CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of Neville Clutton**
Hearing Dates:	**25-27 November 2019 at Newcastle**
Date of Findings:	**11 February 2020**
Place of Findings:	**Newcastle Local Court**
Findings of:	**Magistrate Stone, Deputy State Coroner**
Catchwords:	**CORONIAL LAW – Manner of death – Residential Aged Care Facility – Resident to Resident Aggression in dementia unit – policies and procedures – identifying cause of behaviour and reporting incidents – actions taken to prevent escalation of behaviour – whether actions adequate**
File Number:	**2017/45432**
Representation:	**Mr P Aitken, Counsel Assisting, instructed by the Crown Solicitor's Office** **Ms A Horvath for SummitCare** **Mr M Byrne of the NSW Nurses and Midwives' Association for Ms K Morillas** **Ms M England for the Aged Care Quality and Safety Commission**
Findings:	**The date of death was on 10 February 2017** **The time of death was between 3.30pm and 4.00pm** **The place of death was John Hunter Hospital Newcastle**

The cause of death was complications of head injuries and an antecedent cause was dementia

Manner of death: Neville Clutton died from a push by another person resulting in a fall.

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1. *The Coroners Act 2009* (NSW) (*the Act*) *in s 81(1) requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Neville Clutton.*

2. *I make a non-publication order under s 74 (1) of the Act in relation to the name of Mr [redacted] [redacted] in this Inquest. That order extends and includes any written material within the brief of evidence that has reference to [redacted] name.*

Introduction

3. Neville Clutton died on 10 February 2017, aged 78 years.[1] His death as defined by s 6 of the Act was an unusual death arising from severe injuries he received while a resident in a dementia care unit at an aged care facility and as such it was a "reportable death" to the Coroner. As will be outlined in this decision, I am satisfied his injuries were caused by another resident also suffering dementia. Those injuries were occasioned on 28 January 2017 and included minimal displaced fractures of the right frontal bone, orbit and maxillary sinus and subarachnoid and intraparenchymal haemorrhage.[2] He was transferred to the John Hunter Hospital and despite receiving medical assistance in relation to the injuries he was not able to overcome the trauma and died 13 days later.[3]

The Inquest

4. Section 81 of the Act requires a Coroner to make findings as to:

   - the identity of the person who has died;
   - the date and place of the person's death; and
   - the manner and cause of the death.

5. In addition, under s 82 of the Act, the Coroner may make recommendations in relation to matters connected with the death, including matters that may improve public health and safety in the future.

6. In regard to the following material I have relied extensively on the opening statement of Counsel Assisting and gratefully acknowledge his authorship and assistance.

Background

7. Neville Clutton was born in Newcastle on 29 January 1939, just 8 months before the outbreak of World War II.[4] His father died when he was 5 years old and so from his early years he was raised by his mother. His mother decided that it would be best if he went to Sydney for his education and he was educated at the Masonic School which took in boarders. He returned to Newcastle at age 15 and trained as an accountant ultimately returning to Sydney for employment. He never married, and worked as an accountant for his professional life. Prior to his admission into care he lived in Ashfield, Sydney. He was always a healthy and active person. His leisure interests included reading, cricket, chess, ten-pin bowling, bushwalking and opera.[5] His cousin, Mr David Ponman, during the Inquest provided an insight into the personality of the deceased, and described Mr Clutton as a person with a quiet nature, a dry sense of humour and a quick wit.[6] He was close to Mr Clutton as their mothers were sisters

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[1] Transcript of proceedings 25 November 2019 at T3.42 – 3.44.

[2] Exhibit 1, Tab 5.

[3] Exhibit 1, Tab 1.

[4] Transcript of proceedings 25 November 2019 at T5.25 – 5.26.

[5] Transcript of proceedings 25 November 2019 at T5.29 – 5.31.

[6] Transcript of proceedings 27 November 2019 at T58.42.

and he was also an only child.[7] He neither smoked nor drank. At SummitCare he liked to play board games.[8]

8. During the time he was in care Mr Clutton would be visited on alternate weeks by his cousins Mr Ponman and Mrs Crameri.[9]

9. Mr Clutton received an ACAT assessment in July 2014, after being hospitalised for four months and diagnosed with dementia.[10] In August 2014 application was made for his admission to SummitCare at Wallsend ("the Home"), with symptoms of disorientation, confusion and amnesia, as well as issues with his speech.[11] By coincidence the Home was located very near where he grew up.

The Home

10. Mr Clutton lived in the Home's Lavender Unit in the North Side Wing ("Lavender Unit"). The Lavender Unit consisted of residents with dementia.[12] There were a number of single rooms and a number of share rooms in the Lavender Unit and Mr Clutton shared a room with [redacted]. The Home had three other units: Magnolia, Parkview and Mountview.[13] Some of the residents in the other units also suffered from dementia however not as severe as those in the Lavender Unit.[14]

11. While the Lavender Unit is a locked or secure facility, residents are able to move freely between the rooms within the unit.[15] There was CCTV within at least part of the common area of the Unit which was to assist with the monitoring of residents or movement within the Unit. Staff were responsible for the monitoring of the residents.[16] The Lavender Unit is split up into a South Side Wing and a North Side Wing. The South Side has 5 single rooms and 5 dual occupancy rooms and the North side 8 single rooms and 6 dual occupancy rooms. It accommodated residents with mild to moderate symptoms of dementia and behavioural and psychological symptoms of dementia.[17]

12. From the evidence in the mornings from Monday to Friday in the Lavender Unit there were four care staff, one team leader, one Registered Nurse ("RN") and one activity officer.[18] The afternoon was the same with the exception of the team leader. Similar staff numbers were

[7] Transcript of proceedings 27 November 2019 at T58.45 – 58.48.
[8] Transcript of proceedings 25 November 2019 at T5.31 – 5.32.
[9] Transcript of proceedings 25 November 2019 at T5.34 – 5.35.
[10] Transcript of proceedings 25 November 2019 at T5.35 – 5.37.
[11] Transcript of proceedings 25 November 2019 at T5.35 – 5.39.
[12] Transcript of proceedings 25 November 2019 at T6.7 – 6.8.
[13] Transcript of proceedings 25 November 2019 at T6.11 – 6.12.
[14] Transcript of proceedings 25 November 2019 at T6.12 – 6.17.
[15] Transcript of proceedings 25 November 2019 at T6.19 – 6.21.
[16] Transcript of proceedings 25 November 2019 at T6.21 – 6.22.
[17] Transcript of proceedings 25 November 2019 at T6.27 – 6.29.
[18] Transcript of proceedings 25 November 2019 at T6.35 – 6.38.

rostered onto the weekend shifts. The day of the incident was 28 January 2017 which was a Saturday and the incident involving Mr Clutton occurred in the afternoon.[19]

13. So far as areas of responsibility were concerned, Ms Brittany Saunders, an assistant in nursing ("AIN") and also described in evidence as "care staff" has stated that her role was resident care based, and that she did not play any role in the management processes dealing with the care or safety of residents, and that it was the responsibility of RNs to escalate any concerns to management.[20]

14. Resident notes were recorded electronically on the Home's computer program system known as 'Ecare Progress Notes'.[21]

Events and the Incident

15. Another resident of the Lavender Unit was Mr [redacted], aged 80. [redacted] came to the Unit on 8 June 2016, diagnosed with dementia. He had an assessment in May 2016 where it was identified that he had only managed to get two thirds of questions correct in a mini mental state exam, had regular short term memory problems, was occasionally verbally aggressive (but never physically), and was regularly disorientated to time and place, with a history of wandering.[22]

16. [redacted] at that stage was described as not having a history of aggressive physical behaviour. This is a relevant consideration in examining whether staff and management appropriately reacted to the physical episodes that first emerged in November 2016 as described below.[23]

17. Initially [redacted] settled in well, after a few days of wanting to leave and understandably feeling agitated. He was prescribed Risperidone PRN by his GP Dr Karanam.[24] Ecare notes describe him being verbally aggressive on 26 July, saying he owned the building; on 29 July he yelled that he was "stuck in this hellhole" and wanted to burn the building down.[25] At times he would think his wife had passed away and become upset, or pack his clothes to go home.[26] On 3 October 2016 he tried to climb over the fence and was very abusive and agitated, saying the staff were keeping him from his daughter and everyone was spying and poisoning him. Risperidone was administered to [redacted] but the doctor did not attend.[27]

18. [redacted] Care Plan includes an entry in these terms: "*paranoid that staff are watching him all the time and want him dead*".[28]

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[19] Transcript of proceedings 25 November 2019 at T6.42 – 6.43.

[20] Transcript of proceedings 25 November 2019 at T6.45 – 6.50, T67.18 – 67.22.

[21] Transcript of proceedings 25 November 2019 at T6.50 – 7.3.

[22] Transcript of proceedings 25 November 2019 at T7.7 – 7.13.

[23] Transcript of proceedings 25 November 2019 at T7.13 – 7.19.

[24] Transcript of proceedings 25 November 2019 at T7.22 – 7.24.

[25] Transcript of proceedings 25 November 2019 at T7.24 – 7.26.

[26] Transcript of proceedings 25 November 2019 at T7.26 – 7.29; Exhibit 1, Tab 18(1), p. 2.

[27] Transcript of proceedings 25 November 2019 at T7.34.

[28] Transcript of proceedings 25 November 2019 at T7.41 – 7.42.

19. [redacted] and Mr Clutton were put together in a shared room from 14 June 2016.[29]

20. The first recorded act of aggression was on 25 November 2016. The Ecare note for 25 November shows RN M Zubkacova, reporting that when a staff carer Mr James Murray tried to escort [redacted] back into the Unit after he started following some people out, [redacted] grabbed him around the neck, causing red marks. There is no mention of management being informed but the Ecare entry says "*family informed. Staff incident form attended*".[30]

21. There is no evidence that [redacted] GP was contacted following this incident. There is no entry in the Behaviour Identification and Interventions Chart for [redacted].[31] There is also no Critical Incident Report form for this incident; it is not clear whether this is because a resident was not the focus of the aggression.[32] Ms Kathleen Morillas, Manager of Care and Services at the relevant time, makes no mention in her statement about having knowledge of this incident, but it appears in the Ecare notes.[33] There was no entry for this incident made on [redacted] Care Plan. There is no entry in the Mandatory Reporting Register. The possible reason because it was an act of assault by a cognitively impaired resident on staff.[34]

22. On 15 December 2016 [redacted] told AIN Laver that he was 'going to wring someone's neck today' and demonstrated with his hands.[35] The RN on duty was made aware. There is no entry in the Behaviour Identification and Interventions Chart for [redacted] concerning this incident although he was administered Risperidone (Rixadone) at 10:00am that day.[36]

23. Ecare records an entry by S Laver AIN that on 26 December 2016 "[redacted] *was walking with a belt tightening it and loosening stating to me that he wanted to put it around someone's neck; belt was taken off him and put into trolley*".[37]

24. A facsimile was produced as part of the Home's records for [redacted]. It was addressed to [redacted] GP, however no corresponding fax was produced as part of Dr Karanam's file. That fax is signed by an AIN 'Louraine' and dated 30/12/2016. It reads:

   "[redacted]*'s behaviours have increased by putting his hands around other resident's necks, also using his belt as a noose, stated that "I wonder what it would be like to watch a person trying to breathe". All belts were removed from his room and also pants i/c cords. Is on a sight chart. Would it be possible to have a referral for DBMAS to an assessment done*" [sic].[38]

   On 27 December the same AIN recorded "*Family contacted regarding issue with belt family have taken* [redacted]*'s belts home see previous progress notes RN aware*".[39] There was no entry for

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[29] Transcript of proceedings 25 November 2019 at T7.44 – 7.45.

[30] Transcript of proceedings 25 November 2019 at T8.2 – 8.10.

[31] Exhibit 1, Tab 18(1).

[32] Transcript of proceedings 25 November 2019 at T8.10 – 8.16.

[33] Transcript of proceedings 25 November 2019 at T8.17 – 8.19.

[34] Transcript of proceedings 25 November 2019 at T8.19 – 8.22.

[35] Transcript of proceedings 25 November 2019 at T8.24 – 8.26; Exhibit 1, Tab 47, p. 13.

[36] Transcript of proceedings 25 November 2019 at T8.26 – 8.31.

[37] Transcript of proceedings 25 November 2019 at T9.2 – 9.5; Exhibit 1, Tab 47, p. 10.

[38] Transcript of proceedings 25 November 2019 at T8.39 – 8.50; Exhibit 1, Tab 52.

[39] Transcript of proceedings 25 November 2019 at T9.5 – 9.8; Exhibit 1, Tab 47, p. 10.

this incident made on ’s Care Plan. As it transpired from the evidence, the reference to “other residents necks” was apparently an exaggeration and inaccurate and there is no evidence of such acts to residents.[40]

25. A note in Dr Karanam’s records from 4 January 2017 records that “*asked to see - his behaviours are sometimes threatening to others. Please see the attached fax. Spoke to Nurse Jenni and Nurse Manager Kathleen Morillas - they said that his behaviours have settled down and he is pleasant now*”.[41] A copy of the “attached” fax was not produced as part of Dr Karanam’s records.[42]

26. On 16 January 2017 Mr Clutton had a fall, which was attended by RN Srestha Ranju and medical evaluation was sought.[43] Ecare records that no-one else was involved and that Mr Clutton had attempted to stand up from his chair, slipped and fell back down. A risk assessment sheet was completed and signed off by Ms Morillas on 19 January.[44]

27. Incidents between Mr Clutton and occurred on 18, 22, 24 and on 28 January 2017. They are briefly described below.

28. On 18 January 2017, Judith Mason RN found Mr Clutton on the floor near his room, at about 9:21pm. She checked him out and returned him to bed. The Ecare notes made contemporaneously by RN Mason variously record:[45]

    (i) Mr Clutton being seen to be pulled under his arms from the room by his roommate (which must have been); and

    (ii) That was “*confused and angry and wanting him out of his room. Attempts to orientate to the fact that he shares a room met with little success.*”

29. RN Mason put Mr Clutton on close observations (every 15 minutes) until a review in the morning; it is not clear why wasn’t immediately put on close observations as well given his confusion and antipathy towards his roommate. A risk assessment form was completed and signed by Ms Morillas on 19 January 2017.[46] The plan appears to have been to monitor Mr Clutton. There is no entry in the Behaviour Identification and Interventions Chart for concerning this incident. There is also no indication that Risperidone PRN was administered, either after this incident or after any of the other January 2017 incidents, according to ’s medication charts.[47]

30. On 19 January was put on a 1 hourly sight chart by RN Mason due to his aggression from the 18 January incident. The chart is a computerised log which appears to

[40] Transcript of proceedings 25 November 2019 at T50.41 – 50.44; Transcript of proceedings 26 November 2019 at T17.41 – 18.5.

[41] Transcript of proceedings 25 November 2019 at T8.31 – 8.38; Exhibit 1, Tab 53, p. 10.

[42] Transcript of proceedings 25 November 2019 at T8.39 – 8.41.

[43] Transcript of proceedings 25 November 2019 at T9.22 – 9.23.

[44] Transcript of proceedings 25 November 2019 at T9.27 – 9.29.

[45] Transcript of proceedings 25 November 2019 at T9.34 – 9.39.

[46] Transcript of proceedings 25 November 2019 at T9.45 – 9.46; Exhibit 1, Tab 18A, Annexure E.

[47] Transcript of proceedings 25 November 2019 at T9.49 – 10.1.

have had each entry entered on the hour precisely, which in reality may not have been possible. The first entry contains detail; the others do not.[48] Disturbingly, it includes entries from 4 February when ████ was no longer resident at the Home. ████ was not put on 15 minute observations after the 28 January incident; however he went onto 15 minute observations on 30 January.[49]

31. A note from that afternoon records that ████ was wandering the hallway confused, bored, wanting to go home, packing up his room numerous times a day and very physically agitated.[50]

32. On 20 January 2017, ████ was recorded by AIN Little during the morning as "very paranoid", scared that if he came out of his room "*the man will bash him*". He eventually left for breakfast and then returned and hid under the covers of his bed saying someone would bash him. He was recorded as very confused.[51] The note does not say whether this was escalated to an RN. There is no entry in the Behaviour Identification and Interventions Chart for ████ concerning this incident.[52]

33. On 22 January, Mr Clutton was found on the floor of room 11 of the Home.[53] It is not clear whose room this was. Betcy Ben RN was notified and informed the Manager Care Services Ms Morillas, according to a note on Ecare.[54] No critical incident form appears to have been completed.[55]

34. On 22 January, Mr Ponman visited Mr Clutton. As he was taking Mr Clutton to his room ████ got out of bed and became very verbally aggressive towards both of them. Mr Ponman took Mr Clutton away for his own safety; ████ slammed the door behind them.[56] The RN who entered a note on Ecare, Molly, recorded that "*staff reassured family member that* ██ *is not like this when it is just Neville and staff in the room and he is not in any harm's way*".[57] This is a surprising comment given that ████ had only 3 days before been put on a sight chart due to his aggression towards Mr Clutton on the 18 January. No critical incident form was completed, possibly because no assault occurred.[58]

35. On 24 January 2017, about 8:45pm, AIN Saunders was doing rounds in the Lavender Unit when she heard loud screams from Mr Clutton. She ran up the hallway of the Unit and found Mr Clutton lying in the doorway of his room with ████ standing with one leg either side of Mr Clutton straddling him, yelling aggressively at Mr Clutton. ████ moved away when told to. ████ was asked what happened by Ms Saunders and the attending RN. He said "*He was in my stuff so I dragged him out. I should kick him in the head until he's*

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[48] Transcript of proceedings 25 November 2019 at T10.3 – 10.9; Exhibit 1, Tab 18, Annexure 1.

[49] Transcript of proceedings 25 November 2019 at T10.14 – 10.17; Exhibit 1, Tab 18, Annexure 1.

[50] Transcript of proceedings 25 November 2019 at T10.17 – 10.20; Exhibit 1, Tab 47, p. 6.

[51] Transcript of proceedings 25 November 2019 at T10.22 – 10.24; Exhibit 1, Tab 47, p. 5.

[52] Transcript of proceedings 25 November 2019 at T10.27 – 10.29.

[53] Transcript of proceedings 25 November 2019 at T10.31.

[54] Exhibit 1, Tab 37, pp. 5–6.

[55] Transcript of proceedings 25 November 2019 at T10.33 – 10.34.

[56] Transcript of proceedings 25 November 2019 at T10.35 – 10.39.

[57] Transcript of proceedings 25 November 2019 at T10.39 – 10.43; Exhibit 1, Tab 47, p. 4.

[58] Transcript of proceedings 25 November 2019 at T10.47 – 10.49.

dead".[59] According to the Ecare note made by Ms Saunders, kept on making inappropriate comments about Mr Clutton being on the ground and potentially hurting him, and pacing back and forth.[60]

36. Ms Saunders' subsequent recollection is that she was aware at the time that there had been an earlier incident between the two men and that she raised her concerns with the RN as she was concerned about them sharing a room.[61] The Ecare notes record that the RN making an entry about the incident was RN Ranju. The notes record that said he dragged Mr Clutton onto the floor as Mr Clutton was trying to get into his bed. He said he wanted disinfectant for his room and "*do not want Neville in his room*", said in an aggressive and abusive tone.[62] The notes record that it was explained that it was a shared room. Mr Clutton had evidence of a nose bleed and a swollen and red right ear lobe. Medical intervention was sought and Mr Ponman was notified.[63]

37. Ms Saunders' note on Ecare records that also stripped all the sheets from Mr Clutton's bed and put them on the 'skips' and then slammed the door shut.[64] RN Ranju rang Mr Ponman and advised what had happened; Mr Ponman is recorded in the Ecare notes as saying he wasn't surprised as last time he visited told him to get out and shut the door in his face.[65] A critical incident form was completed and signed by Ms Morillas. The form notes "*potential aggression from residents*" and recommends a sight chart and monitoring, presumably for Mr Clutton.[66] An accompanying risk assessment worksheet for Mr Clutton was not signed by Ms Morillas until 30 January 2017.[67]

38. There does not appear to be any evidence that the GP (for) was contacted about this incident. There is no entry in the Behaviour Identification and Interventions Chart for concerning this incident. There was no entry for this incident made on 's Care Plan. There is no entry in the Mandatory Reporting Register.[68]

39. The Home has conceded that a referral to DBMAS should have been made at this time.[69]

40. The incident on 28 January 2017 which led to Mr Clutton's hospitalisation and death was unwitnessed; however Ms Saunders suspected 's involvement, as she saw him holding a walker near Mr Clutton as he lay bleeding on the ground and saying *'I am sick of your shit'*.[70] Ms Saunders informed staff members RN Ben and AIN Aleisha Eslick of her belief; given the incidents over the previous 10 days it was not unreasonable to form that

[59] Transcript of proceedings 25 November 2019 at T11.3 – 11.12; Exhibit 1, Tab 13A.

[60] Transcript of proceedings 25 November 2019 at T11.14 – 11.16; Exhibit 1, Tab 47, p. 3.

[61] Transcript of proceedings 25 November 2019 at T11.17 – 11.20; Exhibit 1, Tab 13A.

[62] Transcript of proceedings 25 November 2019 at T11.22 – 11.26; Exhibit 1, Tab 47, p. 3.

[63] Transcript of proceedings 25 November 2019 at T11.27 – 11.29; Exhibit 1, Tab 47, p. 3.

[64] Transcript of proceedings 25 November 2019 at T11.30 – 11.32.

[65] Transcript of proceedings 25 November 2019 at T11.33 – 11.37; Exhibit 1, Tab 37, p. 4.

[66] Transcript of proceedings 25 November 2019 at T11.37 – 11.39.

[67] Transcript of proceedings 25 November 2019 at T11.40 – 11.41; Exhibit 1, Tab 18A, Annexure F.

[68] Transcript of proceedings 25 November 2019 at T11.41– 11.48.

[69] Transcript of proceedings 25 November 2019 at T11.50 – 12.1; Exhibit 1, Tab 18A.

[70] Transcript of proceedings 25 November 2019 at T12.4 – 12.8; Exhibit 1, Tab 47, p. 2.

belief. There is no entry in the Behaviour Identification and Interventions Chart for ██ ████ concerning this incident.[71]

41. Despite the incident on 28 January 2017, ████████ remained at the Home. Ecare notes record on 30 January at 10.55am record that ████████ had said "*u better be care as u never know what could happen to u* [sic].[72] The Behaviour Identification and Interventions Chart adds that he was constantly agitated and clapping his hands.[73] At 12:29pm Ms Morillas, the Manager Care Services, noted that she had reviewed the CCTV footage for the 28 January and that showed that ████████ pushed Mr Clutton with force.[74] A phone call was made to the Mater Mental Health Unit for Older Persons ("MHUOP") who advised to have the Medical Officer schedule ████████ so he could be assessed.[75] ████████ was seen by his GP Dr Karanam and told the doctor he could not recall the incident or who Mr Clutton was.[76]

42. A risk assessment worksheet was completed by Ms Morillas on 30 January. The plan appears to have been to monitor wandering residents and for staffing to be reviewed.[77]

43. On admission to the MHUOP on 30 January ████████ was started on Risperidone 0.5mg nocte. No evidence of infection was detected.[78] The discharge summary records a bit more information provided as to his history. It states that ████████ had been confused, thinking his roommate was an intruder and that he had also been showing aggression towards staff and residents. Collateral history from his daughter described premorbidly a gentle, quiet man with no history of aggression. Due to the lack of his wife's presence at the Home he began to harbour ideas that she had left him for another man.[79]

44. The source information for this history comes from the admission notes dated 30 January. They refer to ████████ having been verbally aggressive and threatening to other residents, going into their rooms at night, as well as "*two weeks ago attempted to strangle a staff member*".[80] It is not clear if this is an error and is referring to the two months earlier incident involving Mr James Murray. ████████ said to staff he thought he was in hospital for sunburn; on the 3 February he said he thought he was in a pub.[81]

45. A note from the MHUOP on 31 January 2017 records the GP for ████████ reporting his concern that the Home had not been informing him of ████████'s behaviour before the recent outburst.[82] Collateral history was also obtained from the nurse manager, presumably Ms Morillas, and it recorded increased aggression over the past two weeks and also an unprovoked attack on staff, with "*significant concerns about behaviour*" and unable to

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[71] Transcript of proceedings 25 November 2019 at T12.11 – 12.12; Exhibit 1, Tab 13 at [15].

[72] Transcript of proceedings 25 November 2019 at T12.15 – 12.16.

[73] Transcript of proceedings 25 November 2019 at T12.16 – 12.18; Exhibit 1, Tab 18, Annexure 1.

[74] Transcript of proceedings 25 November 2019 at T12.18 – 12.20; Exhibit 1, Tab 47, p. 1.

[75] Transcript of proceedings 25 November 2019 at T12.20 – 12.22; Exhibit 1, Tab 47, p. 1.

[76] Transcript of proceedings 25 November 2019 at T12.22 – 12.24. Exhibit 1, Tab 53, p. 10.

[77] Transcript of proceedings 25 November 2019 at T12.24 – 12.26.

[78] Transcript of proceedings 25 November 2019 at T12.28 – 12.29; Exhibit 1, Tab 55A.

[79] Transcript of proceedings 25 November 2019 at T12.30 – 12.37; Exhibit 1, Tab 55A, pp. 111–115.

[80] Transcript of proceedings 25 November 2019 at T12.39 – 12.42; Exhibit 1, Tab 55A, p. 139.

[81] Transcript of proceedings 25 November 2019 at T12.47 – 12.49; Exhibit 1, Tab 55A, p. 166.

[82] Exhibit 1, Tab 55A, p. 151.

identify an antecedent, but no concern for UTI (Urinary Tract Infection), constipation or LRTI (lower respiratory tract infection).[83]

46. A further MHUOP note from 1 February 2017 records unit manager Kathleen from the Home reporting that there had been no previous problems apart from 3 recent incidents; the notes record the three incidents from January involving Mr Clutton. The notes record that "*Kathleen believes that* [redacted] *was paranoid about Neville.* [redacted] *would say "he wanted him out", "disinfect the room" and "Neville touches everything*".[84]

47. On 9 February 2017, a MHUOP note records speaking to the Home's care Manager "Catherine", who said that [redacted] was "fixated" on Mr Clutton and there was concern that if he returned the fixation would be transferred to another resident.[85]

48. This inquest is principally concerned with the **manner** of Mr Clutton's death. Other findings that are required to be made as to time, place and direct cause of death are not in issue.

49. The Officer in Charge of the investigation into the death of Mr Clutton provided the brief of evidence to the Office of the NSW Director of Public Prosecutions. By letter dated 25 November 2019 that Office determined that there was a prima facie case against [redacted] [redacted] on a charge of manslaughter by unlawful and dangerous act pursuant to *s 18 (1)(b) Crimes Act 1900* however noted that "it could not be said that there is no reasonable prospect of conviction. Further if [redacted] was charged it would decline to prosecute him on discretionary grounds". I am therefore satisfied that any concerns under s 78 of the Act are met by the Director's decision, one which no party of interest in this Inquest made any comment or submission on.[86]

Post Mortem

50. An autopsy was performed by Dr Leah Clifton a staff specialist in forensic pathology at the NSW Forensic and Analytical Science Service, Department of Forensic Medicine in Newcastle. Her report dated 5 June 2017 formed part of the brief. It was her opinion that Mr Clutton died on 10 February 2017 and that his direct cause of death was "complications of head injuries" and there was an antecedent cause of "dementia". As indicated these matters were not in dispute.[87]

Issues

51. Below are the issues identified for the Inquest. They were distributed in draft to the interested parties and no objection was taken to them.

    1. Determination of the statutory findings required under s. 81 of the *Coroners Act 2009*, as to manner and cause of death, including the cause of the injuries suffered by

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[83] Transcript of proceedings 25 November 2019 at T13.4 – 13.8; Exhibit 1, Tab 55A, p. 151.

[84] Transcript of proceedings 25 November 2019 at T13.12 – 13.17; Exhibit 1, Tab 55A, p. 159.

[85] Transcript of proceedings 25 November 2019 at T13.19 – 13.22; Exhibit 1, Tab 55A, p. 170.

[86] Exhibit 2.

[87] Exhibit 1, Tab 5.

Mr Clutton on 28 January 2017 at the Lavender Unit, SummitCare Wallsend residential aged care home ("the Home").

2. Whether there was adequate supervision of Mr Clutton and [redacted] in the Lavender Unit as at 28 January 2017, given the significant care needs of those patients and the recent behaviours exhibited by [redacted] towards Mr Clutton;

3. Whether there were adequate and timely procedures in place at the Home to review concerns and risks related to patient behaviour and general wellbeing, and then to implement appropriate care and management plans to address those concerns and risks, including:

   (a) Whether GP assessment, DBMAS[88] referral or other specialist assessment (such as a psychogeriatric assessment) should have been arranged for Mr [redacted] prior to 30 January 2017, in light of his behaviours since at least November 2016;

   (b) Whether arrangements should have been put in place as a matter of priority to relocate one or other of [redacted] and Mr Clutton from their shared room once the aggression displayed towards Mr Clutton by [redacted] in January 2017 emerged;

   (c) Whether investigation of the January 2017 incidents preceding the event of 28 January 2017 should have been completed in a timelier manner and with focus on clinical risk rather than work health and safety issues;

   (d) Whether case conferencing should have occurred in relation to [redacted]'s behaviours prior to 28 January 2017; and

   (e) Whether the implementation of a safety/risk management plan by way of observations/sightings of each of Mr Clutton and [redacted] in January 2017 was adequate.

4. Whether the decision not to report the incident of 28 January 2017 to the Department of Health pursuant to s. 63.1AA of the *Aged Care Act 1997* (Cth) was reasonable and/or appropriate in the circumstances of Mr Clutton's subsequent death.

Pursuant to s. 82 of the Coroners Act 2009

5. Are there any recommendations that are necessary or desirable to make in relation to any matter connected to Mr Clutton's death?

[88] The Dementia Behaviour Management Advisory Service.

Witnesses

David Ponman

52. Mr Ponman gave evidence that he was a cousin of Mr Clutton and he and another cousin Mrs Mavis Crameri would regularly visit Mr Clutton when he came to live at the residential aged care facility at Wallsend in the Lavender Unit Wallsend owned by SummitCare.[89] Mr Clutton began living at the Home from 2014.[90]

53. Before being at the Home he had been at another aged care facility in Ashfield in Sydney for about two years before being moved to the Wallsend facility.[91]

54. Mr Ponman's evidence was to the effect that when Mr Clutton was admitted to the Home he was able to have a conversation however by late December 2016 and into early January 2017 his ability to communicate had deteriorated.[92] He could recognise Mr Ponman but he was becoming more difficult to understand and to have any meaningful conversation.[93]

55. When Mr Clutton first commenced to share a room in the Lavender unit there was another gentleman in the room who then moved out into his own room. Another man then moved in but only after a short time he also moved out to another facility. It was then that [redacted] came to share the room with Mr Clutton.[94] Within two or three months of [redacted] moving in to share the room it became increasingly apparent that [redacted] regarded the room as his and resented Mr Clutton sharing it with him.[95] [redacted] questioned why Mr Clutton was there and would also question Mr Ponman when he would visit.[96] Mr Ponman felt that he had mentioned it to the nurses at the home just in general conversation but not as a concern or threat.[97]

56. Mr Ponman did not become aware of [redacted]'s aggression until about 22 January 2017 when he came in to see Mr Clutton. As he was taking Mr Clutton to his room [redacted] got out of bed and became verbally aggressive towards both of them.[98] He remembers the staff informing him of Mr Clutton's fall on 24 January and [redacted] standing over him[99] but he does not recall being told about an incident on 18 January where [redacted] had dragged Mr Clutton out of the room pulling him out of bed and dragging him out under his arms.[100] He

[89] Transcript of proceedings 25 November 2019 at T22.14 – 22.21.

[90] Exhibit 1,Tab 29.

[91] Transcript of proceedings 25 November 2019 at T22.28 – 22.29.

[92] Transcript of proceedings 25 November 2019 at T22.35 – 22.42.

[93] Transcript of proceedings 25 November 2019 at T22.44 – 22.48.

[94] Transcript of proceedings 25 November 2019 at T24.36 – 25.5.

[95] Transcript of proceedings 25 November 2019 at T25.7 – 25.10.

[96] Transcript of proceedings 25 November 2019 at T25.38 – 25.32.

[97] Transcript of proceedings 25 November 2019 at T25.48 – 26.9.

[98] Transcript of proceedings 25 November 2019 at T26.15 – 26.41.

[99] Transcript of proceedings 25 November 2019 at T27.37 – 27.49.

[100] Transcript of proceedings 25 November 2019 at T27.10 – 27.15.

was not told about [redacted] walking around with a belt in his hand and threatening to choke people or about other acts of aggression with staff.[101]

57. It was Mr Ponman's view that sharing a room for two adult males with dementia would be challenging let alone when one of them has behavioural issues.[102] Even with some form of compulsory sighting, unless they were continually watched a push could happen in between sighting times – even at 15 minute intervals there can be an act of aggression in the 15 minutes between sightings.[103]

RN Betcy Ben

58. Ms Ben is a registered nurse who was working at the Home at the time of the incident involving Mr Clutton and [redacted]. She ceased working at the Home in August 2017 and now works at an aged care facility in the suburb of Waratah.[104] She commenced working with SummitCare in 2014.[105] She worked in the Lavender Unit from February 2016 up until the time that she left.[106]

59. She provided evidence in relation to the number of staff that were on each shift. She said there were 4 AINs for the morning shift with one team leader and one registered nurse.[107] In the afternoon shift there were the 4 AINs but no team leader.[108] There was a lifestyle officer that started at about 9:00am and worked through to 4:30pm.[109] The night shift comprised two AIN's and a registered nurse for all of the facility.[110] On weekends there were 4 AIN's, 1 registered nurse, 1 team leader and she thought there was also a lifestyle officer who came in over the weekends.[111] There were times when agency nurses were required for replacement staff.[112] It was her recollection that each of the units at the Home had patients that suffered from dementia. However the dementia of residents in the other units was not as severe as those in the Lavender Unit.[113] If people were exhibiting challenging behaviour such as verbal or physical aggression they would be removed from the other units to the Lavender Unit.[114]

60. In her opinion dragging a resident out of a room under their arms by another resident would have been classed as a form of aggression and should have been recorded.[115] She remembered

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[101] Transcript of proceedings 25 November 2019 at T28.30 – 28.37.
[102] Transcript of proceedings 25 November 2019 at T29.47 – 29.48.
[103] Transcript of proceedings 25 November 2019 at T29.48 – 30.5.
[104] Transcript of proceedings 25 November 2019 at T32.35 – 32.45.
[105] Transcript of proceedings 25 November 2019 at T32.47 – 32.49.
[106] Transcript of proceedings 25 November 2019 at T33.16 – 33.23.
[107] Transcript of proceedings 25 November 2019 at T33.25 – 33.27.
[108] Transcript of proceedings 25 November 2019 at T34.22 – 34.23.
[109] Transcript of proceedings 25 November 2019 at T34.25 – 34.30.
[110] Transcript of proceedings 25 November 2019 at T34.32 – 34.34.
[111] Transcript of proceedings 25 November 2019 at T34.36 – 34.48.
[112] Transcript of proceedings 25 November 2019 at T35.7 – 35.10.
[113] Transcript of proceedings 25 November 2019 at T35.21 – 35.41.
[114] Transcript of proceedings 25 November 2019 at T35.49 – 36.1.
[115] Transcript of proceedings 25 November 2019 at T36.10 – 36.15.

the incident involving a staff carer Mr James Murray.[116] It was her opinion that it was unusual for a resident to exhibit aggression of a physical nature on a staff member.[117]

61. It was usual for staff meetings to occur every month with the registered nurses and a care manager.[118] The purpose of the meetings was to update the residents' care plans and if needed to discuss different ways of managing challenging behaviour by the residents.[119] Other issues such as falls were also discussed and her recollection was that before the meeting there was a form of agenda circulated so that staff knew what was to be discussed prior to going to the meeting.[120] Again her recollection was that minutes were kept of each of the meetings.[121] Her expectation was that the incident involving James, the staff member, should have been raised at one of those meetings.[122] It was her evidence that the responsibility of the registered nurses to record physical acts of aggression (be it on staff or other patients).[123] She could not give a reason as to why the incident involving James Murray was not recorded, nor the incident on 24 January where ██████ was standing over Mr Clutton. She recounted that any issue that needed to be reviewed by a resident's GP should have been on a "doctor's review list".[124] Any staff member who witnessed an incident should have at least recorded it in Ecare.[125] She accepts that the care staff member AIN Saunders made a report of 24 January incident, as did another AIN and that should have then been placed on the care plan for ██████.[126]

62. In Ms Ben's opinion the incident on 18 January should have been referred to a GP for review.[127]

63. Her evidence was that if a chart was created in relation to identifying behaviour concerns then a previous chart for the same patient would become redundant, so if someone sought to review a longer history they would need to reactivate the earlier charts recorded in the system.[128]

64. Ms Ben was taken to the incident on 28 January and noted that it was an unwitnessed fall and wasn't aware of it being an act of aggression until 30 January.[129] She acknowledged that the incident register that is for each resident only recorded physical acts of aggression, not verbal aggression, so that the earlier threat by ██████ that he was going to wring someone's neck on or about 15 December was not an incident that was recorded. However in her view it

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[116] Transcript of proceedings 25 November 2019 at T36.25 – 36.28.
[117] Transcript of proceedings 25 November 2019 at T37.4 – 37.11.
[118] Transcript of proceedings 25 November 2019 at T37.13 – 37.15, T37.25 – 37.27.
[119] Transcript of proceedings 25 November 2019 at T37.18 – 37.20.
[120] Transcript of proceedings 25 November 2019 at T37.42 – 37.46.
[121] Transcript of proceedings 25 November 2019 at T38.20 – 38.22.
[122] Transcript of proceedings 25 November 2019 at T38.47 – 38.49.
[123] Transcript of proceedings 25 November 2019 at T41.25 – 41.26.
[124] Transcript of proceedings 25 November 2019 at T41.37 – 41.43.
[125] Transcript of proceedings 25 November 2019 at T42.36 – 42.41.
[126] Transcript of proceedings 25 November 2019 at T42.45 – 43.2.
[127] Transcript of proceedings 25 November 2019 at T43.4 – 43.7.
[128] Transcript of proceedings 25 November 2019 at T45.5 – 45.29.
[129] Transcript of proceedings 25 November 2019 at T48.22 – 48.33.

should have been recorded on his care plan and on an incident behaviour chart.[130] She has no recollection of anyone telling her about ████'s threat about wanting to choke staff members or anyone else.[131] She was aware that Risperidone had been prescribed to ██ ████ because of agitation.[132] She accepted that if a resident had put their hands around a staff member's neck and left marks then that needed further investigation or likely also bringing to the attention of the treating GP.[133] Her evidence was that ████ being put on a sight check was to try and determine why he was doing it and to see if he was causing any trouble.[134]

65. It was her opinion that to improve outcomes, in future it would be better not to wait for something to happen, but rather to try and prevent something happening.[135] She said that she may have been aware of the friction between Mr Clutton and ████ through handover meetings.[136] It was her opinion that the same staff should look after the same residents so they get to know them.[137] In other words, staff shouldn't be moved between different units while they are working for the same facility.[138] She said that the average time it took for a DBMAS assessment was up to a week – "from weeks to a month".[139] She also remarked that getting assistance from outside resources was always difficult and a lot of trouble.[140]

Brittany Saunders

66. Ms Saunders was an AIN and was employed at the Home. She left the Home in December 2018 and since then has been employed in sales.[141] She worked in the Lavender Unit.[142] Her criticism of the home was that she had little training in the facilities record systems and in particular the Ecare system.[143] She was not aware of the 18 January incident other than from reading progress notes.[144] She recalls staff talking about the staff incident involving Mr James Murray and she remembers another care staff member telling her to keep her eyes on ██ ████.[145] In relation to the incident on 24 January with ████ standing over and straddling Mr Clutton, she accepts that if it had not been recorded in the behaviour intervention chart she should have done so and puts it down to an oversight, being pressed for

[130] Transcript of proceedings 25 November 2019 at T49.34 – 49.46.
[131] Transcript of proceedings 25 November 2019 at T50.27 – 50.33.
[132] Transcript of proceedings 25 November 2019 at T51.29 – 51.31.
[133] Transcript of proceedings 25 November 2019 at T51.50 – 52.2.
[134] Transcript of proceedings 25 November 2019 at T52.40 – 52.44.
[135] Transcript of proceedings 25 November 2019 at T53.17 – 53.18.
[136] Transcript of proceedings 25 November 2019 at T56.16 – 56.30.
[137] Transcript of proceedings 25 November 2019 at T58.3 – 58.9.
[138] Transcript of proceedings 25 November 2019 at T58.8 – 58.9.
[139] Transcript of proceedings 25 November 2019 at T61.28 – 61.36.
[140] Transcript of proceedings 25 November 2019 at T61.40 – 61.41.
[141] Transcript of proceedings 25 November 2019 at T63.5 – 63.8, T64.7 – 64.8.
[142] Transcript of proceedings 25 November 2019 at T64.13 – 64.16.
[143] Transcript of proceedings 25 November 2019 at T73.32 – 73.38.
[144] Transcript of proceedings 25 November 2019 at T66.21 – 66.22.
[145] Transcript of proceedings 25 November 2019 at T66.43 – 66.47.

time and/or poor training.[146] She stated that she had little understanding of why charting was done or about care plans.[147] She saw the updating of care plans as the task of a registered nurse. She accepted that the behaviour displayed by on 25 November, 15 December 2016, 18 January 2017 and 24 January 2017 stood out as incidents and things should have been done differently.[148] In her view to improve outcomes there should be more training, and she accepted that sight charts really don't tell you anything.[149] She also thought that it was necessary for registered nurses to be more involved with each of the residents.[150]

Kathleen Morillas

67. Ms Morillas was the Manager of Care and Services at the Home at the relevant time, also referred to as the "care manager". Her statement to this inquest was made on 8 November 2019. From her evidence, staff identified that 's behaviours had increased in December 2016 and that nursing and care staff had communicated their concerns to 's GP, but also said that first displayed behaviour of concern to another resident on 18 January 2017 and prior to that had "*displayed occasional episodes of behaviour that raised concern to staff but he was easily redirected and reassured*".

68. Ms Morillas also said that "*following the incidents between and Mr Clutton that began to occur in January 2017, I did consider moving them to separate rooms*" due to the agitation when Mr Clutton disturbed 's sleeping or interfered with his belongings, however there were no other available male beds in the Unit. Her recollection was that after the incident on 18 January 2017, when dragged Mr Clutton out of their room, she told the RN Mason that she wanted on a sight chart.[151]

69. Ms Morillas does not recall any formal case conference being conducted prior to 28 January 2017.[152] She maintains that after the incident on 24 January she rang 's daughter and discussed the increase in his behaviour and the need to move him to the MHOUP.[153] Ms Morillas said that they were monitoring and recording incidents for DBMAS referral, including what actions settled the resident.[154] There is no entry by Ms Morillas in Ecare of this discussion with the family. However, there is an entry by RN Ranju which says "*s NOK notified about the incident. NOK felt sorry for the other resident. Informed her that we will keep updating her after the doctor review and management decision*".[155] There is no evidence that Dr Karanam was contacted about this incident, and there is no reference to it in his records. His records suggest contact by Ms Morillas on 30 January, where the previous incidents were raised.

[146] Transcript of proceedings 25 November 2019 at T67.37 – 68.3.
[147] Transcript of proceedings 25 November 2019 at T69.44 – 70.4.
[148] Transcript of proceedings 25 November 2019 at T70.38 – 70.40.
[149] Transcript of proceedings 25 November 2019 at T74.3 – 75.5
[150] Transcript of proceedings 25 November 2019 at T76.42 – 76.45.
[151] Transcript of proceedings 26 November 2019 at T5.3 – 5.17.
[152] Transcript of proceedings 26 November 2019 at T6.3 – 6.6.
[153] Exhibit 1, Tab 16C.
[154] Transcript of proceedings 26 November 2019 at T21.40 – 21.48.
[155] Exhibit 1, Tab 47, p. 1.

70. She agreed that to look at a residents' behaviour overall it might mean having to call up deactivated or archived material and in particular the Behaviour Identification Information chart. She wasn't aware of any previous aggressive behaviour of [redacted] and it wasn't until 19 January that she spoke to staff and arranged for the implementation of a sight chart.[156] She spoke to staff to ensure that they were recording incidents. She agreed that the staff incident on 25 November 2016 involving Mr Murray should have been reported and she should have been told about it.[157] She indicated that she was not aware of the incident and was not told until sometime shortly prior to the incident of 28 January, perhaps between the period 18 January to 24 January or about that time. To her knowledge, [redacted] had not shown signs of aggressive behaviour until 18 January 2017. She agreed that there were monthly meetings however indicated that the behaviour identification information chart was not always a matter that was raised in relation to a resident. At the time, in her opinion [redacted] [redacted]'s behaviour was only recent. She accepted that the purpose of the care plan was to record events as they were occurring.

71. In her opinion, to consult the resident's GP you would show them the notes, the behaviour logs and they could look at the care plan, but generally in her view they weren't necessarily interested in that plan.[158] There was also a doctor's list where certain items could be brought up with the GP about the particular resident. She was asked by Counsel Assisting whether in hindsight that would have been enough action, and her response was to indicate that in the aged care industry staff are "time poor", and that in briefing a GP generally providing some summary of the issue about a resident was enough.[159]

72. It was her understanding that GPs were notified of incidents of aggression generally by fax or sometimes by telephone.[160] It was pointed out to her by Counsel Assisting that the records of the doctor's notes did not include many faxes from the Home. In her opinion the incidents on 18 and 24 January should have been notified to the GP by fax or by telephone.[161]

73. The procedure in relation to case conferencing was that there was a case conference within 6 weeks of the resident being admitted to the Home and thereafter an annual case conference. Ms Morillas said there could be an unscheduled one but it would depend on the resident's behaviour and the particular circumstances surrounding the behaviour to consider whether it was warranted.[162] She accepted that after the staff incident on 26 November 2016, a case conference should have been considered – in her words "it wouldn't have hurt".[163] She gave evidence that after the incidents of 18 and 24 January 2017 a case conference definitely should have happened.[164] At the time, as she saw it, staff at the Home were still recording and

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[156] Transcript of proceedings 26 November 2019 at T4.30 – 5.5.
[157] Transcript of proceedings 26 November 2019 at T8.44 – 8.48.
[158] Transcript of proceedings 26 November 2019 at T9.7 – 9.8.
[159] Transcript of proceedings 26 November 2019 at T9.36 – 9.43.
[160] Transcript of proceedings 26 November 2019 at T10.22 – 10.26.
[161] Transcript of proceedings 26 November 2019 at T10.48 – 49.3.
[162] Transcript of proceedings 26 November 2019 at T11.5 – 11.11.
[163] Transcript of proceedings 26 November 2019 at T11.23.
[164] Transcript of proceedings 26 November 2019 at T11.38 – 11.33.

obtaining information to enable them to obtain a clearer picture of [redacted]'s behaviour, so that scheduling case conference at the time was not considered.[165]

74. There was consideration given to moving Mr Clutton out of the shared room; however there were no male beds available and it was thought unsafe to move [redacted] out of the Lavender Unit as it was the only one that was secured during the day.[166] In her opinion, it was unlikely that [redacted] could be transferred to a hospital, unless he could have been scheduled on an involuntary basis, and that was unlikely to happen. It was accepted that Ms Morillas wasn't aware of all of the relevant incidents so that her opinion about this issue is clouded by that. She was aware that Risperidone had been provided to [redacted] on an earlier occasion in December 2016 but could not give a reasonable explanation as to why it was not considered after the incidents on 18 and 24 January.[167] She accepted that she had not been informed of the incident on 26 December 2016 in relation to [redacted] walking around with a belt and threatening to strangle someone. In her opinion, relatives of Mr Clutton could not be told about the issue with the belt because of privacy concerns involving [redacted].[168]

75. Ms Morillas conceded that the instigation of a sight chart should have also gone on the care plan as part of the overall supervision that was taking place involving [redacted].[169] She has no recollection of talking to [redacted]'s GP after 4 January 2017 and she suspects that was because she saw that incident as an isolated incident and his behaviour appeared to have settled. She accepted that if one viewed all of the incidents as a continuum then a different approach would have likely occurred.[170] She agreed with the suggestion that consideration of a referral to DBMAS would have been appropriate if she had been aware of all of the incidents. She qualified that statement by indicating that the DBMAS would have required charts and other material to make an assessment and because she was not aware of the two incidents on 18 and 24 January in her opinion they were still monitoring [redacted].[171]

76. She accepted in hindsight that if she had looked at the Ecare notes, the January incidents were recorded; however she indicated that she was not prompted to look at those notes at the time and she has no recollection of being asked to do so.[172]

77. She accepted that entries on the care plan notes of 18 January and on 28 January that were made by her could well have been made at the same time and that they could have been made after 28 January.[173] She also accepted that the sighting charts did not disclose how [redacted] appeared. They were merely recording the location where he was observed and nothing more. Therefore it made it difficult to understand or make use of the chart as it was not providing a description of behaviour (or demeanour) that was being observed. She accepted that it would

[165] Transcript of proceedings 26 November 2019 at T12.8 – 12.12.
[166] Transcript of proceedings 26 November 2019 at T12.22 – 12.30.
[167] Transcript of proceedings 26 November 2019 at T14.17 – 14.36.
[168] Transcript of proceedings 26 November 2019 at T16.42 – 16.46.
[169] Transcript of proceedings 26 November 2019 at T19.6 – 19.10.
[170] Transcript of proceedings 26 November 2019 at T21.21 – 20.34.
[171] Transcript of proceedings 26 November 2019 at T21.23 – 22.9.
[172] Transcript of proceedings 26 November 2019 at T22.16 – 22.50
[173] Transcript of proceedings 26 November 2019 at T24.5 – 24.26; Exhibit 1, Tab 18 Annexure 1.

have been an advantage to have a spare room available if needed and this would have been a good example for the use of that room in this particular matter.[174]

78. She agreed with Professor Ibrahim that there was too much focus on outcomes rather than a focus on possible risk, and she accepted that it would have been better management to focus on risk rather than an outcome.[175] She ventured the opinion that all residents were at risk in an aged care facility and that those with serious behavioural issues should not be in an aged care facility and there should be a special facility for them.[176] Ms Morillas also gave evidence that aged care facilities do not have the staff numbers, training or capacity to properly care for high needs residents, nor seclude them from the general population of the unit. She recommended minimum staffing levels and outside training. In her opinion a shared room is outmoded particularly for residents with dementia.[177] From her evidence she said that no one looked at the CCTV footage for the incident on 28 January at the time because it occurred on a weekend and there was not anyone senior enough to access and review it at the time. She accepted that given the incidents on the 18 and 24 of January, the incident on 28 January should have been reviewed when it occurred.[178] She does recall being informed of the incident on the weekend, but stated that because the nurses don't have access to the CCTV it couldn't be reviewed at that time. She accepted it would have been a good idea if someone had access to it on the weekend particularly when senior managers are not present at the Home.[179] In hindsight she accepted that the registered nurses who were supposed to follow policy didn't always do so. She thought having a Deputy Care manager would have been of great assistance and has since learned that one has been appointed.[180]

79. In response to questions from Ms Horvarth she agreed that a staff incident form in relation to Mr Murrays' incident with [redacted] would have had to have been signed off by her or her manger, Mr Glenn Kirkman.[181] If Mr Kirkman had signed it she would have expected Mr Kirkman to have told her about the incident.[182] While she recalled having a discussion about the staff member and the incident she didn't remember when it was, nor who told her, but accepted that it could have been Mr Kirkman.[183] She didn't recall looking at the sight charts after the incident on 24 January when [redacted] was standing over Mr Clutton. She didn't consider whether the sight charts were effective at the time.[184]

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[174] Transcript of proceedings 26 November 2019 at T27.26 – 27.28.
[175] Transcript of proceedings 26 November 2019 at T27.46 – 28.6.
[176] Transcript of proceedings 26 November 2019 at T28.11 – 28.21.
[177] Exhibit 1, Tab 16C at [23].
[178] Transcript of proceedings 26 November 2019 at T29.16 – 29.20.
[179] Transcript of proceedings 26 November 2019 at T29.48 – 30.1.
[180] Transcript of proceedings 26 November 2019 at T30.49 – 31.5.
[181] Transcript of proceedings 26 November 2019 at T31.31 – 31.33.
[182] Transcript of proceedings 26 November 2019 at T31.35 – 31.38.
[183] Transcript of proceedings 26 November 2019 at T31.40 – 31.42.
[184] Transcript of proceedings 26 November 2019 at T32.33 – 32.35.

Michelle Sloane

80. Ms Sloane is the chief operating officer of SummitCare.[185] On behalf of the organisation she extended a very genuine and heartfelt apology to the family of Mr Clutton.[186]

81. She only became aware of the incident with the staff member James Murray in the last couple of weeks before the Inquest commenced.[187] In her opinion that incident would have involved the completion of a work incident form and immediate communication to the Care Manager and General Manager as to what had occurred.[188] It may have also involved a consideration of a review of ███ by DBMAS. She indicated it would be difficult to assess whether a referral would have taken place straightaway, as it would have depended on the circumstances at the time.[189] Ms Sloane gave evidence that at least, ███ would have been screened to see whether or not his behaviours as at November 2016 were escalating and at least talking to his GP.[190]

82. From her review of the notes she noted that there was a discussion with Dr Karanam on or about 4 January 2017 but it appeared that there was general consensus that ███'s behaviour had settled.[191]

83. Evidence at the inquest indicated that all managers are now trained to know that they can make referrals to DBMAS without a referral from the GP.[192] Ms Sloane also accepted that a shorter timeframe may be necessary to collect and collate material, particularly where there is a risk to staff or another resident.[193] She accepted where there were two incidents reasonably close in time then there was no need to delay intervention.[194] Her understanding was that a referral to DBMAS and their Severe Behaviour Response Team could be made within 24 hours.[195] She accepted that their internal policy should make reference to the guidelines for referral to DBMAS and in particular the Severe Behaviour Response Team particularly when there is a risk to the safety of a resident.[196]

84. In her opinion from reading all the material Ms Sloane saw the central issue in this matter as a breakdown in communication between staff and the general care manager Ms Morillas.[197] That ███ should have been removed from the home as it was clear that the presence of Mr Clutton in the room that they shared was triggering his behaviour issues.[198] She also saw

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[185] Transcript of proceedings 26 November 2019 at T25.34.
[186] Transcript of proceedings 26 November 2019 at T34.10 – 34.14.
[187] Transcript of proceedings 26 November 2019 at T35.9 – 35.17.
[188] Transcript of proceedings 26 November 2019 at T35.19 – 35.35.
[189] Transcript of proceedings 26 November 2019 at T35.37 – 35.48.
[190] Transcript of proceedings 26 November 2019 at T36.3 – 36.13.
[191] Transcript of proceedings 26 November 2019 at T36.21 – 36.25.
[192] Transcript of proceedings 26 November 2019 at T35.39 – 36.50.
[193] Transcript of proceedings 26 November 2019 at T37.17 – 37.19.
[194] Transcript of proceedings 26 November 2019 at T37.21 – 37.45.
[195] Transcript of proceedings 26 November 2019 at T38.4 – 38.6.
[196] Transcript of proceedings 26 November 2019 at T38.8 – 38.50.
[197] Transcript of proceedings 26 November 2019 at T39.7 – 39.9.
[198] Transcript of proceedings 26 November 2019 at T39.15 – 39.17.

some sense in having a spare room for emergency situations where a resident was becoming agitated by sharing a room with another resident.[199] She accepted that education in dementia and behavioural issues was important and that there was now an improved education policy in the company. She saw it as an advantage to try and keep staff in the same area so that they became known to the residents and the staff would have some understanding of how the residents behave each day.[200] She is now confident that a staff incident would be reported to senior management and to her very quickly – certainly within the day that it occurred, in that there is now better reporting and a more improved communication channel between senior staff in a facility and the overall senior administrative staff at the SummitCare's head office.[201] She is aware of the need to keep the care plan scrupulously updated. She was taken to the behaviour management procedure policy where it stated that case conferences were held with a resident at the time of admission and annually and further "as required". It was suggested to her by Counsel Assisting that there was no guidance as to what that meant. She accepted that some clarification about what that meant would be an advantage.[202]

85. She accepted that the sight chart was a tool to record observations about a residents' state of mind rather than their location and that the chart should be recording whether or not the resident was confused or agitated or calm, so the staff should be educated about recording their observation of the residents' demeanour rather than simply their location. Ms Sloane was taken to an entry on [redacted] sight chart for 4 February 2017, when [redacted] was no longer at the Home as he had been admitted to the MHUOP. She accepted that should not have occurred and that the staff member was not performing at an appropriate and competent level.[203] She accepted that notifications to the resident's GP by phone or fax needed to be recorded in a better way and that there should be some record of the contact made to the GP in the resident's file. She considered that the information could be uploaded in a location on the resident's file.[204]

86. Evidence at the Inquest indicated that since 2017, significant changes had occurred within SummitCare including a new policy on the management of behavioural and psychological symptoms of dementia which was developed in January 2018. Ms Sloane considered it was appropriate for that policy to indicate that consideration be given to any behavioural issues when assessing whether a resident ought to share a room.[205]

87. In her opinion there was now better management training and an improvement of their processes and she was encouraging the senior staff in each home to spend more time "on the ground".[206] She said there was now a single policy framework for each of the homes operated by SummitCare.[207] Further dementia and behaviour specific in-house training was offered during 2017. Some staff attended a three day dementia essentials course in September 2018.

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[199] Transcript of proceedings 26 November 2019 at T39.49 – 40.2.
[200] Transcript of proceedings 26 November 2019 at T41.40 – 41.42.
[201] Transcript of proceedings 26 November 2019 at T43.37 – 43.42.
[202] Transcript of proceedings 26 November 2019 at T46.46 – 47.3.
[203] Transcript of proceedings 26 November 2019 at T48.47 – 48.49.
[204] Transcript of proceedings 26 November 2019 at T51.43 – 51.50.
[205] Transcript of proceedings 26 November 2019 at T52.40 – 53.29.
[206] Transcript of proceedings 26 November 2019 at T63.11 – 63.15.
[207] Transcript of proceedings 26 November 2019 at T63.25 – 63.30.

A mandatory incident reporting course was given in August 2018. In 2019, further protocols were introduced including a delirium screening protocol and a mental health policy.

88. In response to the report of Dr Ibrahim Ms Sloane acknowledged that resident to resident aggression was a very real challenge.[208] She accepted that there was a need for an increased focus on developing education on dementia care including identifying patterns and when behaviours were escalating. She accepted that it would be better to encourage "over reporting" than none at all.[209] She also accepted that, on occasion, there would be a need for one-on-one nursing specials and a need to act faster in certain situations, particularly where aggression and agitation incidents were escalating.[210]

89. Counsel Assisting made a number of suggestions in relation to the Home's 'Behaviour Management Policy' including referral to DBMAS being made without input from a GP. Ms Sloane acknowledged the suggestions. She also accepted that there was a need for a policy that articulated when case conferences were needed and perhaps identifying when they should happen, other than the standard one when they were initially admitted and annually.[211]

Ann Dominico Wunsch

90. Ms Wunsch is the Executive Director, Quality Assessment and Monitoring Operations of the Aged Care Quality and Safety Commission ("the Commission"). Evidence was provided by her of the particular areas of policy that were addressed in relation to dementia and behavioural issues as they apply to all accredited Aged Care Facilities. As a risk-based regulator the Commission saw its role as being involved to enhance the safety and protection of residents.[212]

91. The *Aged Care Quality Standards* ("the Standards") came into effect from 1 July 2018. The standards are purposely framed to ensure detection of risks and on addressing them, thereby ensuring the protection of the resident. Ms Wunsch accepted there was an emerging issue of resident-to-resident risk factors yet she was confident that the Standards focused on this issue and the behavioural issues of dementia.[213]

92. The former Aged Care Quality and Safety Agency ("the Agency") was established and operated between 1 January 2014 and 31 December 2018. It had responsibilities to accredit residential care services, to register quality assesses of residential and home care services, to provide advice about those aged care services that did not meet the accreditation standards, to promote high quality care and to provide information education and training to approved providers of aged care.[214]

93. Since the Commission was established on 1 January 2019 it has also been responsible for assessing care providers compliance with and performance against the *Quality of Care*

[208] Transcript of proceedings 26 November 2019 at T59.42 – 59.57.
[209] Transcript of proceedings 26 November 2019 at T60.34 – 60.36.
[210] Transcript of proceedings 26 November 2019 at T60.5 – 60.16.
[211] Transcript of proceedings 26 November 2019 at T46.36 – 47.21.
[212] Transcript of proceedings 26 November 2019 at T68.33 – 68.36.
[213] Transcript of proceedings 26 November 2019 at T72.38 – 73.2.
[214] Exhibit 1, Tab 57 at [13].

Principles 2014.[215] The Commission is a single point of contact for the regulation of the quality of care for both care recipients and providers of aged care. At an operational level the Commission's regulatory functions include accrediting residential care services and monitoring the quality of care and services provided by approved providers of residential care services. The Standards that are now in force focus on quality and safety for consumers with a specific individual consumer focus as well is encouraging providers to offer care and services that promote residents' quality of life and well-being.[216]

94. The Commission conducts assessments against the Standards through site audits, review audits and assessment contacts.

Associate Professor Stephen Robert Macfarlane

95. Associate Professor Macfarlane provided a written report dated 14 December 2017 and also gave evidence at the Inquest.[217] He is an Adjunct Associate Professor of Aged Psychiatry at Monash University and he is currently Head of clinical services for the National Dementia Behaviour Management Advisory Service (DBMAS) and the Severe Behaviour Response Team (SBRT) both of which are operated by Dementia Support Australia.

96. He was asked to provide his opinion on a number of questions concerning the care and management of ████. I do not intend to set out in full all of the opinions expressed within the report. Relevant matters in my opinion are the following:

    (a) He noted that the entry in the Mandatory Reporting Register dated 30 January 2017 in relation to the incident of 28 January 2017 indicated that the facility exercised their "discretion not to report" the incident to the Department of Health. Previous incidents on 18 and 24 January were also not reported. In her letter dated 24 October 2017, Sue Smith stated that the discretion not to report was exercised "because ████ had a cognitive impairment in the form of Alzheimer's disease and the facility had put in place for management and care of ████ within 24 hours (of the incidents). In the Professor's opinion:

    "whilst the Aged Care Act does allow facilities discretion not to report on this basis, it is concerning that the facility chose to exercise such discretion in circumstances where the occurrence of incidents rated by the facility as warranting both a critical incident review and the notification of the facilities insurers had occurred. Indeed, notification did not occur even after the death of Mr Clutton, which seems to indicate an inappropriate exercise of such discretion"

    (b) He noted that it was not possible to determine what the care plan contained for ████ prior to 1 February 2017 as it had been updated on that date after ████ had been admitted to hospital. He noted that the document dated 1 February 2017 was comprehensive, personalised, and runs to 6 pages.

[215] Exhibit 1, Tab 57 at [14].
[216] Exhibit 1, Tab 57 at [21].
[217] Exhibit 1, Tab 27.

(c) He accepted that the facility was still investigating the earlier incidents of aggression of [redacted] (which had only commenced as recently as 18 January 2017 against Mr Clutton) and that at the time of the event that led to Mr Clutton's death, the Home had considered his behaviour as uncharacteristic of the relationship that had previously existed between the two since [redacted]'s admission in June 2016. Associate Professor Macfarlane accepted that situation. While a change of room for Mr Clutton (or for that matter, [redacted]) could have been considered, it is entirely possible that even if there was a change in rooms to have been arranged by the facility then [redacted]'s aggression could have been transferred to his new roommate, given the evidence from the progress notes that [redacted]'s aggression was related at least in part to his concerns about a space he perceived as his own being invaded by another. He was of the opinion that the strategies that the Home had put in place were appropriate up to 18 January 2017. And that the aggression that occurred on 18 January was "*at that time, appropriately considered to be a one-off event. Appropriate action in terms of placing both residents on elevated levels of observation was taken in a timely manner following this event*".

(d) He noted that the complaints procedure document required staff who received a complaint to "*speak to the RN in charge of the section…*" And that "*the staff member handling the complaint must follow the steps outlined in the document "steps in the feedback management system"* he noted that staff did not appear to follow this procedure in relation to complaints made by Mr Ponman on 22 and 24 January 2017.

(e) A referral to DBMAS could have been undertaken at any time, by any staff member. The question of what would constitute an acceptable threshold to initiate a DBMAS referral is relevant. Associate Professor Macfarlane stated: *"I am of the view that (at the time) a one-off episode of physical aggression on 18 January 2017 would not have breached, in the mind of a reasonable provider, this threshold of concern. A second episode of physical aggression occurred on 24 January 2017. Had a referral been made at that time, this would have been appropriate given the severity of the aggression. This appears not to have been considered; possibly because the facility still felt that the increased level of physical observation that was in place at the time was sufficient to manage the risk. Even in the case of a referral being made on 24 January 2017, DBMAS response times require that a face-to-face response within 5 business days of the referral being triaged, which would thus have not averted the events of 28 January 2017. If DBMAS perceived the referral to be "high risk" they may have triaged the referral to a higher level of a service response (Severe Behaviour Response Team – SBRT) which has a 48 hour response time. Even in the event of an escalation to SBRT, however, I do not envisage that the attendance of that service within the specified timeframe would have averted the tragic outcome."*

Further, that if other options were being considered, he considered that referrals to other outside facilities (had they been made on or after 24 January 2017) are likely to have not affected the outcome.

(f) He noted that prior to the aggressive event of 18 January 2017 the behaviour shown by [redacted] was within the range of behaviours he would expect for a resident

within such a unit. He considered that regular antipsychotic medication was not indicated prior to the events of 24 January 2017 and that even if it had been instituted at that time he does not believe the outcome would have been different. Antipsychotics have some evidence in decreasing aggression "*but the effect size is slow and the medications take some time to have any meaningful effect*".

(g) Importantly he stated "*a pattern of physical aggression (if indeed two events constitute a pattern) is not evident until the second event on 24 January 2017. The events leading to Mr Clutton's death did not occur until 28 January 2017. I am of the opinion that, even if it had been recognised that the care needs of ████ could no longer be met by the Lavender Unit as early as 18 January 2017, there was an extremely low likelihood of a more suitable alternative placement being found, and a transfer organised, within the timeframe necessary to have altered the outcome for Mr Clutton*".

(h) He was further of the opinion that for ████ to have been moved to a more supervised and restrictive environment it would have been necessary for enduring pattern of behaviour and this was not established in the case of ████.

(i) Overall Professor Macfarlane was of the opinion that ████'s overall care and treatment were appropriate and fell within the expected standard of care for an aged care facility, and that his dementia was appropriately monitored and treated while he was a resident within the Lavender Unit.

97. When he gave evidence Associate Professor Macfarlane told the Inquest that DBMAS receive about 10,000 referrals each year. That there were 34 offices nationally and when contact is made by a facility or Doctor it is triaged by a trained clinician to determine whether they will accept the patient and if so whether it would be a referral to the Severe Response Behaviour Team or DBMAS. The triage process is completed within one day and they are required to commence assessment either within 24 hours for the Severe Response Team or within five days for DBMAS.[218]

98. He provided the opinion that 95% of patients in an aged care facility who have dementia are likely to have some behavioural issues of some kind and that the behaviours that can be exhibited by a resident are very ubiquitous.[219] ████'s acts of verbal or physical aggression prior to 18 January were not directed at Mr Clutton, and so he considered that it would have been difficult for the Home to have sufficiently provided evidence of some form of pattern of behaviour at that time. However by 18 January there was a need for a review at the very least of what was occurring.[220]

99. In his opinion privacy issues should not be considered where there is a risk to another resident as that would have higher priority over the privacy of another resident. For example, informing ████'s family of the belt issue was appropriate, however Mr Clutton's family

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[218] Transcript of proceedings 27 November 2019 at T28.7 – 28.44.

[219] Transcript of proceedings 27 November 2019 at T32.32 – 32.35.

[220] Transcript of proceedings 27 November 2019 at T36.37 – 38.41.

should have been given advice and information about it as well.[221] There was some criticism by Associate Professor Macfarlane in relation to record-keeping in that there was no recording of the incidents of 22 and 24 January 2017 in the Behaviour Identification Chart. He considered that the chart didn't provide sufficient information in any event as to what really was happening, and the process of archiving previous charts didn't allow more senior clinicians and/or medical practitioners to view the overall behaviour of the resident. He said that residents can have behaviours that wax and wane, they will have peaks and troughs so that it was an advantage to have a summary of all behaviours to look at over the whole period that the resident was in the facility.[222]

Professor Joseph Elias Ibrahim

100. The Professor provided a report for this Inquest dated 15 November 2019.[223] He is employed in a part-time capacity at Monash University as head of the Health Law and Ageing Research Unit at the Department of Forensic Medicine. He is also an Adjunct Professor at the Australian Centre for Evidence Based Aged Care at La Trobe University Faculty of Health Sciences. From his report I considered the following matters relevant:

    1. "*That resident to resident aggression (RRA) is an emerging area of research and efforts to fully comprehend the circumstances within which this behaviour occurs and how it can best be managed and prevented is ongoing. However, from what we currently know the typical causes of RRA can be explained by a combination of pre-disposing individual risk factors, proximal triggers and environmental factors*"

    2. In Australia, almost 90% of residents involved in fatal accidents of RRA had a diagnosis of dementia. Typically they have a history of behavioural expressions such as wandering and aggression as was the case in 64% of fatal RRA incidents in Australia. Other behavioural problems such as verbal outbursts and disinhibited sexual behaviour were also common in targets and exhibitors. "*This is evident in this case. ███ ███ (exhibitor) had multiple incidents of aggressive behaviour prior to the event leading to the death of Neville Clutton. The question that is difficult to answer is whether any single event should have prompted more definitive action to either temporarily or permanently separate them from each other.*"

    3. He indicated "*it was not uncommon for residents to have been involved in repeated episodes of RRA as both the exhibitor and target of aggression and in some cases, this may be indicative of escalating violence. In nine cases of fatal RRA (32%), the exhibitor and target of aggression had been involved in at least one prior incident together in the last 12 months*."

    4. It is difficult for staff to predict when an RRA incident is about to occur. Many incidents are unprovoked and there is an "unintentional" target as opposed to a smaller number of cases where a target was exhibiting some form of antagonistic behaviour. In this matter there appeared to be identifiable triggers from ███ ███'s (exhibitor) who was co-located in sharing a bedroom with Neville Clutton.

[221] Transcript of proceedings 27 November 2019 at T38.43 – 39.16.
[222] Transcript of proceedings 27 November 2019 at T39.18-41.11.
[223] Exhibit 1, Tab 27A.

[redacted] had expressed a view that the shared bedroom was his alone. This suggests "an ongoing interpersonal conflict and an unresolved perception of invasion of the exhibitors' space". These factors would make the likelihood of future conflict between the two is probable and arguably the staff should have foreseen there would be further incidents.

5. He did not accept the opinion of Ms Morillas that one or other of the residents could not be moved to separate rooms because they had security of tenure. The Professor indicated that a residents "right of tenure" is intended to protect against elder abuse and provide a degree of certainty about their accommodation. It is intended to stop providers from being wilful and relocating residents against their will for no reason. His interpretation of the rights and responsibilities are that they would not have precluded moving [redacted] to alternative accommodation, and that there was in fact an obligation to relocate him on the basis that they could no longer provide accommodation and care suitable for the care recipient.

6. He considered that the incident of 18 January 2017 where [redacted] was dragging Neville Clutton to be more violent than the event of 28 January. While there were practicalities in achieving relocation and they are not readily achieved in a short time frame, new options or approaches should have been considered at that time in respect of the earlier incident. He accepted that his opinion of this differed from Associate Professor Macfarlane however he approached the matter from a public health, injury prevention perspective. "Waiting until significant harm has occurred to act is too late – unfortunately this is the usual approach throughout the aged and healthcare sector".

7. He was of the opinion that the range of behaviours exhibited by [redacted] were in keeping with experiences of services such as the Lavender Unit which are operating as memory support units. "*The scope of practice of memory support or dementia specific units in Australia is highly variable. However the range of behaviours exhibited in the months of December 2016 and January 2017 are beyond the acceptable range and exceed the Lavender Unit's scope of practice*"

8. The Professor considered that there had been a disconnect between staff and management, noting the statement of Ms Morillas that some incidents had not been reported to her. He considered that a referral to DBMAS or another specialist service would have been appropriate. "A prudent approach would be a comprehensive clinical review with a case conference consulting with staff and family." He also considered that it would have been prudent to report the incident to the Commonwealth Department of Health rather than exercising the discretion not to report it. He acknowledged that reporting the incident may have prompted the Department of Health to ask the Agency to attend the facility to assess their approach to managing residents with responsive behaviours. In his opinion the circumstances around the requirements of facilities to report serious incidents to the Department of Health is a failure of the regulation. He accepted that the facility exercised its discretion as allowed under the Act and he considered the onus was on the Federal Government to correct this issue.

101. In his evidence at the Inquest Professor Ibrahim considered it was difficult to get any real sense of what was occurring from the documentation. He said the awareness of the severity of each of the incidents gets lost from shift to shift.[224] His evidence was that a big improvement would be to design a chart to identify behaviours, how often they happen and when they happen to help really understand the problems for each of the residents. Coherent charting of behaviours then provides an overall picture which perhaps might show a trend as to what was triggering incidents and how to prevent them, or at least preventing them from becoming more severe. That involves the training of staff and getting them to have knowledge about behavioural issues.[225] Again he was concerned about the incident of 18 January where Mr Clutton was dragged out of his room, which he considered would have been more frightening to see than the push of Mr Clutton on 28 January. He said the incident on 18 January was "manhandling", and an event that should have triggered a greater reaction. He thought it was very unusual behaviour.[226]

102. In his opinion one area that could be improved was the training of staff. He said their lack of knowledge about behavioural issues was a part of the problem. He stated that some staff appeared to think some behaviours were "the norm" and therefore the recording of it gets missed. He stated that building a team dynamic is crucial to developing a better understanding of dementia and the behaviours that are associated with it.[227]

103. Professor Ibrahim considered that the privacy issue that had been raised by the Home was secondary to personal safety and that in the circumstances of this matter, privacy of the resident was of less importance.[228]

Resolution of issues

104. From my own observations I do not consider there to be any issues as to credibility. No submission was made by any party in relation to credibility and I am therefore able to make a finding that all witnesses were creditable.

105. **Adequate Supervision**. From all of the evidence I do not make any criticism of the staffing levels of the facility and in particular the Lavender Unit as at 28 January 2017. It appears to me that the number of staff was more likely than not adequate at the relevant time; however the management of ███'s behaviours was given insufficient attention, particularly after the manhandling of Mr Clutton on 18 January 2017. There was poor record keeping. The Behaviour Management Chart was incomplete or had no record of some incidents. This meant senior staff who relied on the document had an incomplete knowledge of the behaviour being exhibited by ██ ███ overall. This was accepted by Ms Sloane as part of her acknowledgment of the breakdown in communication between care staff and senior staff.[229] Professor Ibrahim's suggestion of a chart that identifies all behaviours, be they verbal or

[224] Transcript of proceedings 27 November 2019 at T8.42 – 9.32.

[225] Transcript of proceedings 27 November 2019 at T9.34 – 11.5.

[226] Transcript of proceedings 27 November 2019 at T12.46 – 13.7.

[227] Transcript of proceedings 27 November 2019 at T12.11 – 12.19.

[228] Transcript of proceedings 27 November 2019 at T22.20 – 22.26.

[229] See [84] above.

physical, and the care staff's observation as to what may have provoked the behaviour should be implemented and be compulsory reading for senior staff every week.[230] The chart should not be archived at any stage up until the resident leaves the facility.

106. **Whether GP assessment, DBMAS referral or other specialist assessment should have been arranged**. I prefer the opinion expressed by Professor Ibrahim that consideration should have been given for ██████ to have been referred for a DBMAS review from about December 2016.[231] While I accept Associate Professor Macfarlane's reasoning - there being no evidence of aggression against Mr Clutton before January 2017,[232] I consider the act of aggression against a staff member and the verbal threats made by ██████ of sufficient seriousness to warrant at the very least a review by the GP, a case conference and then if necessary DBMAS referral. If safety is paramount, and it should be for both staff and residents, efforts should be made before an incident of a serious nature occurs.

107. **Relocation from the room.** Both experts considered that a move out of the room by either ██ ████ or Mr Clutton was appropriate.[233] Each expert had a different view as to when that should have occurred. Associate Professor Macfarlane considered the incident on 18 January against Mr Clutton could be viewed at the time as a one-off incident; however by 24 January there were three incidents and that would have given more reason to consider relocation from the room if not from the unit. Professor Ibrahim accepted there should have been a review, not only in relation to relocation of a resident from the room but even looking at another facility if a room could not have been found.

108. **A more timely investigation of the January 2017 incidents**. Ms Sloane conceded there should have been a more timely investigation taking all of the incidents into account. She had already conceded that there had been poor communication between staff and Ms Morillas. She also conceded the lack of appropriate documentation did not assist in recognising all of the incidents, and when they were taking place.

109. **Whether case conferencing should have occurred in relation to ██████'s behaviours prior to 28 January 2017?** Both experts were of the opinion that it should have been done however Associate Professor Macfarlane added the additional comment that if a conference had been held even by about mid-January it may not have affected the outcome.[234] This was an accepted view also from Ms Sloane.

110. **Whether the implementation of a safety/risk management plan by way of observations/sightings in January 2017 was adequate?** It was accepted by Ms Sloane that the sighting charts used were not adequate.[235] The underlying purpose was to look really at the demeanour or state of mind of ██████ rather than at his wandering. The incidents in November and December relating to ██████ were also poorly documented and not included in the behaviour care plan. There was inadequate reporting of the incident against the staff member Mr Murray. There was a failure to keep records, particularly in relation to

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230 See [101] above.

231 See [100(8)] above.

232 See [98] above.

233 See [96(c)] and [100(5)] above.

234 See [96(e)–(g)] above.

235 See [85] above.

communication with the GP and there didn't appear to be follow-up of issues, particularly after the incident on 24 January.

111. While privacy is a legislative issue it was acknowledged by each of the experts that where there is a risk to resident safety, that risk and its mitigation had a higher priority over privacy of a resident.

112. I accept the submission made by Counsel for SummitCare that since Ms Sloane's arrival and her taking a position as the Chief Executive Officer significant changes have taken place, with additional staff being recruited and additional senior managers being recruited to assist in the effective management of each of the facilities owned and managed by SummitCare.[236] I accept that there is a significant emphasis on improved and continuing education.

113. This Inquest attempted to focus on two broad issues; the first whether anything could have been done better to prevent this awful incident from occurring and the second, what can be done in the future to help prevent deaths like this from occurring again in dementia care facilities. The death of Mr Clutton arose from a simple push; yet when combined with age and frailty resulted in a fall to the ground and fatal injuries. From all of the evidence it is acknowledged that keeping people safe, particularly those with dementia, in a residential aged care facility is not a simple task. Those with dementia can exhibit a range of unusual behaviours in what would otherwise have been a placid human being. They exhibit these behaviours for all sorts of reasons including pain, frustration, loneliness, fear and boredom. It is essential that these behaviours are better understood by those who are entrusted with the care of those afflicted with this condition.

114. It is also essential that the staff who are at the forefront (or the coalface) of looking after residents are better trained and educated about the condition of dementia and the behavioural issues that are more often than not associated with the disease. It should be made clear to staff that acts of verbal and or physical aggression witnessed by them should not be regarded as a normal event where nothing is done because that is how people with dementia behave. That thinking/ rationale should be completely discouraged.

115. I accept Professor Ibrahim's opinion that the incident between Mr Clutton and [redacted] on 28 January 2017 should have been the subject of a report to the Aged Care Quality and Safety Commission. There is a need to report incidents, particularly of resident to resident aggression in dementia units. Without reporting there can be no statistical analysis of the numbers of incidents and the ability to study and report on the problem is therefore limited. In my opinion it should be mandatory to report all incidents so that a better and more informed picture of the issue can be gleaned and, if needed, more resources invested into achieving better outcomes for residents and their families and the care staff who work in the industry

116. I have made recommendations that are set out below. It is hoped that SummitCare will recognise the importance of implementing the recommendations, which are designed to improve the quality of care of residents in their aged care facilities. More importantly improving the safety of each of the residents in what has been determined as a "very challenging environment".

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[236] See [87] above.

117. I extend again my sincere condolences to Mr David Ponman and Ms Crameri on the death of their beloved cousin Mr Clutton. I take this opportunity of thanking the Officer in Charge of the investigation Detective Senior Constable Christopher Elliott. I acknowledge the great help and assistance of Counsel Assisting, Mr Peter Aitken and his instructing solicitor Ms Jennifer Hoy from the Crown Solicitor's Office. The help of other Counsel and solicitors who represented persons of interest is also gratefully acknowledged and appreciated. I am also grateful for the manner and pragmatic way they approached the inquest and the assistance provided to the Inquest.

118. I close this Inquest.

Formal Findings:

I find:

The date of death was on 10 February 2017;

The time of death was between 3.30 pm and 4.00 pm;

The place of death was John Hunter Hospital Newcastle;

The cause of death was complications of head injuries and an antecedent cause was dementia.

Manner of death: Neville Clutton died from a push by another person resulting in a fall.

Recommendations:

To SummitCare:

1. That the current guideline CM 3.13 '*Management of Acute Behavioural Disturbance/Behavioural & Psychological Symptoms of Dementia (BPSD)*' be amended as follows:
   (i) That the key step 'Consider Environmental contributing factors' also include whether the resident shares a room as a relevant factor;
   (ii) That the key step 'Emergency Care'also include in the list of non-pharmacological actions "*move the resident to a single room in the Residential Aged Care Facility* ("Facility"), *with one to one staffing as considered necessary*";
   (iii) That the reference documents for 'Emergency Care' include a reference to the severe behavioural disturbance guideline used by SummitCare;
   (iv) That the key step of 'Reassessment' on p. 5 of the document be amended to reflect that *further* assessment is being contemplated by way of the proposed actions; and
   (v) That the document be amended to include an additional section in the Key Steps, reminding staff of the need to report and record all internal (i.e. within the Facility) assessments and steps taken in relation to a resident displaying behavioural and psychological symptoms of dementia.

2. In circumstances where a resident (the Exhibitor) of a dementia unit in the Facility is demonstrating BPSD-related aggression towards other resident(s) (victim(s)), that consideration be given to developing a policy (or amending any applicable existing policy) to provide guidance to staff about disclosure of the relevant risk factors to the next of kin or person responsible for the other resident(s) (victim) at risk.

3. That a record be kept in the resident's file of all written communication with that resident's general practitioner, and that all communication for clinical reasons with that practitioner by Facility staff (whether by phone, fax, email or otherwise) be recorded in the electronic progress notes for that resident.

4. That consideration is given to developing and implementing a chronological summary of a resident's BPSD-related acts of aggression, both verbal and physical, for the purposes of internal management and review, external clinical review and case conferencing as required.

5. That consideration be given to developing and implementing a chart with a graph-based or other suitable pictorial representation of the chronological summary referred to in Recommendation (4) above, to be used in conjunction with that narrative chronological summary.(It is noted that a form of graph may be difficult to implement)

6. That SummitCare's current 'Behaviour Management Procedure' guideline CM 3.02.6 is amended at page 4 to further clarify when case conferences may be required. This may include by providing examples, such as "when any ongoing aggressive behaviours escalate" or "when there are two consecutive incidents of high risk and/or severe behaviour".