

45. On the day of Mr Armstrong's death the police who were called were so concerned about the safety of the railings on the balconies of the building that they contacted the Council. The Council issued the Emergency Order as the balustrades were found to be so dilapidated as to be prejudicial to occupants or persons or property in the neighbourhood.

46. This raises a number of questions.

- Did Wesley Mission know that the balustrades were corroded?

- What action was taken by Wesley Mission to address the issues raised by Mr Cook?

- Were regular maintenance checks carried out at the Lodge?

- Why didn't the Accreditation process identify the unsafe railings?

Did Wesley Mission know that the balustrades were corroded?

47. Wesley Mission had commissioned several independent reports from Building Consultants for the purpose of trying to maintain the Lodges' compliance with the Accreditation Standards.

48. The Rice Daubney Group completed a report in 1999 titled 'Capital Development Options'.

49. The report recommended a number of areas that needed to be addressed for the 2002 Assessment. Under s 3.4.2 Target 2002 it listed under point 2, (titled Hazards) to

    'Repair rusting balustrades anchored within concrete slab edges'.[i]

    (Note: The Quotation for replacing the balustrades was $15,000.00).

    In point 4.1 under the issue of 'Safety' it refers to a quotation to

    "*rectify heights of balustrades and handrails'* which at the time was said to be $8000."

50. In 2006, Mr Butler from Maitland and Butler Pty Ltd, Architects, was engaged by Wesley Mission to come up with some ideas for the external balustrades. By 2006 it seems that the main concern about the balustrades was that they were considered to be too easy to climb over.

51. On 3.10.06 Mr Butler sent an email setting out the different types of balconies that would be suitable and which would comply with the BCA for the premises. It is not known what if anything further occurred in relation to this proposal during 2007.

52. In 2008 Mr Butler was again asked to provide plans as to the refurbishment of all external balustrades. At some stage in early 2008 a prototype replacement balcony was created and was installed in the Manager's office at the Lodge for display.

53. According to Ms Orr, General Manager (Aged Care & Enterprise) at Wesley the balcony replacement was approved in the budget for the 2008/09 financial year and final approval was obtained by the Wesley Mission Board in June 2009.

54. A development application was first submitted on 24th December 2009 but no plans were included in the application and it was sent back to Wesley Mission on the 31st December 2009.

55. On the 4th Feb 2010, nine days before Mr Armstrong's death, a development application for *'balustrade'* renewal was lodged with Council by Maitland and Butler Architects Pty Ltd on behalf of Wesley Mission. Attached to that application was a statement of Environmental Effects which recorded that

> *'the renewal of the balcony balustrades is necessary for 'safety' reasons, as the existing timbers display signs of rotting. As well as this, the existing railings are of a height and configuration which were approved under previous building codes but do not conform to the current BCA or present day safety standards because they are easily climbable and too low to be safe for hostel residents'.*

56. There can be no doubt that Wesley Mission were aware that the balustrades were "rusting" and in need of repair for safety reasons. It was spelt out in the Rice Daubney report and in 2010 in the development application.

Why did the Wesley Mission take so long to address the issues of the safety railings and why did they take no immediate action when Mr Cook raised the alarm?

57. The Rice Daubney report not only highlighted problems with the balustrades. It said that remedial work, disabled access and fire safety upgrading must be taken in the short term and re development of the facility was necessary by 2008. The focus was on the fire safety concerns and these concerns dominated the agenda of the Property Department. Extensive work was carried out at the lodge to upgrade in the following years. It appears that the concerns about the balustrades were left to one side.

58. Wesley Mission concedes that there was a systemic failure in that the issues raised by Rice Daubney report in relation to the balustrades were not effectively managed or addressed.

59. Prior to the Quality Agency attending for an Assessment of the Lodge in 2009 Mr Rod Cook, an employee from Wesley Mission, was asked to attend the facility in the first week of August to carry out some required maintenance work. Mr Cook attended with a team of 4 people. His team conducted an internal and external inspection of the building.

60. Mr Cook formed the view that the majority of the handrails were in urgent need of repairs especially the external units that were exposed to the weather.

61. He instructed a colleague Mr James Brooker to take photographs of the building. He said he reported the conditions to senior management and was advised that the matter would be looked at and addressed. He said he remained working at the site for about a week.

62. According to Mr Cook, after a week or so he contacted his direct Supervisor Mr Chris England Residential Development Executive Manager Wesley Mission to find out what action had been taken.

63. As a result of that call Mr England sent an email to Mr Mike Amor, Group Manager Wesley Mission indicating the concerns that Mr Rod Cook had raised. The email made specific reference to the need for "urgent safety work in relation to hand-railings" and that the approvals to get the repairs started, needed to be pushed through. Attached to the email were three or four photographs taken by Mr Brooker. One was said to indicate the "protective hand railing that appears to be in imminent danger of collapse" and another "appears to be a case of concrete rot near hand railing supports". (Neither of these photos were photos of Mr Armstrong's railing or the other railings on his side of the building)

64. Mr Amor responded by saying that the team were onto it however he had to wait for Accreditation to go through.

65. It is conceded by Wesley Mission that no immediate response was made to the issues raised by Mr Cook.

66. It is submitted on behalf of Wesley Mission that the more significant concern raised by the email was the photograph and reference to the deteriorated western balustrade. Mr Crossfield, the Property Department officer in charge of the balcony upgrade, said that he had inspected the western balustrade and was satisfied that he did not consider it to be of imminent danger. He described the damaged timber handrail as a non-structural part of the railing and that the metal railings below it had not failed in any way.

67. Mr Murray of Work Health and Safety during a two-day internal audit on 17 and 18 June 2009 had noted the "broken wooden handrail opposite room F 204" needed replacement but had not raised it as an imminent safety concern or hazard.

68. Mr Amor indicated in his evidence that he had been *'reassured'* by the Operations Manager's that Mr Cook's concerns were being addressed and that in fact there was no *'imminent'* danger posed by the rotting timber hand railing. This appears to have been a miscommunication.

69. The Centre Manager and the Operation Manager's have all indicated that they were not aware of the *'concerns'* raised by Mr Rod Cook at the time the email was sent to Mr Amor or at any time up until the death of Mr Armstrong. Mr Amor indicated he did raise the concerns with Ms Elizabeth Orr although her evidence is that she was not advised of the *'safety'* issues that Mr Cook had brought to the attention of Mr England.

70. When Mr Cook discovered that repairs to the handrails had actually been authorised the previous financial year but that work had not yet commenced

due to financial reasons he was so appalled by the perceived lack of care for the residents and the upkeep of the facility that he left his employment with Wesley Mission.

71. The history of the Wesley Mission's knowledge and response to the need for the balcony railings to be repaired, highlights a lack of clear communication and follow up within the Wesley Mission organisation. During the course of this inquest Ms Jodie O'Sullivan from the Property Department of Wesley Mission handed up a document called the 'Aged Care Strategic Property Plan". She said that the Property Department now conducts annual inspections of all it's facilities to ensure that all of its buildings are now properly maintained, including railing inspections. This was not the case in 2009. Wesley have made the following further changes to ensure that in the future building safety is attended to;

    a. The establishment of a Property Committee on 13 March 2012, that comprises representation of the CEO / Superintendent, relevant General Managers, Property Manager, Major Projects Manager and the Legal Counsel. The committee is governed by Terms of Reference that include matters relevant to ensuring the safety of property and its condition.

    b. The development of an Aged Care Strategic Property Plan in February 2014 which implements a multi-disciplinary approach in property planning and management with participation from Aged Care Operations, Wesley Mission's Property Department and Work Health & Safety Department. This plan includes annual building inspections and audits that are designed to identify any relevant risks and to plan and implement necessary actions to address them.

    c. The development of actions plans in response to both internal and external audits. As a standard practise, these plans include identified areas of concerns, risks or non-compliance, planned actions to address them, person responsible, timeframes and evaluation of effectiveness of implementation. Action plans are developed and reviewed by multi-

disciplinary teams and at different levels of management. Both Quality Risk and Compliance Managers at the portfolio and organisational level monitor and report on the completion rate of action plans on a regular basis.

d. Commenced Work Health & Safety training alerting employees to dangers to balconies.

72. I am informed that the procedures are already in place. In those circumstances I do not propose to make any recommendations in relation to the Wesley Mission's to ensure that this neglect of a safety issue does not occur again.

Were regular maintenance checks carried out at the Lodge?

73. Since the death of Mr Armstrong a copy of the maintenance records for the facility has been provided to the Court for the period January 2009 to May 2010. Maintenance workers at the Lodge, Mr Karl Tifan and Mr Fred Metusula had principle responsibility for the day-to-day maintenance of the Lodge. Maintenance schedules and hazard logs were positioned in the reception area and were available for any resident, visitor or staff member to complete if an issue of maintenance, or safety was identified. There were approximately 350 logged jobs for various maintenance problems recorded at the facility during this period, which included plumbing, electrical, cleaning, building security as well as pest issues. There were no requests made or documented related to balcony safety or concerns with railings.

74. The Lodge also had a preventative maintenance program in place, which included the balconies being checked on a weekly basis. These records have been produced for the purpose of the Inquest. It is clear from the evidence that this process did not include an inspection of the safety of the railings and was undertaken more for the purpose of keeping the balconies clear and clean.

75. It was conceded by Wesley Mission at the commencement of the inquest that the maintenance processes were ineffective in identifying a significant structural safety issue at this facility

76. As is indicated above the Wesley Mission hopes to rectify the deficiencies in the identification of possible structural dangers by its new protocol of engaging a multi-disciplinary approach to annual inspections of facilities involving members of the Property Department, Operations Managers and WH & S officers. Work Health and Safety training has also been modified to specifically alert employees to balcony railing safety issues.

Why didn't the Accreditation process identify the unsafe railings?

77. This inquest received a joint letter from the Australian Government Department of Social services and the Australian Aged Care Quality Agency dated 2 April 2014. It sets out a summary of the accreditation system as follows;

> *"Certification*
> *The Department of Social Services (**the Department**) currently administers a program of certification of residential aged care services. An approved provider of residential aged care services may only charge accommodation bonds or accommodation charges or receive accommodation supplements or concessional resident supplements in respect of a residential care service if the service has been certified under Part 2.6 of the Aged Care Act1997 (Cth).*
> *In essence, residential aged care services achieve certification by meeting the requirements of the Aged Care Certification Assessment Instrument (**ACCAI**) and other considerations relating to the quality and amenity of the service.*
> *The Certification program and the ACCAI were originally introduced in 1997, with the objective of bringing older building stock up to a more contemporary standard by encouraging and rewarding continuous*

improvements in the physical quality, safety and amenity of residential aged care facilities. All Commonwealth subsidised residential services are currently certified.

The Department notes when the ACCAI was developed in 1997, it drew on the BCA as a tool for assessing building quality. In particular, sections one and two of the ACCAI focus on fire safety and hazard management, which reflects to a significant degree the content of the BCA. Inevitably, the Certification program results in duplication with the responsibilities of state and local governments for building regulation, however, certification was never intended to override state and territory responsibilities in this regard.

On 19 March 2014, the Australian Government introduced legislation to remove the requirement for Commonwealth subsidised residential aged care services to be certified. If passed, it is proposed that the removal of certification will take effect from 1 July 2014. .

Accreditation

*The Department's program of Certification is to be contrasted with the role of the Australian Aged Care Quality Agency **(Quality Agency**), which administers a program of accreditation of residential aged care services. An approved provider of residential aged care services that operates a service which is accredited may be eligible to receive a residential care subsidy, a form of payment by the Commonwealth for providing residential care to care recipients.*

*In essence, residential aged care services achieve accreditation by demonstrating compliance with the Accreditation Standards (**the Standards**) as outlined in Schedule 2 of the Quality of Care Principles 1997 (Cth).*

There are four Standards:

- *Management systems, staffing and organisational development;*
- *Health and personal care;*
- *Resident lifestyle; and*
- *Physical environment and safe systems.*

Each of those Standards is further particularised by a number of Expected Outcomes. There are 44 Expected Outcomes in total. Standard 2 Health and personal care has the greatest number of Expected Outcomes (17 in total)

and Standard 4 Physical environment and safe systems has the least number of Expected Outcomes (8 in total).

The matters to which the Standards and Expected Outcomes pertain are many and varied. Some of the Standards and Expected Outcomes concern matters that may already be properly covered by state and territory laws. For example, the interface between food safety regulations and Expected Outcomes 4.7 Infection control and 4.8 Catering, cleaning and laundry services. In respect of such matters, part of the Quality Agency's role is to evaluate systems put in place by the provider to ensure compliance with the applicable regulatory standards, and this would typically also involve consideration of any recent inspection by the relevant food authority. The Quality Agency does not, however, itself assess compliance with those regulatory standards.

In this way, the Quality Agency fulfils an important but limited oversight role without intruding into the areas of responsibility held by local authorities and minimising regulatory impost. The Standards - and the associated outcomes - take account of the interface with legislation and regulations for which the States and Territories have singular responsibility."

78. On 10-11 August 2009, two assessors from the Quality Agency, Ms Maggy Franklin and Ms Maria Toman, conducted a site audit at the Lodge.

79. The assessors were not directed towards particular rooms, and were not accompanied by staff throughout their visit. They were free to, and did, speak to residents and ask to see residents' rooms as they roamed about the building.

80. The assessors met with Wesley Management and Lodge Staff, including Mr Turner and Ms Lesianawai. They were required to assess all 44 Accreditation Standards, divided into four categories: (i) Management systems, staffing and organisational development; (ii) Health and personal care; (iii) Resident Lifestyle, and (iv) Physical Environment and safe systems. Ms Franklin was responsible for assessing the first and fourth categories.

81. The assessors were not told about the plans to replace the balcony railings at a cost of $132,000.00 for stage 1. This information was not included in the "Preventative Maintenance Programme" shown to the assessors.

82. The Lodge was re accredited for a further three years. It was satisfied that 44 of the 44 Expected Outcomes in 2009 had been met. Under the heading "Expected Outcome 4.4 Living Environment" the lodge was noted to be 'clean, odour free, with well maintained equipment and furniture to be at a comfortable internal temperature".

83. It is submitted by Mr Bushrod the General Manager of the Quality Agency that it is not possible for the assessors to personally examine every aspect of a home's systems, processes and facilities. Rather, the Quality Agency relies upon a web of information, which, if the systems are operating should identify any apparent potential safety issues.

84. Ms Franklin's evidence is that, while she has no present recollection of inspecting any of the balconies or balustrades at the Lodge, consistent with her usual practice she would have inspected at least one resident's room and would have stepped out onto the balcony if there was one. There is no basis to doubt this evidence, or to suggest that her inspection should have identified to her the problem with the balconies at the Lodge.

85. The evidence of Mr Gilmore from the Council makes it quite clear that something more than visual inspection is required in order to assess structural integrity of a balcony, and that visual inspection may well not identify matters such as wood rot.

86. The Quality Agency cannot verify that every item recorded by an approved provider in their own record systems, across the range of the 44 Accreditation Standards, is completely accurate. Assessors rely on a sampling approach,

their own observations, conversations and interviews with management, staff, residents, family and visitors.

87. The Quality Agency is reviewing their sampling method with a view to enhancing the recognition and identification of triggers requiring further investigation.

88. One way of identifying triggers may have been by keeping a check on the continuous improvement work plans. In 2003 the continuous improvement work plans provided by the lodge noted, “balcony rails need to be checked and monitored for safety”. In 2006 and 2009 continuous improvement work plans recorded a plan to “Upgrade the room balconies to meet the Building Code”. The assessors did not make further enquiries about what was happening with the railings. A comparison of previous continuos improvement work plans may have assisted in identifying that the balcony railings safety had not been dealt with.

89. This Inquiry has shown that the balcony upgrades remained outstanding on the continuous improvement work plans. A comparison of continuous improvement work plans by the assessors may have assisted in identifying that the balconies safety were still in issue and had not been attended to.

90. The Quality Agency has undertaken a review of its processes in light of the death of Mr Armstrong. It is considering introducing a new step generally to be taken in the Site Audit process whereby prior to site visits, assessors are provided with copies of the previous continuous improvement work plans submitted by the approved provider. This approach may assist assessors to determine whether continuous improvement work plans are being effectively implemented.

Conclusion

91. The issues brought to light by this inquest suggest that there is a need to further bolster the system of accreditation of providers as to the safety of their facility. The current system does not pick up whether balcony railings in a facility are safe. There are approximately 2700 providers in NSW. It is important that balcony railings as they age are considered for safety.

92. The City of Sydney Council quite correctly pointed out that the primary responsibility for safety of a building rests with the owner or occupier of the building. The Wesley Mission has given evidence that while the safety of the railings was identified as an issue in 1999 that the issue of fire safety in the building was also identified and that it was prioritised and dealt with. The issue of the railings were put aside and somewhat overlooked. It is unfortunate that this incident occurred 9 days after they finally submitted plans to Council to have the railings replaced. The Wesley Mission has now introduced procedures to ensure that this does not happen in relation to any of their other properties.

93. The Quality Agency accredited the Lodge as safe in August 2009 and it is most ironic that the Council of the City of Sydney placed an Emergency Order on the building as unsafe in February 2010.

94. This anomaly is explained by the fact that the assessors for the quality agency are not appropriately trained to inspect the structural integrity of the railings of a building and there is no system in place to require the provider to demonstrate that the railings are sound.

95. The Council of the City of Sydney has acknowledged that it is the regulatory authority for building safety issues. It proposes that there could be a system of certification of the structural integrity of balustrades by requiring a provider to lodge a certificate from an appropriately qualified external expert with the Council. The Quality Agency could then check that such certification had been

obtained in the course of assessing approved providers' compliance with the Standards.

96. This is similar to one aspect (among others) of the Quality Agency's current approach to the assessment of Accreditation Standards 1.2 and 4.2 (regulatory compliance) and 4.6(Fire, security and other emergencies) in relation to fire safety. Quality Agency Assessors inspect documentation that indicates the home has met local and State or Territory government fire safety regulations. The Quality Agency does not comprehensively assess whether the provider's facilities in every respect comply with the regulations; rather the Quality Agency confirms that the provider holds the requisite certification or documentation and Quality Agency assessors, among other things, make observations within their expertise and evaluate the systems in place within a care facility.

97. I note that Mr I Scott, Group Manager, Aged Care Quality and Compliance Group, Department of Social Services and Mr N Ryan, Chief Executive Officer, Australian Aged Care Quality Agency in their letter dated 2 April 2014 have informed this Inquest that The Commonwealth , through the quality Agency, does ensure that regulatory compliance systems of approved providers are monitored by checking that any required certification had been obtained in the course of assessing approved providers compliance with the standards. That assessment occurs every three years.

98. On a final note, I wish to pass on my sincere condolences to all those people who knew and cared for Lesley during his life and in particular during his time at RJ Williams Lodge who have been affected by his sudden and untimely death. For your efforts, may I extend my gratitude to you and for all those people who are involved in the ongoing care and support provided each day to the elderly and vulnerable members of our community.

C.Forbes
Deputy State Coroner
2nd May 2014