CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Judith Chrupalo & Christopher Clee
Hearing dates:	29 March 2021 to 1 April 2021; 30 & 31 August 2021
Date of findings:	23 December 2021
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, identity of deceased persons, NSW Public Guardian, Dubbo Base Hospital, Lourdes Hospital and Community Health Care Service, NSW Civil and Administrative Tribunal, guardianship application, Aged Care Assessment Team, assessment of capacity self-discharge against medical advice, service providers, elder abuse, self-neglect, community nursing care, welfare checks
File number:	2016/77465 2016/77480
Representation:	Ms E Raper SC, Counsel Assisting, instructed by Ms T Howe (Crown Solicitor's Office) Ms J Needham SC for the New South Wales Public Guardian, instructed by New South Wales Trustee & Guardian Mr S Barnes for Dr K Smith, instructed by Avant Law Mr T Buterin for Lourdes Hospital and Community Health Service, instructed by Catholic Healthcare Ltd Mr P Rooney for Western New South Wales Local Health District, instructed by Makinson d'Apice Lawyers

Findings:

In relation to Judith Chrupalo:

Judith Chrupalo died sometime between about 16 February 2016 and 2 March 2016 at Dubbo NSW 2380. Mrs Chrupalo died of natural causes. However, due to the effects of decomposition the postmortem examination was unable to ascertain the cause of Mrs Chrupalo's death. Therefore, the limited available evidence does not allow for any finding to be made as to the cause of Mrs Chrupalo's death.

In relation to Christopher Clee:

Christopher Clee died sometime between about 16 February 2016 and 2 March 2016 at Dubbo NSW 2380. Mr Clee died of natural causes. However, due to the effects of decomposition the postmortem examination was unable to ascertain the cause of Mr Clee's death. Therefore, the limited available evidence does not allow for any finding to be made as to the cause of Mr Clee's death.

Recommendations:

See Appendix A

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1. Introduction

1.1 On the evening of 9 March 2016 police officers conducted a welfare check at the home of Mrs Judith Chrupalo and her son, Mr Christopher Clee, in Dubbo after they both had not been seen for a number of weeks. Mrs Chrupalo and Mr Clee were found inside their home, with no signs of life and in an advanced state of decomposition. It was evident to the police officers that the home showed signs of squalor and poor living conditions, and that Mrs Chrupalo and Mr Clee had been deceased for a significant period of time.

1.2 Subsequent investigations identified the involvement of a hospital, community health service and the Public Guardian with Mrs Chrupalo and Mr Clee during the latter stages of 2015 and early part of 2016. This raised a number of questions regarding the nature and extent of this involvement, and the circumstances leading to Mrs Chrupalo and Mr Clee having been found deceased following this period of involvement.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 Certain deaths are reportable to a Coroner. Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of person's death may not immediately be known. In the case of both Mrs Chrupalo and Mr Clee, although a postmortem examination was performed, the cause of their deaths could not be ascertained, as the examinations were adversely affected by the effects of decomposition. Further, what was initially known about the months preceding the discovery Mrs Chrupalo and Mr Clee raised a number of questions regarding responsibilities associated with the care of older persons, issues of capacity, and concerns in relation to safety, neglect and elder abuse. For all of these reasons, an inquest was required to be held.

2.3 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation, and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Recognition of the lives of Mrs Chrupalo and Mr Clee[1]

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that the death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the lives of Mrs Chrupalo and Mr Clee in a brief, but hopefully meaningful, way.

3.3 Sadly, very little is known about the personal backgrounds of Mrs Chrupalo and Mr Clee. This is largely because the information gathered as part of the coronial investigation related to their previous contact with a number of medical and support services, with very little information regarding their personal lives.

3.4 Mrs Chrupalo was born on 19 June 1942. Those who knew Mrs Chrupalo were unable to provide investigating police with much information regarding Mrs Chrupalo's family other than noting that Mrs Chrupalo's parents passed away many years ago. It is believed that Mrs Chrupalo was married at one stage but later divorced.

3.5 Mr Clee was born on 5 June 1961. Again, very little is known regarding his personal background.

3.6 It appears that Mrs Chrupalo and Mr Clee spent some time in Sydney before moving to Dubbo in July 2002. They later bought a house in August of that year, and remained living in that house until 2016.

3.7 Mrs Chrupalo and Mr Clee would occasionally visit friend and acquaintances, but that they otherwise kept largely to themselves.

3.8 Despite the paucity of information regarding Mrs Chrupalo and Mr Clee, it is recognised that an inquest can never hope to provide a balanced reflection of the whole of their lives, nor hope to portray them fully as people.

[1] In many inquests, deceased persons are referred to by their first name, typically at the request of family members. In this case, there are no family members available to express a preference as to how Mrs Chrupalo and Mr Clee should be referred to. Therefore, out of respect, they will be referred to as Mrs Chrupalo and Mr Clee in these findings.

4. Summary of relevant background[2]

4.1 In July 2002, Mrs Chrupalo and Mr Clee moved to Dubbo together. A month later they bought a house at 61 Windsor Parade, Dubbo (**the Windsor Parade property**).

4.2 Both Mrs Chrupalo and Mr Clee were heavy drinkers, and both had previously attended hospital for alcohol related issues: By way of example:

(a) On 31 October 2006, Mr Clee was brought to Dubbo Base Hospital (**the Hospital**) by ambulance, stating he was seeking help to "*dry out*" and detox from alcohol. He was not admitted but referred to drug and alcohol services.

(b) On 8 January 2014, Mrs Chrupalo was admitted to the Hospital after a fall at home while intoxicated.

4.3 Mr Clee was Mrs Chrupalo's carer. Although his mother required a high level of care, which brought with it its own challenges, Mr Clee remained dedicated to his role. Medical records reveal that in August 2007 Mr Clee was admitted to hospital after presenting with chest pain, but later discharged himself against medical advice after several days, indicating that he had to look after his mother and that there were "*no other care options for her*".

First admission to hospital

4.4 On 12 June 2015 Mr Clee called an ambulance for Mrs Chrupalo because she "*had lost her appetite for the last week*". Attending paramedics noted that the Windsor Parade property was unkempt and very dirty, and that Mrs Chrupalo was lying in urine stained sheets and faeces. Mrs Chrupalo was taken by ambulance to the emergency department at the Hospital where she was admitted (**First Admission**). It was noted that Mrs Chrupalo had generalised weakness and electrolyte derangement.

4.5 Mrs Chrupalo improved clinically during the First Admission and was later discharged into the care of Mr Clee on 17 June 2015. Medical records note that during Mrs Chrupalo's admission, various community and home services were offered but they were "*firmly refused*".

4.6 On 18 June 2015, paramedics were again called to the Windsor Parade property after Mrs Chrupalo suffered a fall at home, and Mr Clee was unable to lift her. Attending paramedics notified the Hospital and requested that Mrs Chrupalo have a review of some kind, due to very poor living conditions at home.

Second admission to hospital

4.7 On 19 June 2015, Mr Clee called an ambulance for Mrs Chrupalo, indicating that his mother was unable to get out of bed, and that he was unable to cope at home. Attending paramedics found Mrs Chrupalo in a pool of her own faeces and poorly kept. Mrs Chrupalo indicated that she was now keen to receive home help that had been offered to her during her last admission to hospital. Mrs

[2] This factual background has been drawn from the helpful opening submissions of Counsel Assisting.

Chrupalo was subsequently taken to the Hospital where she was admitted to the general medicine ward where she remained until discharged on 8 July 2015 (**Second Admission**).

4.8 On 23 June 2015, Beverley Sparkes, the Nurse Manager in Acute to Aged Care Related Services (**AACRS**) conducted a complete screening assessment of Mrs Chrupalo, including an ED Aged Care Assessment and an Abbreviated Mental Health Test.

First Aged Care Assessment Team assessment

4.9 On 29 June 2015, Toni Murie conducted an Aged Care Assessment Team (**ACAT**) assessment of Mrs Chrupalo (**First ACAT Assessment**). Mrs Chrupalo was noted to have "*mild cognitive changes*" and to have scored 22 or 23/30 on the Mini-Mental State Examination (**MMSE**). As a result of the assessment, Mrs Chrupalo was approved for permanent residential care and residential respite care at a high level, due to her very high level care requirements. However, Mrs Chrupalo elected not to accept care outside the home.

Self-discharge and assessment of capacity

4.10 On the morning of 7 July 2015, Mrs Chrupalo expressed a desire to return home (acknowledging the need for more services) and advised she would discharge herself the following day if she was not allowed to be discharged. Later that day, Dr Kathleen Smith, Visiting Medical Officer (**VMO**) psychiatrist, assessed Mrs Chrupalo and determined that she had capacity (**the Capacity Assessment**). Dr Smith noted the following:

> At this time it would be very hard to justify the position that Mrs Chrupalo cannot competently make the decision regarding her services and accommodation. She could tell me the risks of going home, although she minimised them somewhat. She could tell me why she believed that a nursing home would not be her preference. She was able to articulate the advantages for being at home. She has worked as a nurse in a rehabilitation facility and these experiences have shaped her poor opinion of institutional care. She reports that this admission to hospital and all the fuss made about her health has made her realise she must accept some formal/professional help. She also intends to eat better and do some bed/bedtime exercises to improve her strength. She reports that her son and her have mostly a good relationship and can talk about her health honestly. She declined any thoughts of entry into outpatient/inpatient physical reconditioning program – her son was willing to encourage her to outpatient physio if this was available. She shows no sign of depression or psychosis. She is competent to refuse services and discharge despite her MMSE score. Capacity will need to be reassessed regularly though, especially if she fails to keep the commitment to allow services in.

4.11 On 8 July 2015, Mrs Chrupalo discharged herself against medical advice. The discharge summary records that:

> […] mental health review was sought to assess capacity; it was found that Ms Chrupalo had sufficient capacity and understood the risks and potential adverse consequences of not undertaking care placement…she voluntarily completed a discharged against medical advice form.

4.12 The Capacity Assessment was not replicated in the discharge. The discharge summary referred to the First ACAT Assessment and noted that due to the high level of care Mrs Chrupalo required, she did not qualify for home services and was only eligible for placement.

4.13 On 10 July 2015, Mr Clee phoned the hospital, asking for help with his mother's care. Catherine Brady, an Aged Care Clinical Nurse Consultant at the Hospital, took the call and made a referral for a further ACAT assessment with a view to a high level care package. The following was noted:

> Mrs Chrupalo had an ACAT attended in the last few weeks but approval for packages was not approved. Mrs Chrupalo has refused to go to respite or permanent care but the son is struggling to meet her care needs but wishes to respect her wishes to remain at home.

Second Aged Care Assessment Team assessment

4.14 On 16 July 2015, Ms Patricia Wheeler, the ACAT assessor, attended Mrs Chrupalo's home and assessed Mrs Chrupalo (**Second ACAT Assessment**). A further MMSE assessment was not conducted at this time because one had been conducted during the ACAT Assessment, and because a MMSE can be quite confronting. Ms Wheeler did not have available to her copies of either the discharge summary or the mental health assessment performed by Dr Smith. Following Ms Wheeler's assessment, Mrs Chrupalo was approved for permanent residential care, residential respite care and Home Care Packages Level 3 and 4. Ms Wheeler referred Mrs Chrupalo to Lourdes Hospital and Community Health Service (**Lourdes**) to receive community nursing for wound care management and for occupational therapy.

Community nursing care

4.15 Between 24 July 2015 and 25 August 2015 Lourdes community nurses attended Mrs Chrupalo at her home to treat her pressure wounds. Progress notes from these attendances record the nurses' continuing concerns about Mrs Chrupalo's living conditions and neglect.

4.16 On 31 July 2015, Registered Nurse (**RN**) Board referred Mrs Chrupalo to the Commonwealth Carer Respite and Carelink Service (**CCRC**) at Dubbo. However, the CRCC did not have any high care beds available at that time as they were all occupied until November 2015.

4.17 On 21 August 2015, Lourdes occupational therapists assessed Mrs Chrupalo and made some recommendations that ultimately Mrs Chrupalo refused.

4.18 On 26 August 2015, staff at Lourdes discussed their concerns about Mrs Chrupalo's wellbeing and decided to make an application to the NSW Civil and Administrative Tribunal (**the Tribunal**) for the possible appointment of a guardian for Mrs Chrupalo.

4.19 On 26 August 2015, at the request of Ms Kaylene Green, NSW Police conducted a welfare check on Mrs Chrupalo.

Application for guardianship

4.20 On 26 August 2015, Ms Green made an application to the Tribunal for the New South Wales Public Guardian (**Public Guardian**) to be appointed.

4.21 On 4 September 2015, Ms Green served Mrs Chrupalo with the guardianship application. In response, Mrs Chrupalo said to Ms Green words to the effect of, "*Why do we have to do this?*" and "*Get out and don't come back*".

4.22 On 10 September 2015, the guardianship application was listed for hearing, however neither Mr Clee nor Mrs Chrupalo attended. As a result, the hearing was adjourned to 8 October 2015 for Mrs Chrupalo and/or Mr Clee to attend.

4.23 On 11 September 2015, the Lourdes community nurses attended Mrs Chrupalo for the last time. Following this, despite five attempts on separate days, they were unable to access the property again. On 17 September 2015, the Lourdes Community nurses and Mr Evans attended the property. They were refused entry by Mr Clee, who told them, "*Mum would be happy to see you tomorrow…there's too much going on, too much intervention and we want to be left alone*."

4.24 On 18 September 2015, a final unsuccessful attempt was made by Lourdes to attend upon Mrs Chrupalo. Following this, Mrs Chrupalo was discharged from the Lourdes service.

4.25 On 8 October 2015, the Tribunal made a guardianship order appointing the Public Guardian as Mrs Chrupalo's guardian for three months. The functions of the guardian included accommodation, health care, medical and dental consent and services. Despite this appointment, neither the Public Guardian nor Lourdes had any communication with Mrs Chrupalo or Mr Clee for the remainder of 2015.

4.26 On 22 October 2015, Michelle Binny[3], Guardian in the Western Team, at the Office of the Public Guardian, was allocated Mrs Chrupalo's file. On 2 December 2015, Ms Binny spoke with Ms Green regarding the guardianship application.

4.27 On 7 January 2016 the Tribunal, having heard from Ms Green and a representative of the Public Guardian, decided not to renew the guardianship order. Following this decision, no one from the Public Guardian, Lourdes or the Hospital contacted Mr Clee or Mrs Chrupalo.

[3] It was submitted on behalf of the Public Guardian that any actions taken by Ms Binny, as the officer responsible for Mrs Chrupalo's file, were made under delegation of the Public Guardian, and should be taken to be actions of the Public Guardian, rather than Ms Binny personally. On this basis, it was submitted that it would be appropriate to de-identify Ms Binny by referring to her as a delegate of the Public Guardian. It was further submitted that such a course is available pursuant to section 8(1)(e) of the *Court Suppression and Non-Publication Orders Act 2010* (**CSNPO Act**), and consistent with the principles of open justice as enunciated at section 6 of the CSNPO Act. Whilst the CSNPO Act does not apply to the Coroners Court (*Commissioner of NSW Police v Deputy State Coroner for NSW* [2021] NSWSC 398 at [78]), it is accepted that a de-identification of the kind sought would be available pursuant to section 74(1)(b) of the *Coroners Act 2009* where it would be in the public interest to do so. However, the submissions on behalf of the Public Guardian do not identify why such an order is said to be in the public interest, or address and if the non-exhaustive list of criteria set out at section 74(2). To the extent that any determination on this issue is required, it is noted that principles of open justice do not generally recognise embarrassment or reputational damage as providing a basis for the making of a non-publication or pseudonym order. Further, even if officers of public agencies were acting under delegated authority, identification of such officers would ordinarily be required to ensure accountability for the proper exercise of public authority.

Welfare check and discovery of Mrs Chrupalo and Mr Clee

4.28 On 9 March 2016 police officers from Dubbo police station conducted a welfare check at the Windsor Parade property after neighbours raise concerns that Mrs Chrupalo and Mr Clee had not been seen for a matter of weeks, and that there was an offensive odour coming from within the property. After gaining entry to the Windsor Parade property, attending police officers found it to be littered with empty alcohol bottles and refuse, and to be in a generally squalid and very unhygienic condition.

4.29 A deceased male person was found lying on his back on the floor in the lounge room in an advanced state of decomposition. In a nearby bedroom, a deceased female person was found lying on the bed, also in an advanced state of decomposition. A wheelchair was found in the bedroom's walk-in wardrobe, and the bedroom was found to be similarly unclean as the remainder of the house, with a number of cigarette butts and bottles of alcohol lying around.

5. Establishing identity

5.1 As noted above, one of the statutory requirements of section 81 of the Act is to establish the identity of deceased persons where a reportable death has been reported to the Coroner. In these cases, whilst the deceased persons found inside the Windsor Parade property were strongly believed to be Mrs Chrupalo and Mr Clee, it is necessary to outline the evidence that allows for formal findings to be made as to identity.

5.2 Due to the advanced state of decomposition, the deceased persons could not be visually identified. Further, whilst forensic samples were obtained from both persons, a DNA profile could only be recovered from the male person. Analysis of a partial DNA profile recovered from a blood sample was consistent with the same originating from Mr Clee. Further, the DNA analysis identified that the two persons were biologically linked: DNA recovered from the male person could have originated from a biological child of the female person; and DNA recovered from the female person could have originated from the biological mother of the male person.

5.3 The evidence established the following in relation to the Windsor Parade property:

(a) It was owned by Mrs Chrupalo;

(b) Relatives, neighbours, police officers, members of the ACAT and Lourdes community nursing staff had all previously visited it and found Mrs Chrupalo and Mr Clee to be living there;

(c) The police examination, documentary material found at the scene, and accounts provided by persons who had previously attended did not identify any evidence that any other person (apart from Mrs Chrupalo and Mr Clee) lived there;

(d) A vehicle located there belonged to Mr Clee;

(e) Mail found inside was addressed to Mr Clee or Mrs Chrupalo;

(f) The electricity account connected there, which had been connected since 2012, was in Mrs Chrupalo's name, with Mr Clee listed as an authorised contact;

(g) The landline connected there was in Mr Clee's name.

5.4 **Conclusion:** The persuasive circumstantial evidence described above establishes that, on the balance of probabilities, the female person found on 9 March 2016 at the Windsor Parade property was Mrs Chrupalo, and that the male person found at the same location was Mr Clee.

6. Cause and manner of death

6.1 Following the discovery of Mrs Chrupalo and Mr Clee on 9 March 2016, they were taken to the Department of Forensic Medicine at Newcastle where a postmortem examination was performed by Dr Jane Vuletic, forensic pathologist, on 15 March 2016.

6.2 The police investigation did not identify any suspicious circumstances or third party involvement in Mr Clee's death. Further, the postmortem examination did not identify any traumatic injuries or anything to indicate the involvement of another person in Mr Clee's death. However, due to the extent of decomposition, the autopsy was unable to positively demonstrate the cause of Mr Clee's death.

6.3 Medical records, and the observations of the Lourdes community nurses, indicate that Mr Clee was a heavy drinker. In the autopsy report, Dr Vuletic noted that alcohol-induced liver disease may have been a cause of, or contributing factor to, Mr Clee's death. However, although a blood alcohol level was detected from routine toxicology at autopsy, it is likely that this reading was the result of decomposition and postmortem artefact. Dr Vuletic considered that the blood alcohol level would have been higher if it was sufficiently toxic to cause death.

6.4 **Conclusion:** Having regard to the above, the limited available evidence allows for a conclusion to be reached that Mr Clee died of natural causes. However, the limitations of the postmortem examination mean that the precise cause of Mr Clee's death cannot be determined on the available evidence.

6.5 As for Mr Clee, neither the police investigation nor the postmortem examination identified any suspicious circumstances associated with Mrs Chrupalo's death. Mrs Chrupalo had a number of pre-existing medical conditions including malnutrition, alcoholic liver disease, cognitive impairment, immobility, urinary incontinence and smoking induced lung disease. Further, the autopsy identified evidence of severe coronary artery narrowing which itself could be independently fatal. Although the autopsy was unable to ascertain the precise cause of Mrs Chrupalo's death, due to the severe state of decomposition, there was nothing to indicate that she died from anything other than natural causes.

6.6 Routine toxicology that the concentrations of alcohol and acetone in the postmortem blood samples. Dr Vuletic noted that the presence of acetone may be indicative of a pre-existing disease, and may have been due to a prolonged period of fasting, starvation or chronic alcoholism. Notwithstanding, Dr Vuletic noted that the concentrations of alcohol and acetone may have been the result of decomposition, although if the alcohol had been sufficiently toxic to cause death, Dr Vuletic again would have expected the alcohol level to be higher.

6.7 **Conclusion:** The limited available evidence allows for a conclusion to be reached that Mrs Chrupalo died of natural causes, but does not allow for the precise cause of death to be determined. Again, the advanced state of decomposition and lengthy postmortem interval has precluded the cause of death from being ascertained with any certainty.

7. Date of death

7.1 The following evidence is relevant to the question of when Mrs Chrupalo and Mr Clee died:

(a) Records for telephone service 02 5806 7067 list Mr Clee as the subscriber from 9 March 2010 until 27 January 2016, when it was cancelled. There were 63 calls made to this number, with many appearing to be automated. Two calls to this number were answered on 22 October 2015 and 28 October 2015. No calls were made from this number.

(b) Records for mobile service 0427 094 191 indicated that Mr Clee was the subscriber between 6 January 2010 and 3 January 2016, when it was disconnected. Call records indicate that this number received many of what appear to be unsolicited automated calls, and that no calls were made from this number from 30 September 2015 to 9 March 2016.

(c) Call records for 0427 095 191 indicate that two calls were made to taxi companies on 16 February 2016. Records from a taxi company indicate that there was a booking made on 16 February 2016 with the Windsor Parade property as the pick-up address and Orana Mall being the destination. Bank records indicate a debit from Mr Clee's account to a Woolworths in Orana on 16 February 2016. It can be inferred that on this day Mr Clee took a taxi from his home on 6 February 2016 to do some shopping. As Mrs Chrupalo was known to be bedbound at the time, it can reasonably be inferred that she did not go shopping on 16 February 2016.

(d) Records for telephone service 02 6885 0687 list Mr Clee as the subscriber from 2 February 2016 to 11 May 2016. Call records for 02 6885 0687 indicate that four outgoing calls were made from this service on 16 February 2016, with no further outgoing calls made after this date.

(e) Bank records for Mr Clee's account indicate number of regular purchases from the Woolworths in Orana Mall, with the last regular transaction occurring on 16 February 2016. No other transactions occurred after this date with the exception of a number of automatic payments.

(f) Bank records for Mrs Chrupalo's account indicate that a Centrelink payment was paid fortnightly into the account with cash withdrawals made from the account, usually on the same day or the next day, but sometimes up to a week later. As Mrs Chrupalo was bedbound, and the transaction record for Mr Clee account indicates that he visited Orana Mall regularly, it can be inferred that it was Mr Clee who made the cash withdrawals from Mrs Chrupalo's account.

(g) On 18 February 2016, Mrs Chrupalo's fortnightly Centre payment was deposited into her account but this was not followed by the usual cash withdrawal. This suggests that:

(1) For some reason Mr Clee departed from his usual behaviour; or

(2) Something happened to Mr Clee on or about 16 February 2016, meaning that he was unable to make his usual cash withdrawals.

7.2 Dr Vuletic was unable to determine the date of Mr Clee's death, other than noting that he had been deceased for a number of days prior to 9 March 2016. Given the severe state of decomposition, Dr Vuletic expressed the view that it is likely that Mr Clee had been deceased for at least a week. However, Dr Vuletic could not be any more precise in terms of a timeframe. Dr Vuletic also could not determine whether Mr Clee, or his mother, died first, but noted that there was nothing to indicate any significant difference in the timing of their deaths.

7.3 The available evidence indicates that Mr Clee was still alive on 16 February 2016 when he booked a taxi, travelled to Orana Mall, and went grocery shopping at the Woolworths there. Given that there was no cash withdrawal on the same day that Mrs Chrupalo's pension was paid into her account on 18 February 2016, it is reasonable to infer that an intervening event or occurrence took place which interrupted Mr Clee's usual routine. However, it cannot be similarly inferred that Mr Clee died on the same day as this likely event or occurrence took place.

7.4 **Conclusion:** The available evidence indicates that Mr Clee died sometime between about 16 February 2016 (when documentary evidence confirms he was last known to be alive) and 2 March 2016 (based on the most likely postmortem interval identified by Dr Vuletic).

7.5 Unlike for Mr Clee, there is no objective evidence to establish that Mrs Chrupalo was alive on any particular day in February 2016. The last confirmed date when Mrs Chrupalo was known to be alive was on 16 September 2015, when the Lourdes community nurses heard her yelling from inside her home.

7.6 Mrs Chrupalo's medical records from the Hospital, and the observations of Lourdes staff is that as at 21 August 2015, Mrs Chrupalo was bedbound, doubly incontinent and relied on her son to meet her physical needs. Therefore, if Mr Clee died on or after 16 February 2016, or became physically incapacitated due to a medical event, there would have been no one to care for Mrs Chrupalo, and in particular to provide her with food or water. Dr Vuletic noted that the presence of acetone may have been an indication of starvation, or that Mrs Chrupalo had not eaten for some time prior to her death.

7.7 Dr Vuletic did not have available to her any investigative methods that could be utilised to determine when Mrs Chrupalo's death occurred. Given the advanced state of decomposition, it is likely that Mrs Chrupalo had died at least a week before she was found on 9 March 2016. However, Dr Vuletic could not be more precise in terms of the timing of Mrs Chrupalo's death.

7.8 **Conclusion:** The available documentary evidence confirms that Mrs Chrupalo was last known to be alive on 16 September 2015. Given what is known regarding the relationship between Mrs Chrupalo and her son, it is likely that if Mrs Chrupalo had died sometime between 16 September 2015 and 16 February 2016, Mr Clee would have responded to his mother's death, meaning that her death would have been identified prior to 9 March 2016. Further, it is also likely that if Mrs Chrupalo had died prior to 16 February 2016, there would have been a similar basis for the neighbours of Mrs Chrupalo and Mr Clee to raise a concern for welfare with police, which did not occur.

7.9 Therefore, the available evidence indicates that Mrs Chrupalo died sometime between about 16 February 2016 (when documentary evidence confirms Mr Clee was last known to be alive) and 2 March 2016 (based on the most likely postmortem interval identified by Dr Vuletic).

8. What issues did the inquest examine?

8.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues:

(1) Whether the decision by Dubbo Base Hospital to discharge Mrs Chrupalo on 8 July 2015 was appropriate?

(2) What additional steps, if any, could Dubbo Base Hospital have taken to ensure that Mrs Chrupalo received adequate care and medical treatment after 8 July 2015?

(3) Whether the decision by Lourdes to discharge Mrs Chrupalo from their services on 18 September 2015 was appropriate?

(4) What additional steps, if any, could Lourdes staff have taken to ensure that Mrs Chrupalo received adequate care and medical treatment after 18 September 2015?

(5) The appropriateness of the steps taken by the Public Guardian following the making of the guardianship order for Mrs Chrupalo on 8 October 2015?

(6) What additional steps, if any, could the Public Guardian have taken after 8 October 2015 to ensure that Mrs Chrupalo received adequate care and medical treatment?

(7) What additional steps, if any, could Lourdes staff have taken after 8 October 2015 to ensure that Mrs Chrupalo received adequate care and medical treatment (including but not limited to ensuring that a welfare check was undertaken in January 2016)?

8.2 Each of the above issues is discussed in detail below. In order to assist with consideration of some of these issues, opinion was sought from the following experts as part of the coronial investigation. Each of the experts provided reports which were included in the brief of evidence, and each expert also gave evidence during the inquest:

(a) Professor Joseph Ibrahim, consultant specialist in geriatric medicine, and Head of the Health Law and Ageing Research Unit, Victorian Institute of Forensic Medicine.

(b) Ms Diane Robinson, member of the NSW Ministerial Advisory Council on Ageing, and former President of the Guardianship Tribunal.

9. Was the decision by Dubbo Base Hospital to discharge Mrs Chrupalo appropriate?

9.1 As noted above, the Capacity Assessment was performed by Dr Smith on 7 July 2015. Progress notes from a ward round on 8 July 2015 disclose the following:

> Pysch review noted with thanks - patient has capacity to make decisions
> - Patient insisted on discharge today
> - Does not wish for placement - family present and also insisted on this
> - Best option would be for maximal services at home - ACAT nurse currently working on this
> - From physio and medical standpoint, she is not currently safe for discharge. We recommend that patient is for nursing home.
> - However, Mrs Chrupalo has capacity to decide and if she is insistent on discharged home then we cannot stop that.

9.2 Mrs Chrupalo later signed a Discharge Against Medical Advice Form on 8 July 2015.

A patient's right to self-discharge against medical advice

9.3 An adult patient with capacity generally has the right to refuse any medical treatment and leave the hospital against medical advice. Section 35 of the *Guardianship Act 1987* provides that it is an offence to carry out a medical or dental treatment a patient unless consent has been given the treatment is otherwise authorised. Section 33(2) provides that a person is incapable of giving consent if the person is incapable of (a) understanding the general nature and effect of the treatment; or (b) indicating whether or not he or she consents would does not consent to the treatment being carried out.

9.4 Mrs Chrupalo did not demonstrate any signs of satisfying the criteria contained in Schedule 1 of the *Mental Health Act 2007*. Therefore, without a guardianship order, the Hospital did not have any power to restrain or require her to remain at the Hospital against her will. The Hospital could not simply refuse to arrange ambulance transportation.

9.5 Professor Ibrahim gave evidence that the approach to Mrs Chrupalo's indication that she wished to self-discharge against medical advice should have been one of negotiation and partnership rather than a more clinical response. Professor Ibrahim considered that if Mrs Chrupalo was not agreeing with further care, then the question that required determination was whether she had capacity. In essence, Professor Ibrahim considered that the issue in Mrs Chrupalo's case was the adequacy of her in-hospital care, rather than the question of her self-discharge.

9.6 It was submitted on behalf of the Western NSW Local Health District (**WNSWLHD**) that the concept of the need for negotiation and partnership seems "infinitely difficult" to Hospital staff faced with a patient with capacity, unable to be involuntarily detained, and who is determined to self-discharge.

9.7 However, as Ms Murie noted, additional discussion and planning is required for a patient such as Mrs Chrupalo who lived without adequate care services in the community, and who had been the subject of intentional or unintentional neglect, in order to ensure the best outcomes for her. This

supports the opinion expressed by Professor Ibrahim especially given the duration of Mrs Chrupalo's admission to hospital, the Hospital's understanding of Mrs Chrupalo's reluctance to enter residential aged care, and Hospital staffing resources able to specifically address post-discharge care for elderly patients.

Failure to make an application for the appointment of a Public Guardian

9.8 Adele Punton, a social worker, considered the possibility of a guardianship application on 3 July 2015. Her progress note from the same date indicates the following:

> Social Welfare: discussed D/ch planning with Jade. Guardianship is NOT an option because Mrs Chrupalo can be seen to be making an informed decision by refusing placement. Would need a Psych assessment supporting inability to make informed decisions + this, based on her MM, would be highly unlikely. Despite all the concerns we have no option but to d/ch home in care of son [original emphasis]

9.9 Ms Punton gave evidence that it was her understanding that a guardianship application could only be made for a person if that person lacked capacity. In her experience, a psychiatric assessment was always required for such an application. In contrast, Catherine Brady, an Aged Care Clinical Nurse Consultant, gave evidence that it was her understanding that a guardianship application could have been made if Mrs Chrupalo was at risk and there were no other options.

The Hospital's current understanding of when a guardianship application may be made

9.10 Dr Geoffrey Hardacre, the Director of Medical Services at the Hospital explained that in 2015, the "*staff were technically able to make such applications. However the threshold for making those applications was perceived to be higher*". Dr Hardacre gave evidence that Ms Punton's views regarding the availability of a potential guardianship application had a strong influence given her experience in guardianship and capacity matters. Further, Dr Hardacre described Mrs Chrupalo's situation as "*an absolutely extreme case*", and that it was the most extreme case of guardianship and capacity that the Hospital had seen between 2015 and 2021.

9.11 Dr Hardacre gave evidence that if Mrs Chrupalo presented today, the Tribunal would immediately be notified. Similarly, Debra Bickerton, the Hospital General Manager, gave evidence that if Mrs Chrupalo were in hospital now, she would like to think that the Hospital would make an application for guardianship. Therefore, it appears that the Hospital now accepts that the option of making an application to the Tribunal for the appointment of a guardian was available in 2015, and such an application should have been made before or after Mrs Chrupalo's discharge.

9.12 Dr Hardacre maintains that even if a guardianship application had been made by the Hospital, it does not necessarily follow that the Tribunal would have made an order appointing a Public Guardian, or made a coercive order that allowed for decisions to be made and enforced, over Mrs Chrupalo's objection, regarding accommodation or medical treatment. This is because at the time of discharge there was no evidence that Mrs Chrupalo lacked capacity. However, the Guardianship Act does not require that a person must lack capacity before the Tribunal will appoint a guardian. Further, even if an order appointing a Public Guardian, or a coercive order, was not made prior to

Mrs Chrupalo's discharge, the Hospital could have provided information that would have been of assistance to the Tribunal and to the Public Guardian.

Whether a guardianship application should have been made

9.13 The following matters are relevant to the question of whether the Hospital should have made an application to the Tribunal for the appointment of a Public Guardian:

(a) Mrs Chrupalo was a person with a physical disability. Due to her inability, she was totally incapable of managing her person, and unable to meet her own personal, hygiene, nutritional, medical and household needs.

(b) Mrs Chrupalo lived in squalor and her poor living circumstances contributed poorly to her physical health.

(c) There were specific concerns raised regarding neglect and elder abuse.

(d) In circumstances where Mrs Chrupalo was bedridden and wholly reliant on her son for care, there were serious risks to Mrs Chrupalo's health and safety if she were discharged home. Mr Clee had stated that, without assistance, he was experiencing difficulties caring for his mother's needs. Further, Mrs Chrupalo had been readmitted only two days after her previous discharge. Indeed, Mrs Chrupalo was found at home, dehydrated, malnourished, with poor hygiene and a urinary tract infection.

9.14 Having regard to each of the above matters, Professor Ibrahim expressed the view that it would have been appropriate for the Hospital to make an application for the appointment of a guardian while Mrs Chrupalo was an inpatient.

9.15 As at 2015, the following provisions of the *Guardianship Act* relevantly applied:

(a) the Hospital, as a person concerned for Mrs Chrupalo's welfare, could have made an application to the Tribunal for the appointment of a guardian under Part 3.

(b) The Tribunal could make a guardianship order in respect of the person, if satisfied that the person is in need of a guardian.

(c) A person in need of a guardian is defined to mean "*a person who, because of a disability, is totally or partially incapable of managing his or her person*".

(d) A person who has a disability includes a person "*who is intellectually, physically, psychologically or sensorily disabled*" and the person "*who is of advanced age*", and "*who, by virtue of the fact, is restricted in one or more major life activities to such an extent that he or she requires supervision or social habilitation*". The expression "*social habilitation*" "*may be taken to refer to a need for services to help a person to be, or become, able to function normally in community with others*".[4]

[4] *P v NSW Trustee and Guardian* [2015] NSWSC 579 at [303].

9.16 The understanding of the staff at the Hospital in 2015 appeared to reflect an understanding of Part 5 of the *Guardianship Act*, rather than Part 3. The former deals with consent to medical and dental treatment, whilst the latter deals with guardianship orders. The NSW Health Policy Directive *Consent to Medical Treatment – Patient Information (PD2005_406)* sets out requirements for the provision of information to patients and obtaining consent to medical treatment. It refers to the circumstances in which substitute consent may be obtained under the *Guardianship Act* and refers to the making of applications of the Tribunal for consent. This reflects a focus on applications to the Tribunal for consent to the carrying out of medical or dental treatment on a patient. However, it does not reflect the circumstances in which a person may more broadly make an application for the appointment of a Guardian where there are concerns for the welfare of the person.

NSW Health Guidelines introduced since 2015

9.17 In 2016, NSW Health introduced *The Guardianship Application Process for Adult Inpatients in NSW Health Facilities (GL2016_026)*. This was later replaced in 2017 by a document of the same name (*GL2017_013*) and remains in effect (**the Guardianship Application Guidelines**). The Guardianship Application Guidelines set out the circumstances in which clinicians should file an application for guardianship. Dr Hardacre gave evidence that, due to recent policy training, staff at the Hospital now have a better understanding of the circumstances which should trigger guardianship applications. Dr Hardacre acknowledged that whilst capacity is an important consideration, it is no longer the primary determinant for determining whether a guardianship application should be made. Dr Hardacre explained that guardianship applications are now regularly made when it is in the best interests of a patient to do so.

9.18 The Guardianship Application Guidelines note that factors such as concerns of neglect, squalid living conditions, and threats to safety may suggest that a person is vulnerable and at risk, and may in turn trigger a clinician to consider the need for a guardianship application. However, the Guardianship Application Guidelines state that the Tribunal must have evidence of incapacity, before appointing a guardian. Incapacity is described as lacking capacity by a person to make their own informed decisions in one or more areas of decision-making. Capacity is defined to mean a person's ability to make decisions about things that affect their daily lives. This emphasis on mental capacity to make decisions does not immediately reflect the circumstances in which the Tribunal may appoint a Guardian under Part 3 of the *Guardianship Act*.

9.19 The Guardianship Application Guidelines emphasise decision-making capacity, rather than whether a "*person who, because of a disability, is totally or partially incapable of managing his or her person*". For example, the description of what must be considered in order to make an application is as follows:

> In order for the Tribunal to consider an application, in must have evidence of diminished capacity. In Australia there are a number of legal tests which determine the person's capacity, depending on the type of decision to be made.

9.20 The Guardianship Application Guidelines also state the following:

> Before appointing a guardian, the Tribunal must have evidence of the following:
>
> 1. Disability – The person has some form of impairment or disability that impacts on their ability to make informed decisions e.g. dementia, brain injury, mental illness or cognitive impairment; and
> 2. Incapacity - the person has been formally assessed as lacking capacity to make their own informed decisions in one or more areas of decision-making; and
> 3. Need - There is a need for a decision to be made or current concerns which would warrant the person having a guardian appointed at this point in time. There are no informal means by which the decision can be made.

9.21 The definition of "*disability*" in the Guardianship Application Guidelines differs from, and is narrower, than that in the *Guardianship Act*. This may be contrasted with the reasons for decision provided by the Tribunal when the interim guardianship order was made on 8 October 2015. In determining that Mrs Chrupalo was a person in need of a guardian, based on the circumstances disclosed by the Hospital documents, the Tribunal held that the medical evidence concerning her cognitive capacity was inconclusive, and that there was no indication that her decision-making capacity was assessed. However, consideration of decision-making capacity or cognitive ability is not necessarily a threshold issue in determining whether a guardian should be appointed as the Guardianship Application Guidelines seem to suggest, which appears to be a common misapprehension.

9.22 A review of the Guardianship Application Guidelines may be warranted in the following respects:

(a) the requirement of mental incapacity for making a guardianship application is inconsistent with the statutory requirements that a person have a disability and be totally or partially incapable of managing his or her person;

(b) The commencement of the Health Guardianship Project in 2019 involving NSW Health, The Public Guardian and the Tribunal. As at March 2021, neither Dr Hardacre nor Ms Bickerton was aware of the project, suggesting a need to raise awareness of the Project with Local Health Districts, particularly in regional areas.

9.23 **Conclusions:** It is accepted that the challenging circumstances of Mrs Chrupalo's case presented the most extreme case of guardianship and capacity seen by the Hospital at the relevant time. This, together with a lack of understanding by Hospital staff regarding the threshold for a guardianship application, contributed to a failure by the Hospital to make an application for guardianship.

9.24 The expert evidence establishes that it would have been appropriate for the hospital to have made a guardianship application for Mrs Chrupalo's given that she was incapable of managing her own person and medical and household needs, that her poor living conditions adversely contributed to her health, there was concern for neglect and elder abuse, and there were concerns regarding Mr Clee's ability to care for her mother if discharged.

9.25 Since 2015 the introduction of the Guardianship Application Guidelines, supplemented by policy training introduced by the Hospital, has improved understanding by Hospital staff as to the circumstances in which a guardianship application can, and should, be made. However, the available evidence also identified a degree of inconsistency within the Guardianship Application Guidelines regarding whether a person's decision-making capacity is a threshold issue before a guardian may be appointed for that person. In addition, the evidence also demonstrated a lack of awareness, at least within the WNSWLHD, in relation to the Health Guardianship Project. Therefore, it is necessary to make the following recommendation.

9.26 **Recommendation 1:** I recommend that NSW Health review *The Guardianship Application Process for Adult Inpatients in NSW Health Facilities (GL2017_013)* in relation to the requirements for making an application under the *Guardianship Act 1987*, particularly in relation to the concept of disability, including physical disability, and the Health Guardianship Project.

9.27 The evidence established that the following training is available in relation to guardianship applications:

(a) Junior Medical Officers at the Hospital must undergo compulsory education as part of their orientation process which covers the Guardianship Act, and relevant policies and procedures.

(b) The Health Education and Training Institute (**HETI**) of NSW Health has developed the Guardianship Learning Pathway which consists of online training in relation to the implementation of the Guardianship Application Guidelines. This training is available through the My Health Learning portal and staff from the Hospital's Aged Care Services, Mental Health Services for Older People, social workers and nursing staff have completed the Guardianship Learning Pathway.

(c) The Public Guardian has held an information session on her role and guardianship within the Local Health District.

9.28 **Conclusion:** The evidence establishes that no specific training at the Hospital has been made available in relation to guardianship applications and the Health Guardianship Project. As noted above, this is largely due to lack of awareness within the Local Health District as to the commencement of the Health Guardianship Project. Further, the training that is available to Hospital staff is elective and it is unclear whether other clinical staff at the Hospital, who have not completed such training as part of their orientation process, have undertaken it. Having regard to these matters, necessary to make the following recommendation.

9.29 **Recommendation 2:** I recommend that Dubbo Base Hospital introduce procedures and provide training to staff in relation to guardianship applications that set out: (a) the circumstances in which it is necessary and appropriate to make an application; (b) who is responsible for coordinating such an application; (c) the requirements for guardianship applications including the reports to be provided to the NSW Civil and Administrative Tribunal and appointed guardian to support the application and guardianship process (whether a private guardian or the Public Guardian is appointed); and (d) coordination with the Office of the Public Guardian in relation to the Health Guardianship Project.

Adequacy of assessment by Dr Smith

9.30 The assessment performed by Dr Smith was an assessment of whether Mrs Chrupalo had capacity to make the decision to discharge herself against medical advice and decline placement in respite and residential care. Dr Smith viewed the question of whether Mrs Chrupalo had capacity to discharge herself as part of the same decision an assessment as her capacity to refuse residential care.

9.31 In order to assess a patient's decision-making capacity to self-discharge, a person performing such an assessment needed to understand the following:

(a) The risks to the patient in order to assess whether there were any serious risks that the patient was not identifying;

(b) What services were going to be available to the patient on discharge; and

(c) The circumstances of the patient's family and carer.

9.32 The following details would be relevant to any assessment of a patient's capacity:

(a) An overview of the patient's clinical situation;

(b) the risks and benefits of different courses of action;

(c) what efforts have been made to assess the patient's capacity to date;

(d) what information the patient has been provided with; and

(e) the referring doctor's view on whether or not the patient has decision-making capacity.

9.33 On 7 July 2015 Dr Smith concluded that Mrs Chrupalo was competent to refuse services and to discharge herself. Associate Professor Christopher Ryan, the Director of Consultation-Liaison Psychiatry at Westmead Hospital, was engaged on behalf of Dr Smith to provide an expert report, and also gave evidence during the inquest. Associate Professor Ryan considered that, on the restricted information available to Dr Smith, it seemed more likely than not that Mrs Chrupalo had the ability to understand the relevant information, and the ability to use and weigh it. Professor

Ibrahim considered that there was insufficient documentation to make a determination as to whether the assessment conducted by Dr Smith was sufficient to determine capacity and/or permit Mrs Chrupalo to self-discharge against medical advice. In particular, Professor Ibrahim noted that there was no initial comprehensive cognitive assessment or reassessment of cognition, and no formal diagnosis regarding Mrs Chrupalo's cognitive impairment. Professor Ibrahim noted that there was insufficient objective, documentary evidence "*to support the notion that Mrs Chrupalo had demonstrated her capacity was intact for decision making*".

9.34 There were a number of material deficiencies in the information available to Dr Smith, namely:

(a) Dr Smith did not speak with any members of Mrs Chrupalo's clinical team, nurses or Ms Murie;

(b) Dr Smith did not have information as to the concerns raised by ambulance officers and medical staff that Mrs Chrupalo had been the subject of neglect;

(c) Dr Smith was not aware that concerns had been raised by ambulance officers with the hospital on a prior admission, and requests made that Mrs Chrupalo be the subject of an assessment or review;

(d) Dr Smith did not have access to records of the previous admission;

(e) Dr Smith did not speak to Ms Murie who conducted Mrs Chrupalo's first ACAT assessment. Ms Murie's progress notes raise concerns as to Mrs Chrupalo's capacity. Ms Murie explained that Mrs Chrupalo was not realistic about the fact that she was returning to an environment that she was struggling to live in, had two admissions close together and was not doing well. Dr Smith should have spoken to Ms Murie, or sought access to the records of the ACAT assessment. Dr Smith gave evidence that she could have spoken with Ms Murie, or could have requested a copy of her assessment, but not in the timeframe that was available to her;

(f) Dr Smith expected that Mrs Chrupalo would be provided with some form of home care service. However she had not thought through what would happen if a high level of care was not immediately available and there was a period of time in which Mrs Chrupalo would not have services available to her. However, Dr Smith expressed the view that she did not think the absence of available services would dramatically change her assessment;

(g) Dr Smith accepted that if she had been aware that Mrs Chrupalo had previously made decisions that put herself at risk and may have caused herself harm, this may have had some bearing on Dr Smith's consideration of Mrs Chrupalo's ability to make decisions in similar circumstances;

(h) Dr Smith did not retain records of her MMSE examination;

(i) Dr Smith was aware of concerns that Mrs Chrupalo was alcohol dependent. Dr Smith accepted that the MMSE test is not specific to executive functions and that it would not reflect domains that are affected by alcohol dependency. Dr Smith also accepted that it would have been beneficial to further assess due to this executive functioning;

(j) Dr Smith did not speak with Mr Clee in the course of conducting her capacity assessment. However, Dr Smith accepted that ideally, she would have been in a position to learn a lot more about Mr Clee. Despite knowing that Mrs Chrupalo had been found in faeces, had poor nutrition, was dehydrated, Dr Smith said that she had no evidence of Mr Clee's failure to adequately care for Mrs Chrupalo, or his capacity. Dr Smith said that she knew that Mr Clee was stressed and had sought help, but stated that no other concerns had been articulated to her about Mr Clee. Dr Smith gave evidence that if she had known that Mr Clee had given a nurse the impression that he was not happy about losing his mother's money to someone else, and said that he could manage a soon as money was mentioned, this was a matter that might have had a bearing in her assessment;

(k) Dr Smith did not have any particular understanding provided by the Hospital on what services were available to older persons upon discharge.

9.35 There were also a number of limitations associated with Dr Smith's capacity and ability to conduct a more detailed or different assessment:

(a) The assessment was not of a kind that was commonly performed by Dr Smith, and she could not recall whether she had performed one prior to 2015. Dr Smith did not have access to support within the Hospital from a geriatrician or psychogeriatrician.

(b) While the remainder of the assessment could have been deferred to the next day, Mrs Chrupalo had indicated that she proposed to discharge herself on the day of assessment. Given her usual workload, Dr Smith could not be certain of being able to return to complete the assessment. Although Dr Smith accepted that it was open to her to indicate additional time was required to conduct the assessment, she understood that the discharge of a person should not be delayed unless they were made an involuntary patient or fell within the provisions of the *Mental Health Act*. Similarly, Professor Ryan expressed some caution in enlisting the support of the clinician team, which might have delayed the assessment, so as not to deceive Mrs Chrupalo.

(c) The scope of the request made of Dr Smith, and the time available to her, does not appear to have allowed for a diagnosis of Mrs Chrupalo's known cognitive impairment.

9.36 On 30 June 2015 Mrs Chrupalo indicated that her ultimate desire was to return home. This placed the Hospital on notice that a capacity assessment may be required. Further, Ms Punton's progress note entry of 3 July 2015 referred to discharge planning, which should have represented an additional prompt for the Hospital to consider the need for a capacity assessment.

9.37 **Conclusion:** The evidence establishes that there were a number of limitations associated with Dr Smith's assessment of Mrs Chrupalo's capacity. Dr Smith did not have available to her information regarding previous concerns raised on behalf of Mrs Chrupalo, or information from previous admissions regarding Mrs Chrupalo's decision-making in similar circumstances. Further, some of these limitations were time sensitive and precluded potential options such as deferral of the assessment, and diagnosis of Mrs Chrupalo's cognitive impairment from being performed.

9.38 By 7 July 2015 the Hospital was aware that discharge planning involving the need for a capacity assessment was required in circumstances where Mrs Chrupalo had earlier expressed a desire to return home. Dr Hardacre accepted that the capacity assessment that was performed was rushed and done at short notice. Therefore, if discharged planning had occurred in a more timely manner it may have ameliorated some of the limitations described above.

9.39 Without this time pressure, further steps may have been able to have been undertaken. In addition, it might have allowed for a number of assessment tools to be utilised including the following: clinical assessment, gathering of collateral information, the MMSE, the Roland Universal Score and the Addenbrooke Score (although Dr Smith considered that the latter would not have added any benefit above the MMSE).

Failure to identify the underlying cause and degree of cognitive deficit

9.40 Professor Ibrahim considered that a two-step process ought to have been undertaken: first, more effort should have been applied to identify the underlying cause and degree of Mrs Chrupalo's cognitive deficit and second, to address any concerns associated with the capacity assessment. Relevantly, Professor Ibrahim explained that if the underlying cause of the cognitive impairment could be understood, then it would be possible to know what deficits and strengths to look for, whether the condition is temporary, long-standing or chronic, and whether there is a reversible component for which treatment should be provided. Ultimately, Professor Ibrahim considered that there was too much emphasis on Dr Smith's opinion, and the decision was not reviewed, discussed in detail or documented.

9.41 In contrast, Professor Ryan noted that Dr Smith was not tasked with providing an opinion on Mrs Chrupalo's diagnosis and that in any event such a diagnosis was unnecessary for the purpose of assessment. In addition, Professor Ryan noted that there was some evidence of a possible underlying cause for cognitive impairment (alcohol-related brain injury) but considered that even when finding a cause, the effect on cognition will be variable in any event. Finally, Professor Ryan expressed the view that there was no evidence of executive dysfunction. As to this last matter, Professor Ibrahim considered that executive dysfunction could not be identified unless it was formally tested for, and in any event believed there was evidence of dysfunction.

9.42 **Conclusion:** Whilst it is accepted that some evidence was available to the hospital as to the underlying cause of Mrs Chrupalo's cognitive deficit, the evidence of Professor Ibrahim establishes that it would have been useful to better understand the nature and degree of this deficit. Again, it appears that the time pressures described above did not allow for such efforts to be undertaken.

Availability of additional qualified assessors

9.43 In 2015, the Hospital did not have available to it a geriatrician, psychogeriatrician, neuropsychologist or neurologist who could have conducted or contributed to the capacity assessment. Whilst consultation with a geriatrician at Royal Prince Alfred Hospital was available, this would not have involved a geriatric assessment. An occupational therapist could have

conducted a cognitive assessment of Mrs Chrupalo. However the occupational therapist at the Hospital may not have conducted many assessments of this kind.

9.44 Since 2015, the availability of personnel and services to assist with capacity assessment has improved. The Hospital has employed an inpatient neurologist, recently advertised for a geriatrician, and has received approval to develop a "*consultation liaison team*" including a full-time trainee psychiatrist and part-time consultation liaison psychiatrist. Further, the Hospital now has a telehealth psychiatry service available to it.

9.45 Whilst the Hospital does not have access to a neuropsychologist, clinicians are able to contact a geriatric medicine service nurse specialist for guidance, and a psycho-geriatrician at Orange/Concord hospital who is available for support. A geriatric medicine and Complex Care Service within the WNSWLHD can manage consultations with a specialist physician geriatric medicine.

The absence of policies in relation to the assessment of decision-making capacity

9.46 In July 2015 the Hospital did not have in place any policies in relation to the assessment of decision-making capacity. To date, no specific policy exists in relation to capacity assessments. However the Guardianship Application Guidelines and the NSW Attorney General's Capacity Assessment Toolkit contain some guidance regarding the making of capacity assessments. The Guardianship Application Guidelines note that comprehensive, interdisciplinary assessments need to be completed to assist in establishing a person's capacity. These assessments may include medical assessments, completed cognitive screening tools, a psychologist or clinical neuropsychologist assessment, Allied health assessments (occupational therapy, physiotherapy, dietician, social work and speech pathology if appropriate) and functional assessments. Dr Hardacre indicated that this type of assessment can either be multiple assessments from different disciplines within the Hospital, or one person using various assessment tools.

Reliance on the capacity assessment within the context of the wider approach the Hospital could have taken

9.47 Professor Ibrahim queried whether the approach taken by the Hospital should have been one of negotiation and partnership, rather than a more narrow, clinical response as to whether Mrs Chrupalo was agreeing to further care or seeking discharge against medical advice. Professor Ibrahim considered that the Hospital effectively treated the discharge against medical advice as a basis for ceasing care when it was clear that Mrs Chrupalo required ongoing care, without fully engaging with Mrs Chrupalo and Mr Clee regarding the need for further care and exploring with them the alternatives for providing continued care, within a hospital or at home.

9.48 There is evidence that the Hospital took steps through the family meeting, the ACAT assessment, the OT assessment and various conversations between medical staff and that Mrs Chrupalo and Mr Clee to promote this negotiation and partnership model. However, it appeared to break down at the point where Mrs Chrupalo was discharged. This appears to have been due to a lack of ownership in arranging services and further outpatient care when it became clear that Mrs

Chrupalo would not agree to permanent residential care and ACAT refused funding for a Home Care Support package because of Mrs Chrupalo's high needs.

9.49 **Conclusion:** Overall, the evidence identified deficiencies in the capacity assessment performed by Dr Smith. Although it would have been preferable for further steps to have been taken, or more assessments to have been conducted, the practical difficulties facing Dr Smith must also be acknowledged. The evidence of Professor Ryan supports a conclusion that Dr Smith's assessment was conducted in a manner consistent with the views of other clinicians of similar expertise. Further, the Hospital now has further resources available to it. However, given the absence of any specific training or policy regarding capacity assessments, it is necessary to make the following recommendation.

9.50 **Recommendation 3:** I recommend that Dubbo Base Hospital introduce procedures and provide training to staff for capacity assessments that: (a) set out the appropriate circumstances where such assessments should be undertaken; (b) identify who the appropriate health practitioners and/or clinicians may be depending on the nature of the assessment; (c) identify the appropriate range of assessment tools are available; (d) require early referral for capacity assessments, pre-discharge, to ensure adequate time for undertaking an assessment; (e) identify the available options for a capacity assessment or other negotiator pathways that are available where there is a possibility of discharge without medical advice; (f) ensure that, if there is a referral to a clinician for assessment, the purpose(s) of such assessments are clearly identified and documented and all relevant information is made available to the clinician conducting the assessment; (g) ensure that ultimately the assessment is undertaken within a multidisciplinary framework; and (h) require documentation of any assessment, including any tests undertaken.

Availability of alternatives to discharge

9.51 Professor Ibrahim identified a number of steps that were available to the Hospital as alternatives to discharge:

(a) Negotiating an extended inpatient stay;

(b) Enlisting the support of Mr Clee to encourage his mother to remain as an inpatient;

(c) Consulting with social worker or a psychologist;

(d) Changing the clinical team to allow for a "fresh start";

(e) Seeking a second opinion or further cognitive assessment;

(f) Escalating the matter to senior executive clinical staff or management;

(g) Seeking legal advice; and

(h) Considering a short period of day leave.

9.52 However, there were a number of limitations associated with these possible alternatives. First, a number required Mrs Chrupalo's consent. Second, once Mrs Chrupalo had expressed a desire to discharge against medical advice, there were time limitations in exploring possible alternatives once Mrs Chrupalo was assessed as having capacity. Professor Ibrahim acknowledged these limitations, but queried whether the Hospital had exhausted its powers of persuasion and could have done more in terms of being considerate of her needs, rather than simply stating or accepting the fact of capacity.

9.53 Professor Ibrahim also considered that a multidisciplinary meeting could have been held to explain the situation and importance of ongoing care and treatment. Whilst a family meeting was held on 24 June 2015, it would have been preferable for a similar meeting to be arranged prior to discharge, although no such meeting was in fact arranged. With reference to the time limitations prior to discharge, Dr Hardacre accepted that from at least 3 July 2015 when discharge was imminent, it would have been ideal for such a meeting to have been arranged.

9.54 **Conclusion:** The evidence establishes that the Hospital had available to it alternatives to discharge, and that these alternatives should have been implemented before or after Mrs Chrupalo's discharge. These alternatives included: adopting a more conciliatory approach to negotiate an extended inpatient stay, enlisting the support of Mr Clee to encourage her mother to remain as an inpatient, making an urgent application to the Tribunal; giving early consideration to the need for an assessment of capacity or cognitive assessment; better discharge planning and arranging services to be available upon discharge; and identifying and responding to possible neglect and abuse.

10. What additional steps, if any, could the Hospital have taken to ensure that Mrs Chrupalo received adequate care and medical treatment after 8 July 2015?

10.1 Dr Smith recorded in Mrs Chrupalo's progress notes that her capacity "*would need to be reassessed regularly through, especially if she fails to keep the commitment to allow services in*". Dr Smith expected that this specific advice would be included within the discharge summary for other treating professionals to see. While Dr Smith's advice carried significant force, it was not included in Mrs Chrupalo discharge summary. Ms Bickerton accepted that this was an omission.

Responsibility for discharge planning and arranging services upon discharge

10.2 For a patient in Mrs Chrupalo's circumstances it was critical to have support in place at discharge to prevent patient decline and carer strain, resulting in a return to hospital. Instead, Mrs Chrupalo was discharged home without having been referred to any services to provide support. Mrs Chrupalo and Mr Clee had indicated their willingness on a number of previous occasions (including on 19 June 2015, 21 June 2015, 24 June 2015, 1 July 2015 and 6 July 2015) to receive services at home to assist with this care.

10.3 Ms Bickerton gave evidence that she had spoken with staff who were "*adamant*" that Mrs Chrupalo had refused "*everything*" and "*all services*". However this refusal is contrary to the written records. Therefore, there was insufficient identification as to who was responsible for discharge planning, and mistaken assumptions as to that responsibility.

10.4 In addition, there were assumptions made by various Hospital staff that services were in fact being arranged for Mrs Chrupalo. However there is no clear identification of whose responsibility it was to arrange such services:

(a) Ms Sparkes was the nurse manager in the AACRS team at the Hospital. Ms Sparkes' principal role was assessing all aged inpatients with complex care needs, in order to coordinate discharge planning and referral to community-based care services. On 16 June 2015, during the first admission, Ms Sparkes discussed permanent residential aged care with Mrs Chrupalo and Mr Clee and they adamantly refused placement in aged care. On 22 June 2015, during the second admission, Ms Sparkes spoke with Mrs Chrupalo about discharge and noted that home services were required. It is unclear why Ms Sparkes did not commence organising support services at home from that point, at least as a short-term measure, when she was aware from Mrs Chrupalo's earlier discussion that permanent residential aged care would likely be refused, and that home care packages were very difficult to get at the time.

(b) Ms Brady was an Aged Care Clinical Nurse Consultant at the Hospital. She was asked to see Mrs Chrupalo as Ms Sparkes was away. Ms Brady did not recall being asked to organise any further services for Mrs Chrupalo on discharge. She expected that someone would have referred Mrs Chrupalo to her or called her if she was expected organise such services.

(c) Ms Punton stated in a 3 July 2015 progress note entry that the Hospital would look at arranging discharge to allow "*for preparation of a package*", referring to a temporary package for home

care assistance, and assistance with cooking and shopping. Ms Punton expected that someone at the Hospital would have been arranging those referrals prior to discharge.

10.5 Although Hospital staff recognised that services were required for Mrs Chrupalo, and assumed that they would be put in place, no services were actually arranged. Therefore, there was no clear understanding by those making assessments or decisions as to what services were or were not available to Mrs Chrupalo, or were able to be arranged. Further, there was also no clear understanding as to whose responsibility it was to arrange for such services.

10.6 The Hospital was likely aware from 24 June 2015, and at least aware from 3 July 2015, that Mrs Chrupalo was opposed to permanent residential aged care, but would accept support services at home. As noted above, the Hospital was on notice that Mrs Chrupalo's discharge was imminent. Despite this, no arrangements were made for support services to be available to Mrs Chrupalo at home. Further, even after discharge the Hospital could have taken steps to arrange services (and did do so) by the making of an application for an ACAT assessment, with consent.

10.7 The Hospital took the following steps:

(a) Providing the carer respite number to Mr Clee;

(b) Requesting the First ACAT Assessment whilst Mrs Chrupalo was an inpatient;

(c) Requesting the Second ACAT Assessment after Mrs Chrupalo had been discharged, specifically seeking home care packages; and

(d) Ms Sparkes stated that, with Mrs Chrupalo's consent, she made a referral to the Special Mental Health Nurse for Older People (**SMHNOP**), however it is unclear if this took place as the Hospital and the SMHNOP have no records of the referral.

10.8 As for the availability or non-availability of home or community care services for Mrs Chrupalo:

(a) The First ACAT Assessment determined that Mrs Chrupalo was not eligible for a home care package because of her high-level need. However the Second ACAT Assessment was organised following her discharge with the knowledge that it would not meet her needs but that it was better than providing Mrs Chrupalo with no assistance at all.

(b) The Hospital witnesses considered that Mrs Chrupalo was not eligible for ComPacks services, which were short-term services that included domestic care, personal care, transport and social support. If an application was submitted for Mrs Chrupalo, it may have been rejected as not suitable, given her high care needs.

(c) Ms Brady was unaware of any other services that would support Mrs Chrupalo's need, short of a high care package.

(d) The NSW Transitional Aged Care Package (**TACP**) may have been available, however this required an ACAT assessment to determine a patient's suitability. Ms Sparkes did not believe

that Mrs Chrupalo would be eligible for TACP because she was not mobile, and did not arrange an ACAT assessment for a TACP.

(e) A package could also have been organised by the Hospital under the Home and Community Care (**HACC**) program, which was transitioned into the Commonwealth Home Support Program on 1 July 2015. Ms Sparkes said that the Hospital applied for packages for patients made up of single services from different service providers, although she did not consider that this would have been sufficient for Mrs Chrupalo, presumably in the long term. Ms Wheeler arranged wound care and occupational therapy for Mrs Chrupalo under the HACC program after conducting the Second ACAT Assessment for the home care package on 16 July 2015.

(f) Following the Second ACAT Assessment, the Hospital was not informed of the approval of Mrs Chrupalo for Level 3 or 4 Packages. The Hospital did not have an ongoing role, even though it was the referrer, in relation to the arrangement of those services.

(g) The Hospital could have made a referral to a general practitioner in order for a geriatrician to provide an assessment. Ms Bickerton emphasised that this was something that ACAT could also do.

(h) If Mrs Chrupalo was approved for Level 3 or 4 services through an ACAT assessment, those services could have been arranged, although it is likely that there would have been a wait for those services. However, single services could have been sought while awaiting that package.

(i) It is unclear whether the Hospital could have arranged single services in 2015, such as domestic personal care, cooking assistance under TACP or ComPacks. The ability to arrange such services arose possibly after the transition from NSW based services to the Commonwealth My Aged Care Scheme. However, Ms Punton stated that packages such as home care, meals on wheels and transport could be arranged by making a referral under the HACC prior to discharge, and those services would make an appointment to visit Mrs Chrupalo at home.

(j) The Hospital could have arranged for a community care referral for wound care prior to discharge.

10.9 **Conclusion:** Given that the progress notes record that "[f]rom physio and medical standpoint, [Mrs Chrupalo] is not currently safe for discharge", it is troubling that no services were arranged, or attempts were made, for Mrs Chrupalo upon discharge. The options available to the Hospital to refer Mrs Chrupalo for home services may have been limited given her high-level and complex needs.

10.10 However, there appeared to be differing levels of knowledge within the treating team as to the available options, and there were different views as to whether any services were in fact able to be arranged for Mrs Chrupalo. When it became clear that Mrs Chrupalo and Mr Clee would not accept permanent residential care, the Hospital did not develop a strategy to ensure that her short and long-term needs were met following discharge from hospital. Therefore, it is necessary to make the following recommendation.

10.11 **Recommendation 4:** I recommend that Dubbo Base Hospital review procedures for discharge against medical advice and advance discharge planning to ensure that the health and welfare of patients is protected with adequate post-discharge support that is consistent with the Hospital's duty of care.

Failure to properly identify and respond to neglect and possible elder abuse

10.12 According to the NSW Health Policy Directive, *Identifying and Responding to Abuse of Older People,* elder abuse may be defined as "*a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person*". It can include financial abuse, psychological abuse, physical abuse, sexual abuse or neglect.

10.13 There was information available to the hospital which indicated that Mrs Chrupalo may have been the subject of elder abuse, carer neglect or self-neglect:

(a) Paramedics expressed concerns for Mrs Chrupalo's welfare on her admission on 8 January 2015. Mrs Chrupalo was very unkempt, her clothes and skin were dirty, and she admitted to drinking alcohol and smoking in bed. It was noted that Mrs Chrupalo's home was in a very poor state, filthy and dishevelled, and that the bed was very dirty. Further, Mrs Chrupalo reported that Mr Clee drank large amounts of alcohol.

(b) On Mrs Chrupalo's admission to the Hospital on 12 June 2015, paramedics again reported that Mrs Chrupalo's house was unkempt and very dirty, and that she was found lying in urine-stained sheet and faeces.

(c) Progress notes made by Hospital clinicians referred to neglect, carer neglect and self-neglect.

(d) Following Mrs Chrupalo's discharge from the Hospital on 17 June 2015, paramedics were again called to Mrs Chrupalo's house. The paramedics contacted the hospital and requested a review of some kind due to Mrs Chrupalo's very poor living conditions at home. The hospital records note that a degree of carer neglect may have been occurring.

(e) On Mrs Chrupalo's readmission to hospital on 19 June 2015, paramedics again reported that she was found in a pool of her own faeces, and was poorly kept.

10.14 Other matters relevant to possible carer neglect or elder abuse included:

(a) Ms Murie, who conducted the First ACAT Assessment, clearly considered that there was neglect occurring. However, this is not recorded in Ms Murie's progress notes, and the detail of the ACAT assessment was not provided to the Hospital.

(b) Ms Punton stated that when Mr Clee came to appointments, he was usually intoxicated. This is not recorded in the Hospital's records. Ms Punton had concerns that Mrs Chrupalo was being neglected, but stated that Mrs Chrupalo gave an assurance that everything was OK.

(c) Ms Sparkes raised concerns on the basis that she had the distinct impression that residential care or respite care were refused by Mr Clee due to the cost of those services. However, Ms Sparkes did not record this impression in the progress notes and did not speak with anyone regarding this concern. Ms Sparkes gave evidence that she was aware that Mrs Chrupalo could possibly have been a risk, but she stated that Mr Clee could manage her quite well.

10.15 Professor Ibrahim opined that there should have been a greater investigation into the home circumstances and possibility of elder abuse being perpetrated by Mr Clee, noting that there was a high probability that Mrs Chrupalo was living in squalor.

10.16 **Conclusions:** Overall, there was an under identification of the possibility of elder abuse by Hospital staff, particularly during Mrs Chrupalo's second admission. One of the likely reasons for this is a failure to recognise that neglect constituted elder abuse. For example, Ms Bickerton was of the view that there was no indication of elder abuse, whilst at the same time accepting that it was "*very clear that [Mrs Chrupalo] was neglected either by carer or self-neglect*".

10.17 Another theme that continued throughout the evidence of Hospital staff was intentional self-neglect and refusal of services by Mrs Chrupalo. For example, Ms Bickerton indicated that Mrs Chrupalo "*chose to be bedridden*". However, there is no evidence that these issues were medically or psychologically examined, nor were they the subject of expert opinion at the inquest.

10.18 Since 2015, there have been improvements in the Hospital's processes for identifying and responding to elder abuse. In January 2020, NSW Health introduced a Policy Directive, *Identifying and Responding to Abuse of Older People*. This was a likely brought to the attention of staff through the patient safety officer circulating new policies and directives, mainly to Heads of Department and Nurse Managers, who raised new policies at ward meetings, or through HETI training. However, it does not appear that there has been any specific training for staff on elder abuse identification. Therefore, the following recommendation is necessary.

10.19 **Recommendation 5:** I recommend that Dubbo Base Hospital introduce written procedures and provide training in relation to elder abuse, neglect and exploitation of patients, which provides guidance on the indicators, the means of responding, and the duty of care and responsibilities of staff. Such procedures and training would refer to the procedures relating to appointment of the Public Guardian or a hospital guardian, the availability of assistance from the Ageing and Disability Commission and the operation of the Health Guardianship Project.

10.20 It was submitted on behalf of the WNSWLHD that the online training modules available through HETI appear to cover most aspects of the guardianship application process, including the roles and responsibilities of staff, and the requirements for the application. However, the submissions also acknowledge that it is unclear whether these training modules address a number of relevant matters, including: the roles and responsibilities for coordinating guardianship applications, the requirements for an application, the manner in which the guardianship process should be coordinated with the Public Guardian, the available options for a capacity assessment or other negotiated pathways, the duty of care and responsibilities of staff in managing elder abuse, neglect and exploitation of patients, and steps to be taken to ensure the patient has adequate post-discharge support.

10.21 Accordingly, it was appropriately submitted that the WNSWLHD will give strong consideration to implementing all of the recommendations made in relation to the Hospital, and implement any further revisions to the Guardian Application Guidelines following finalisation of the review being carried out by NSW Health.

11. Was the decision by Lourdes to discharge Mrs Chrupalo from their services on 18 September 2015 appropriate?

11.1 There are four matters relevant to consideration of whether the decision by Lourdes to discharge Mrs Chrupalo from their services was appropriate.

11.2 First, Ms Green gave evidence that it was her understanding that Mrs Chrupalo "*discharged herself*" from Lourdes services on 18 September 2015. Ms Green indicated that she reached this understanding because:

(a) Lourdes staff had been told by Mr Clee that Mrs Chrupalo wanted to be left alone;

(b) There were no responses to knocks on Mrs Chrupalo's door; and

(c) Lourdes considered that a guardianship order was the only way that services could be put into place, because Mrs Chrupalo had refused all other help that had been offered.

11.3 The above suggests that Ms Green accepted that representations made by Mr Clee to Lourdes nurses were capable of representing Mrs Chrupalo's wishes to "*self discharge*". However, this is difficult to reconcile given that Ms Green made an application to the Tribunal on 26 August 2015 which stated the Lourdes were "*concerned about Mr Clee's (Mrs Chrupalo's carer) capacity due to his alcohol abuse*".

11.4 Progress notes for 17 September 2015 record that Mr Clee told Lourdes nurses that he and Mrs Chrupalo were "*having a bad day*" and that "*Mum would be happy to see you tomorrow […] There's too much going on, too much intervention and he want to be left alone*". Whilst this statement was internally inconsistent, it did nonetheless contain an invitation for Lourdes staff to return to Mrs Chrupalo's home the following day. Although failed attempts were made to access Mrs Chrupalo on 15, 16, 17 and 18 September, the Lourdes nurses did not speak with Mrs Chrupalo on any of these occasions. Further, no statement was made at a later date that Mrs Chrupalo and Mr Clee did not want Lourdes' services. Also, during the time that Mrs Chrupalo was a patient of Lourdes there was a recurrent practice of failed attempts to access Mrs Chrupalo before access was eventually permitted. For example, on 3 July 2015 there was a failed access attempt, followed by four subsequent visits.

11.5 As to the invitation extended by Mr Clee, Ms Green indicated that the Lourdes community nursing team had reached the conclusion that this was not genuine, and that Mrs Chrupalo no longer wanted to receive community nursing. This conclusion, according to Ms Green, was based on the relationship between Lourdes and Mrs Chrupalo and Mr Clee which had "*progressively soured*", due to an escalation in interventions, including police conducting a home visit and the Tribunal application. However, the Lourdes community nursing team did not test or check the genuineness of Mr Clee's invitation directly with Mrs Chrupalo herself.

11.6 It should be noted that on 4 September 2015 Ms Green provided Mrs Chrupalo with the Tribunal documents and Mrs Chrupalo responded, "*Get out and don't come back*". However, despite this, Mrs Chrupalo's statement was not seen as a self-discharge at the time. Indeed, Lourdes nurses saw

Mrs Chrupalo on the same day, and again on 8 and 11 September, with no difficulties in attending. Ms Green accepted that Mrs Chrupalo's statement was expressed in the context of an issue with guardianship, and not the provision of community nursing services.

11.7 Professor Ibrahim opined that it was not reasonable for Lourdes to conclude that Mrs Chrupalo had voluntarily discharged, noting evidence of self-neglect, as well as elder abuse and neglect by her carer:

> [I]t is not reasonable to conclude that an absence of response to requests for health services is evidence that a person has made a voluntary and considered decision to separate from the service. There are many plausible and reasonable explanations for absence of response from cognitively intact patients requiring home care and treatment […] There is a much greater onus on the health service to demonstrate a patient has made an informed decision to self-discharge when managing a person who has cognitive impairment or, where here there is evidence of self-neglect or elder abuse. These risk factors were present with Mrs Chrupalo.

11.8 Second, Ms Green gave evidence that Lourdes received a referral for wound care and occupational therapy. However, Ms Green said that she understood that at the time of discharge, Mrs Chrupalo's wounds had healed and occupational therapy recommendations had been refused by Mrs Chrupalo. Therefore, Ms Green considered that Lourdes continued to provide nursing care which was not required for psychosocial reasons. However, in the guardianship application, Ms Green referred to a pressure area that had not healed and that Mrs Chrupalo was at risk of developing sepsis. Ms Green gave evidence before the Tribunal that there was no need for further nursing services in relation to the pressure wound.

11.9 Third, Ms Green gave evidence that another basis for discharge was "*resource allocation*". This was raised for the first time during the inquest. It does appear that Mrs Chrupalo was discharged in part because Lourdes was frustrated by the difficulties in gaining access to Mrs Chrupalo, and the squalid conditions in which nursing staff were required to provide services.

11.10 Fourth, Ms Green gave evidence that Lourdes had assumed a psychosocial role, and that staff felt there was a need to go and care not only for Mrs Chrupalo, but because Mr Clee's actions may have represented an impediment to Mrs Chrupalo receiving the support that she needed. The notes taken by Lourdes staff indicate that Mrs Chrupalo was attempting to communicate with them but that Mr Clee (if he was home) was not providing access.

Failure to seek Mrs Chrupalo's, rather than Mr Clee's, views

11.11 Kathryn McKenzie, Director of Operations for the NSW Ageing and Disability Commission (**Commission**), explained that it is a common scenario for a service provider to accept or act upon a decision made by a family member of a person under care, despite that family member's lack of authority to make the decision. The decision of the family member may not reflect that of the person under care.

11.12 Professor Ibrahim expressed a similar view, noting that Lourdes had not ascertained Mrs Chrupalo's views directly which would have been essential given the concerns expressed about Mr Clee's cognitive impairment and carer stress. In effect, this resulted in Lourdes relying upon Mr

Clee "*as the gatekeeper*" and decision-maker, in circumstances where there were concerns about his "*diminished capacity due to alcohol abuse*" as at 26 August 2015 when an application for guardianship was made.

11.13 In the circumstances, it may have been appropriate for Lourdes to:

(a) Involve the police to gain access in order to ascertain Mrs Chrupalo's wishes as to discharge or the continuation of services. Ms Green gave evidence that whilst this might have assisted with access, she did not believe that it would have "*changed anything*".

(b) Give Mr Clee some breathing space before deciding that it was futile to keep offering treatment. Whilst Mr Evans accepted that it was open to do this, Ms Green stated that this would be "*going above and beyond what [they] normally would do*". The evidence suggests that if Mr Clee had been given some breathing space he may have been more receptive. The evidence indicates there was a cycle of responsiveness and unresponsiveness involving Mr Clee. When Mr Clee indicated on 17 September 2015 that Mrs Chrupalo would be happy to see nursing staff the following day, no agreed time was negotiated for this to occur.

(c) Sought input from Mrs Chrupalo's GP before discharge (although Ms Green expressed the belief that the GP was not actively involved).

11.14 Ms Robinson gave evidence that Lourdes should not have discharged Mrs Chrupalo while the guardianship application had not yet been decided. She indicated that the duty of care is not abrogated by the making of a guardianship application.

11.15 Professor Ibrahim expressed the view that Lourdes should not have ceased providing services, given that Mrs Chrupalo had multiple, substantial clinical, social and welfare issues that remained unresolved, and her health and well-being were compromised.

11.16 **Conclusion:** Lourdes should not have discharged Mrs Chrupalo, until at least the Public Guardian was appointed, having regard to the following matters: (a) Mrs Chrupalo never directly communicated to Lourdes that she did not want to receive community nursing care; (b) As at 18 September 2015, as described by Lourdes in its guardianship application, there remained a material risk that Mrs Chrupalo would develop sepsis; (c) Mrs Chrupalo was dependent on Mr Clee for all home care and facilitating outside assistance in circumstances where Lourdes was of the view that he had diminished capacity due to alcohol abuse; (d) Lourdes do not provide Mrs Chrupalo or Mr Clee with any notice of its intention to discharge Mrs Chrupalo from its service before the decision was made to do so; (e) Mrs Chrupalo had no means to communicate, independent of Mr Clee, directly with Lourdes to seek readmission into its service; and (f) As at 18 September 2015 , the grave risks identified by Ms Green in her guardianship Application had not in any way abated.

Improvements to policies and procedures since 2015

11.17 Since 2016, Lourdes has developed a new policy regarding discharge of clients from community nursing. This policy addresses a patient's right to withhold consent and refuse treatment, and

counselling that should be provided to a patient in such circumstances. However, the following aspects of the policy are noted:

(a) Whilst a patient can be discharged if they "*refuse*" entry and "*preferably signs a discharge form*", the policy does not stipulate that such refusal must be the action of the patient, and not someone else;

(b) The policy does not emphasise the need to obtain an understanding from a patient directly as to their wishes, rather than rely on communications, acts or omissions of a family member or carer;

(c) The policy does not provide for a patient to be informed of imminent discharge, prior to it occurring, if the patient continues to refuse access;

(d) The policy does not ensure that a patient's GP is informed of the fact of refusal and potential discharge;

(e) The policy does not identify options available to community nurses to enlist the assistance of police to gain access and/or the support of a patient's GP to seek to obtain a patient's views directly regarding the continuation of the service or the prospect of discharge; and

(f) The policy does not address how to approach the question of discharge where there are concerns as to the capacity, disability of the patient and/or carer, and what options are available for community nursing in such circumstances.

11.18 Lourdes has also considered its *Collaboration with Treatment* policy, which sets out a process to be followed when a client refuses treatment. Ms Green gave evidence that the policy was reviewed in 2020 and revised so that community nurses actively participate in the discharge process, all admissions and discharges are discussed at a case conference and there is a specific discussion regarding whether or not a GP has been contacted about the prospect of discharge. Ms Green also indicated that Lourdes has provided a range of education regarding elder abuse and other topics relevant to Mrs Chrupalo's case. In addition, Lourdes received training from the Public Guardian in October 2020.

11.19 **Conclusion:** Since 2016 Lourdes has developed and review policies which appropriately address matters relating to the discharge of a patient from community nursing in circumstances where issues relating to refusal of treatment may arise. However, these policies do not provide for a number of circumstances which this inquest has highlighted, namely the need to obtain a direct understanding from a patient as to their wishes, and for the patient and the patient's GP to be informed of an imminent discharge.

11.20 In addition, Lourdes staff have not been provided with specific in-house training in relation to the identification of elder abuse and how to respond to it. Rather, education regarding such issues is available as an optional online resource. Therefore, it is necessary for the following recommendation to be made.

11.21 **Recommendation 6:** I recommend that Lourdes Hospital and Community Health Services review procedures for discharge, including against medical advice, to ensure that the health and welfare of patients is protected and consistent with Lourdes duty of care including ensuring that Lourdes has received a direct communication from the patient that he or she no longer wishes to receive care (a communication from a carer being insufficient) before discharge, liaise directly with the patient's GP regarding the possibility of discharge, and has before discharge, informed the patient of the possibility of discharge and what other services are, or are not, available.

12. What additional steps, if any, could Lourdes staff have taken to ensure that Mrs Chrupalo received adequate care and medical treatment after 18 September 2015?

12.1 On 26 August 2015, staff at Lourdes, based upon their concerns regarding Mrs Chrupalo's well-being, made an application to the Tribunal for the Public Guardian to be appointed. During the Tribunal hearing on 8 October 2015, Ms Green appropriately raised with the Tribunal the fact that Mrs Chrupalo had cut all contact with Lourdes and refused to go into care, and queried what would occur if she continued to refuse. This application was entirely appropriate and represented an attempt to ensure that Mrs Chrupalo received adequate care and medical treatment both prior to, and after, her discharge.

Arranging respite care

12.2 On 31 July 2015, Mrs Chrupalo and Mr Clee initially agreed to respite care during a home visit by Lourdes nurses. A referral to the CRCC was prepared, but all CRCC managed beds were occupied until November 2015. An option remained for ACAT-funded respite care to be provided in a private facility and for up to 63 days of subsidised residential respite care. Lourdes records do not indicate whether any further enquiries were made of any private respite care facilities. However, Ms Neill gave evidence that she spoke to Mrs Chrupalo on the phone who informed her directly that she did not want to go into respite care. Therefore, it appears that arranging respite care was a step that was not available to Lourdes.

Arranging level 3 or Level 4 Home Care Packages

12.3 On 16 July 2015, Mrs Chrupalo was approved for Level 3 or Level 4 Home Care Packages. Lourdes did not provide such Home Care Packages, but there were a number of providers in the Dubbo area. However, it is unclear whether anyone offered to assist Mrs Chrupalo or Mr Clee with arranging home care services. Ms Green gave evidence that whilst she did not have carriage of the ACAT service at the time, she accepted that the ACAT could have sought Mrs Chrupalo's consent to contract service providers on her behalf.

Contact with general practitioner and referral back to hospital

12.4 Ms Green accepted that it was open for Lourdes to seek input from Mrs Chrupalo's GP prior to discharge, and that the current policy envisages that the referrer and patient's GP will be contacted if the patient discharges against medical advice or the service is unable to be provided. Further, Ms Green gave evidence that if Lourdes had known about the advice in Dr Smith's assessment on capacity (that reassessment should be undertaken if services were refused), Lourdes may have "*referred back to that psychiatrist*" by alerting Mrs Chrupalo's GP to the issue. This may have precipitated Mrs Chrupalo's continued acceptance of Lourdes' care. In addition, as at 18 September 2015, Ms Green accepted that an ambulance would have been called to transfer Mrs Chrupalo back to hospital given that there were concerns for her welfare.

Referral to Lourdes' geriatric evaluation and management inpatient program

12.5 Ms Green gave evidence that, as at 2015, Lourdes provided limited additional aged care services for geriatric evaluation and management, upon referral from an ACAT. The purpose of such a referral is to provide non-acute inpatient care, such as medication management, assistance with delirium and other short-term problems that require monitoring or are capable of being fixed within a 28 day period.

12.6 Ultimately this does not appear to have been an option given that Ms Green was of the view that Mrs Chrupalo's wounds had healed upon discharge, and that the geriatric service did not include an inpatient assessment where there were concerns regarding capacity because Lourdes did not provide any psychogeriatric service.

Request for police welfare check

12.7 Ms Green gave evidence that the NSW Police Force (**NSWPF**) had declined to take any steps in the matter, given that there was no suggestion of any criminality involved, and because the NSWPF advised that they could do nothing further other than arrange for a cleaning service.

12.8 The evidence establishes that the NSWPF never informed Ms Green that they would not conduct a welfare check; rather, it was indicated that they could not do anything beyond checking on Mrs Chrupalo. This appears to have been misunderstood by Ms Green in her written evidence. However, during oral evidence, Ms Green appeared to accept that it was open at any time for Lourdes to enlist the assistance of the NSWPF to check on Mrs Chrupalo. Notwithstanding, Ms Green indicated that after 18 September 2015 it was her opinion that Mrs Chrupalo had been discharged from Lourdes' service, and that it would be up to the Public Guardian to make decisions regarding Mrs Chrupalo's health care and accommodation.

12.9 The evidence from the NSWPF is that they would have conducted a welfare check if requested to do so, and had the power to force entry into the premises in certain circumstances. It is not a requirement for an alleged crime to have been committed before a welfare check will be conducted. The effect of this evidence was that if Ms Green had requested a welfare check in January 2015, NSWPF officers would have attended and made an assessment of the information before them at that time.

12.10 **Conclusion:** The evidence indicates that the continued availability of NSWPF assistance was known to Lourdes. In these circumstances, Lourdes should have arranged for another police welfare check to assist in gaining access to Mrs Chrupalo to ascertain her views directly regarding discharge or continuation of the services, and to check on Mrs Chrupalo's welfare after 18 September 2015. The evidence indicates that such a welfare check would have been performed, if requested.

Lourdes' understanding of the role of the Public Guardian

12.11 The guardianship application for Mrs Chrupalo was the first such application that Ms Green had made in community nursing. Ms Green gave evidence that she understood that if a Guardian was appointed, someone would visit Mrs Chrupalo, ascertain her wishes, and make decisions about her

needs, accommodation and care, and ensure that these matters were met by whoever was most appropriate to meet them. The evidence establishes that Lourdes had limited experience with the Public Guardian, and a limited understanding of the Public Guardian's role. In particular, Lourdes had a limited understanding of the processes involved with appointment, and the inability for the Public Guardian to take any action until appointment.

12.12 **Conclusion:** Lourdes' application for the Public Guardian to be appointed represented the most appropriate step that was available to ensure that Mrs Chrupalo received adequate care and medical treatment after 18 September 2015. There was a lack of understanding by Lourdes regarding the application process, the timeframes involved and the role of the Public Guardian. This resulted in other available steps to check on Mrs Chrupalo's welfare by inquiring about the possibility of respite care or seeking input from Mrs Chrupalo's GP not being undertaken.

13. What additional steps, if any, could Lourdes staff have taken after 8 October 2015 to ensure that Mrs Chrupalo received adequate care and medical treatment?

13.1 Following the Lourdes guardianship application on 26 August 2015, limited further information was provided to both the Tribunal and to the Public Guardian. This information effectively amounted to a statement as to staff concerns (27 August 2015), advice that Lourdes was no longer visiting Mrs Chrupalo at her request (2 December 2015); and Ms Green informing the Tribunal on 8 October 2015, in the absence of the Public Guardian, that the last contact Lourdes had with Mrs Chrupalo was several weeks earlier.

13.2 The Public Guardian was not aware until 2 December 2015 that Lourdes was no longer providing services to Mrs Chrupalo.

13.3 Ms Green does not recall whether at this time she knew that the Public Guardian had not taken any proactive steps. Notwithstanding, Ms Green expressed the view that even if she had known at the time the Public Guardian had not taken any such steps, Lourdes would not have taken any action given that Mrs Chrupalo had been discharged from the service and was not a current client.

13.4 Ms Robinson stated that there are no legislatively prescribed obligations on an applicant for guardianship, but an applicant might be asked to provide background information, inform the Public Guardian of the concerns, and discuss options for future care. Ms Robinson indicated that once Mrs Chrupalo was no longer a client, it was arguable that Lourdes no longer had further obligations, but that Ms Green could have considered it as part of her duty of care to provide information to the Public Guardian.

13.5 **Conclusion:** Whilst it would have been helpful if Lourdes had been more proactive in providing information to the Public Guardian, it was for the Public Guardian, once appointed, to perform its statutory role in accordance with the orders made on 8 October 2015. This included obtaining information regarding Mrs Chrupalo's health care and care status of a matter of urgency.

Provision of insufficient and potentially misleading information to the Tribunal and to the Public Guardian

13.6 Ms Green told Michelle Binny, the Public Guardian's officer who was assigned Mrs Chrupalo's guardianship, that Mrs Chrupalo and Mr Clee had made *"threats*" to Ms Green. These alleged "*threats*" played a key role in the Public Guardian's approach and the Tribunal hearing on 7 January 2016.

13.7 On 4 September 2015 Ms Green served the original papers for the Tribunal hearing at Mrs Chrupalo's home. Mrs Chrupalo was described as appearing to be "*cross*", with Mr Clee described as "*gruff*". When Ms Green explained there was going to be a Tribunal hearing due to concerns for Mrs Chrupalo safety, Mrs Chrupalo stated, "*Why do we have to do this?*" and "*Get out and don't come back*". This is the only incident that has been identified as a possible "*threat*".

13.8 Although Ms Green was told by Lourdes staff that Mrs Chrupalo had made a voodoo doll of her with a pin stuck through it, Ms Green did not consider this to be a threat. However, Ms Green gave

evidence that her staff were in a "*threatening situation*" because Mr Clee appeared "*agitated*", as he was described as moving quickly around the room and making apparent that he wanted Ms Green to leave.

13.9 Despite there being no threats from Mr Clee, Ms Green told Ms Binny in an email of 2 December 2015 that Mrs Chrupalo "*and her son had threatened me*". Ms Green provided no explanation as to the content of that "*threat*".

13.10 On 7 January 2016 Ms Green told the Tribunal that the only time she was threatened was when she attended Mrs Chrupalo's home to serve the original papers. Again, Ms Green did not provide any further information regarding this purported "*threat*". Ultimately, Ms Binny made submissions regarding the threats, referring to "*all the various threats that have been made to people there*", that both Mrs Chrupalo and Mr Clee had made threats, and that other service providers were aware of the threats. Ms Green also did not correct incorrect statements made by Ms Binny, despite an invitation from the Tribunal to "*add anything*".

13.11 **Conclusion:** The information provided by Ms Green to Ms Binny and to the Tribunal regarding the nature and extent of purported threats made by Mrs Chrupalo and Mr Clee were potentially misleading, without clarification. Such clarification was not provided by Ms Green to the Tribunal, despite an invitation to do so. Having regard to the emphasis given to the purported threats, it was necessary for Ms Green to provide precise information as to the precise nature of this alleged conduct, and that other service providers were not aware of any such conduct.

Other service providers

13.12 On 7 January 2016, Ms Green told the Tribunal that "*we'd exhausted our services here*". This is despite Ms Green accepting that the Lourdes community nursing team would have assisted if the Public Guardian had asked Lourdes to provide services to Mrs Chrupalo. Further, Ms Green did not correct Ms Binny when she indicated to the Tribunal that there was effectively no utility in maintaining the guardianship order because Lourdes was unwilling to provide services.

Request for police welfare check

13.13 On 7 January 2016 Ms Binny indicated at the Tribunal hearing that "*the only avenue left*" was the possibility of a police welfare check. It was indicated by the Tribunal that this issue was a matter for local service providers or health care professionals to determine.

13.14 Ms Green gave evidence that she did not take steps to arrange for a further police welfare check after 7 January 2016 for the following reasons:

(a) Ms Green was aware that police had previously declined to conduct a welfare check because no crime had been committed. However, Ms Green also accepted in evidence that as at 7 January 2016 she knew that police could conduct a welfare check and report this back to her.

(b) Ms Green was aware that Mrs Chrupalo and Mr Clee had not been pleased with the first referral to police that Ms Green made in August 2015.

(c) A police welfare check was only raised by the Tribunal as a possibility.

13.15 Ms Green maintained that she did not believe that the Tribunal were specifically asking her to do anything. The Tribunal's decision refers to there being discussion between the participants regarding whether a police welfare check would be undertaken, and that "*Ms Green acknowledged that this was something to which consideration will be given*". However, Ms Green gave evidence that she was not "*served with the reasons for decision*", it was not her understanding of what had happened at the hearing, and maintained that it was not something that Lourdes should have done, and it was not her place to do it, given that Mrs Chrupalo and Mr Clee were no longer clients.

13.16 **Conclusion:** It is noted that Ms Green attended the Tribunal hearing on the telephone, had not appeared in the Tribunal before, and was not in the same position as Public Guardian. In contrast, the Public Guardian was a party, had (or should have had) an intimate understanding of Tribunal processes, operation of the Guardianship Act and the limits of the Tribunal's powers. Therefore, given the concerns plainly raised at the Tribunal hearing, it was for the Public Guardian to ensure that a police welfare check was done, even if it was understood that Lourdes was being asked to make such arrangements.

Lourdes' check on Mrs Chrupalo's welfare with police assistance

13.17 Ms Green submitted to the Tribunal on 7 January 2016 that Lourdes did not want to check on Mrs Chrupalo because she did not want to put her staff at risk. Ms Green gave evidence that this meant that a new risk assessment needed to be undertaken before Lourdes could attend. However Ms Green accepted that an available option was for Lourdes to have checked on Mrs Chrupalo in the presence of police.

Continuation of Guardianship order

13.18 Ms Robinson opined that it was reasonable for Ms Green to propose that the guardianship order should continue, and to raise the possibility of a coercive order with the Tribunal. Whilst Professor Ibrahim was of the opinion that it was reasonable to seek a continuation, he noted that the onus and sole responsibility should not be put on Lourdes as it was a widely held belief that the question lies with the Public Guardian. Professor Ibrahim noted that very few clinical services would pursue a second guardianship order when there was an existing medical opinion as to capacity, and that whilst a guardianship order had been in place, no action was taken by the Public Guardian.

13.19 Further, whilst this option was open to Lourdes, it is noted that Lourdes did not have experience dealing with this kind of application, did not know that this was something they could apply for, and Ms Green understood that it was a matter for the Tribunal to decide.

13.20 **Conclusion:** Lourdes staff had a limited understanding of the guardianship process. In particular, Ms Green's evidence revealed a lack of understanding by Lourdes regarding the availability of police welfare checks, and utilising police assistance to gain access where there were serious concerns regarding a patient. Lourdes did not have its own policies and procedures regarding guardianship applications, nor required any specific training regarding such applications and the availability of welfare checks in similar circumstances.

13.21 Having regard to the way in which Mrs Chrupalo's discharge was handled, Lourdes appeared to fail to understand the need for direct communication with a patient, and not to rely on communications with carers in circumstances of potential elder abuse and neglect. Further, Lourdes has no specific policies or compulsory training regarding the identification and management of elder abuse and neglect cases. Having regard to these matters, it is necessary to make the following recommendations.

13.22 **Recommendation 7:** I recommend that Lourdes Hospital and Community Health Services introduce written procedures and provide training to staff in relation to guardianship applications that set out the circumstances in which it is appropriate to make an application, the requirements for guardianship applications, the information and support to be provided to the NSW Civil and Administrative Tribunal and appointed guardian to support the application and guardianship process (whether a private guardian or the Public Guardian is appointed), the role of the Public Guardian once appointed, and co-ordination with the Office of the Public Guardian in relation to the Health Guardianship Project.

13.23 **Recommendation 8:** I recommend that Lourdes Hospital and Community Health Services introduce written procedures and provide training in relation to elder abuse, neglect and exploitation of patients, which provides guidance on the indicators, the means of responding and the duty of care and responsibilities of staff. Such procedures and training would refer to the procedures relating to appointment of the Public Guardian or a hospital guardian, the availability of assistance from the Ageing and Disability Commission and the availability of the police to assist in providing welfare checks.

14. Adequacy of steps taken by the NSW Public Guardian

14.1 The Public Guardian has a statutory role created by the *Guardianship Act*, with the primary role to make substitute decisions for people with disability who are unable to make health and lifestyle decisions on their own or with support. Section 78 of the *Guardianship Act* provides that the Public Guardian's decision-making authority is delegated to guardianship staff within the Office of the Public Guardian.

14.2 The principles of the guardianship system require that every person exercising functions under the *Guardianship Act* with respect to persons who have disabilities observe the principles that are set out at section 4 of that act, which are:

(a) the welfare and interests of such persons should be given paramount consideration,
(b) the freedom of decision and freedom of action of such persons should be restricted as little as possible,
(c) such persons should be encouraged, as far as possible, to live a normal life in the community,
(d) the views of such persons in relation to the exercise of those functions should be taken into consideration,
(e) the importance of preserving the family relationships and the cultural and linguistic environments of such persons should be recognised,
(f) such persons should be encouraged, as far as possible, to be self-reliant in matters relating to their personal, domestic and financial affairs,
(g) such persons should be protected from neglect, abuse and exploitation,
(h) the community should be encouraged to apply and promote these principles.

14.3 On 10 September 2015, the Tribunal held its first hearing for the guardianship application in relation to Mrs Chrupalo. Ms Green attended the hearing by telephone. The Public Guardian did not attend, despite being a party to all guardianship applications at the time and having received a notice of hearing on 31 August 2015. The Tribunal was unable to contact Mrs Chrupalo and Mr Clee, and adjourned the hearing to 8 October 2015 to give them an opportunity to be heard in relation to the application.

14.4 On 16 September 2015, the Public Guardian received the orders made by the Tribunal on 10 September 2015, but not the reasons for decision. The following day, the Public Guardian received notice of the 8 October 2015 hearing.

14.5 On 8 October 2015, the Tribunal made a guardianship order in relation to Mrs Chrupalo for a period of three months, appointing the Public Guardian as guardian. The order was a limited guardianship order, and gave a Public Guardian the following functions:

(a) Accommodation: to decide where Mrs Chrupalo may reside;

(b) Health care: to decide what healthcare Mrs Chrupalo may receive.

(c) Medical and dental consent: to make substitute decisions about proposed minor or major medical or dental treatment when Mrs Chrupalo is not capable of giving a valid consent; and

(d) Services: to make decisions about services to be provided to Mrs Chrupalo.

14.6 A condition of that order was that the Public Guardian shall take all reasonable steps to bring Mrs Chrupalo to an understanding of the issues and to obtain and consider her views before making significant decisions.

14.7 The Public Guardian received a copy of the order on 13 October 2015 but not a copy of the reasons for the decision or a transcript. On 22 October 2015, Mrs Chrupalo's file was allocated to Ms Binny who subsequently met with her supervisor, Principal Guardian, James Conna, on 23 October 2015 and discussed the matter with him. The discussion included:

(a) Whether Mrs Chrupalo should be placed in an Aged Care Facility;

(b) A plan to contact Ms Green to discuss a plan around implementing the order;

(c) Seeking Mr Clee's views on the guardianship, and their concerns about Mr Clee's alcohol use;

(d) The services that were in place, if any;

(e) Obtaining a copy of Mrs Chrupalo's aged care assessment;

(f) Check if there are any advance care directives in place; and

(g) If a formal written report was required for the upcoming hearing.

14.8 On 2 November 2015 Ms Binny wrote an email to Ms Green requesting some further information. There was no response to that email. Ms Green stated that she never received the email at the time it was sent. Ms Binny did not follow up this email or take any further steps in the matter until 1 December 2015 when she attempted to call Ms Green and left a message. Ms Binny sent a further email to Ms Green attaching a medical consent form to be completed by Mrs Chrupalo's GP.

14.9 On 2 December 2015 Ms Binny received the Tribunal's Reasons for Decision for 8 October 2015. On that same date Ms Green responded to Ms Binny's email of 1 December, advising that she had no knowledge of Mrs Chrupalo's current situation.

14.10 After sending that email Ms Green spoke to Ms Binny by telephone. There is some dispute between Ms Green and Ms Binny as to the content of this phone call. However, Ms Binny's file note for that call records that Ms Green advised Ms Binny that Mrs Chrupalo was "*refusing all services and won't allow staff or community nurses into the property*", that "*Community services discharged Mrs Chrupalo from their service weeks ago at Mrs Chrupalo's request*" and that "*There is no further need for a guardianship order given Mrs Chrupalo's refusal to services or assistance from the community*". Ms Binny did not make any enquiries as to the currency of the information that was provided by Ms Green, or the last contact that Ms Green had with Mrs Chrupalo.

14.11 It was submitted on behalf of the Public Guardian that Ms Binny was entitled to rely upon the information provided by Ms Green as correct and accurate. Further, it was also submitted that it

would not be feasible for guardians to be required to independently verify all information provided by an applicant; such a requirement would mean the Public Guardian, according to Ms Osborne, "wouldn't ever make any decisions". However, it is not suggested that Ms Binny needed to verify information provided by Ms Green; rather, she should to have sought more detail regarding the information, particularly as to its currency, that was provided to her.

14.12 On 7 January 2016, the Tribunal, having heard from Ms Green and Ms Binny, decided not to renew the guardianship order.

Failure to take appropriate steps in relation to Mrs Chrupalo after 8 October 2015 and failure to identify urgency of the situation

14.13 With the possible exception of attempts to contact Mrs Chrupalo, Ms Binny took no steps between 2 November 2015 and 1 December 2015, and between 2 December 2015 and the Tribunal hearing on 7 January 2016. The steps that were discussed at the 23 October 2015 meeting between Ms Binny and her supervisor were not progressed beyond the request for information from Ms Green. Further, there was no follow-up to this request until 1 December 2015 when Ms Binny left a telephone message with Ms Green.

The Public Guardian had received information upon which it could act

14.14 On 16 September 2015, the Public Guardian received Mrs Chrupalo's medical records from the Hospital. These records identified Mrs Chrupalo's GP and numerous medical practitioners who had assisted her, together with the fact that an ACAT assessment had been performed. This information provided the Public Guardian with a basis to:

(a) Identify alternate means to contact Mrs Chrupalo; and

(b) Obtain an understanding of Mrs Chrupalo's needs and condition, and what resources were available in Dubbo to assist her.

14.15 Notwithstanding the above, Megan Osborne, the Public Guardian at the time of the inquest, gave evidence that there was a lack of information available to be able to plan, and referred to the high workload of guardians. Although Ms Binny had carriage of 55 to 65 guardianship files, the steps referred to above could have been progressed by way of telephone call. It is noted that the Public Guardian knew who had provided previous care at the Hospital, and knew the details of Lourdes, the GP and the ACAT assessors.

14.16 A decision as to whether Mrs Chrupalo should go into aged care could not be made without a specific proposal and information from service providers. However, this does not mean that no steps should be taken by the Public Guardian to first ensure Mrs Chrupalo's safety, and then identify a potential service provider and/or case manager.

14.17 The Public Guardian was formally notified that the Tribunal considered Mrs Chrupalo's matter to be "*urgent*" upon receipt of the reasons for decision on 2 December 2015. Despite this, the Public Guardian stated that the urgency was not apparent from the timetable set by the Tribunal.

However, the urgency of the situation was apparent from the medical records and other information including the guardianship application, which the Tribunal had provided to the Public Guardian. Ms Robinson stated that relying on this information, rather than the Tribunal's timetable, was arguably a better guide to the urgency of the matter.

14.18 The Application submitted by Ms Green indicated that Mrs Chrupalo:

(a) was being physically abused or neglected;

(b) was being exposed to verbal abuse, intimidation or conflict;

(c) required medical treatment or services;

(d) was refusing medical treatment or services;

(e) was, due to her behaviour, exposed to harm or damage; and

(f) was at risk because of an exploitative relationship.

14.19 The Application stated "*[m]y staff are fearful she will die either of sepsis or from fire due to her smoking in bed while intoxicated*".

14.20 Ms Binny gave evidence that on the face of the application, or in the contact from the Tribunal, there was nothing to indicate that there was any urgency. However, Ms Binny later accepted that as at 23 October 2015 she was aware that this was a matter that needed to be actioned without delay, in order for the Public Guardian to be in a position where decisions could be made to ensure Mrs Chrupalo's safety.

14.21 Ms Osborne did not necessarily expect that Ms Binny would have recognised the urgency of the situation. However, Ms Osborne now has an expectation that the urgency of the situation would be picked up during a triage process, or in a supervision meeting, and the matter would be attended to accordingly.

14.22 **Conclusion:** By 16 September 2015 the Public Guardian had sufficient information in order to make enquiries as to alternate means to contact Ms Chrupalo. Doing so would have allowed for an understanding of Mrs Chrupalo's needs and what services were available to meet these needs. It is accepted that further information would have been required from service providers in order to progress the steps that were required to be undertaken.

14.23 However, there was nothing to prevent concurrent enquiries being made by the Public Guardian to ensure that there were no immediate concerns for Ms Chrupalo's welfare. The need to do so would have been apparent from the content of the guardianship application, and at least by 2 December 2015 when the degree of urgency was communicated unequivocally by the Tribunal. The available evidence does not establish that any resource limitations represented a barrier to such enquiries being made, or at least commenced. Instead, no such steps were taken, despite the Public Guardian knowing that Mrs Chrupalo was a person with very high care needs who had not been provided with any community services for more than two months.

Inadequacy of attempts to contact Mrs Chrupalo and Mr Clee

14.24 The evidence indicates that Ms Binny attempted to call the home number for Mrs Chrupalo and Mr Clee, and that this number was disconnected. Despite her usual practice, Ms Binny did not make any file note regarding her attempt to contact Mrs Chrupalo. However, it is noted that the Tribunal also tried to call the same number and expressed the view that the number was disconnected. It is noted that records from Optus appear to show that the number was not disconnected and no calls were received from Ms Binny. However, it is possible that Mr Clee had physically disconnected the phone line so that calls could not get through. It is noted that no calls were made from the number for Mrs Chrupalo and Mr Clee from 12 October 2015 to 23 February 2016.

14.25 Although the telephone number provided to the Public Guardian was disconnected, Ms Osborne accepted that there were other ways that Ms Binny could have attempted to contact Mrs Chrupalo and Mr Clee. This included seeking alternative contact details from Mrs Chrupalo's GP, the ACAT assessor or the hospital, or requesting police to conduct a welfare check. Ms Murie gave evidence that if she had been contacted by the Public Guardian, she would have recommended that police conduct a welfare check, and discussed with her supervisor whether she should conduct a welfare check herself. Ms Robinson acknowledged that there were significant difficulties making contact with Mrs Chrupalo, but that "*alternative means of contact were not explored*".

14.26 The Public Guardian has recently introduced a policy, *Recognising and responding to allegations of violence, abuse, neglect and exploitation of customers* (**Abuse Policy**), which recommends engagement with emergency services when a person cannot be contacted. For infrequent situations where contact cannot be made or resistance is encountered, the Public Guardian states that the matter is raised on review. However, there is no evidence that such a review occurred in Mrs Chrupalo's case. Further, Ms Osborne also gave evidence that if the Public Guardian was having trouble contacting the person under a guardianship order, it may engage third parties to ascertain the person's views as to accommodation or otherwise.

14.27 Whilst accepting that other steps were available to contact Mrs Chrupalo and that such a step should have been taken, it was submitted on behalf of the Public Guardian that even if they had been taken they would likely have been "*fruitless*". This is because, it was submitted, neither the Hospital nor the ACAT had any alternative means of contact. However, the use of a police welfare check was available to both initiate direct contact with Mrs Chrupalo, and to check on her health and welfare. Relevantly, and as noted above, the Abuse Policy now provides for a police welfare check to be requested if a person is unable to be contacted and is considered to be at "*immediate risk*".

14.28 **Conclusion:** As a condition of the Tribunal's orders, the Public Guardian needed to take reasonable steps to ensure that Mrs Chrupalo understood the guardianship issues relevant to her needs and welfare, and to obtain her views before making significant decisions. This is consistent with a principle of the *Guardianship Act* that Mrs Chrupalo's views should be taken into consideration.

14.29 Equally, given that the welfare and interests of Mrs Chrupalo were paramount, it remained important for the Public Guardian to progress enquiries in relation to what services were required, and what decisions needed to be made, for Mrs Chrupalo. The inability to contact Mrs Chrupalo did not preclude the Public Guardian from making such enquiries, and seeking to identify potential providers of services that were likely to meet Mrs Chrupalo's needs.

Information should have been sought from sources other than Lourdes

14.30 The Public Guardian sought further information solely from Ms Green and Lourdes. Whilst it is standard practice for the Public Guardian to rely heavily on information from an applicant, for good reason, the Public Guardian accepted that information could have been sourced independently of Ms Green and that this would not have been onerous.

14.31 Ms Robinson opined that the efforts of the Public Guardian to understand Mrs Chrupalo's situation and her decision-making needs were inadequate, and that there was a significant delay in seeking and obtaining information. Ms Robinson stated that it was concerning that the only information obtained by the Public Guardian came from the applicant, particularly as the applicant was no longer involved in Mrs Chrupalo's care.

14.32 It was open to Ms Binny to take a number of steps to progress the plan formulated on 23 October 2015, including:

(a) To phone Ms Green when she did not receive a response;

(b) To seek information from sources other than Ms Green, including: the Hospital, Mrs Chrupalo's GP, the ACAT assessment from the Aged Care Assessment Centre (**ACAC**).

14.33 If the Public Guardian had contacted the hospital or ACAC, information could have been sought as to community service providers, respite services and permanent care services that were available in Dubbo.

14.34 If the Public Guardian had contacted ACAT assessors they would have been able to provide a copy of the ACAT assessment which contained information on Mrs Chrupalo's capacity and needs. This could have been used to determine what other services and supports could be appointed. Further, if the Public Guardian had contacted Ms Murie, she would have worked with the Public Guardian to provide information to make decisions about Mrs Chrupalo's safety and welfare. In addition, the Public Guardian could have requested a further ACAT assessment to obtain up-to-date information. Ms Osborne stated that engaging with ACAT is one of the first steps that would now be taken in considering an accommodation decision.

14.35 Whilst acknowledging that further enquiries should have been made of the Hospital and ACAT for information regarding Mrs Chrupalo's circumstances and needs, it was submitted on behalf of the Public Guardian that even if such enquiries had been made it was unlikely that there was any available service to assist her. This is due, it was submitted, to the absence of public aged care respite services with available places in the region, and Mr Clee's general unwillingness to engage with services.

14.36 The evidence of Ms Murie and Ms Neill is that there were four or five residential aged care providers in Dubbo in 2015 that provided high-level respite care. Some of these may have been available to Mrs Chrupalo due to her ACAT approval for respite care. However, no direct enquiries were made by Lourdes regarding the availability of such providers. Further, no enquiries were made regarding the availability of other types of services, such as provision of Home Care Packages, that may have been provided to Mrs Chrupalo. Therefore, the likelihood of services being available to assist Mrs Chrupalo even if she had been willing to accept such services, cannot be definitively determined.

Failure to take steps where no service provider presently providing services

14.37 When it became apparent on 2 December 2015 that Lourdes was no longer providing Mrs Chrupalo with services, Ms Binny took no steps to identify an alternative service provider or appoint an alternative case manager. Ms Robinson stated that a guardian will liaise closely with service providers to see what other attempts could have been made to provide the services that Mrs Chrupalo required. In particular, the high-level Home Care Package which had been approved by ACAT could have been investigated. The Public Guardian could also have organised for the appointment of a case manager so that services could be coordinated and options identified and explored.

14.38 The Public Guardian's position is that it is not a case manager or service provider and relies heavily on those closely involved in a person's life, such as Lourdes, to provide information of any changes, concerns or the need for decision making relating to a person's health and welfare. The Public Guardian stated that it does not seek proposals itself from services or undertake investigation; rather, it relies on information from community health professionals, the person and their family. Ms Robinson agreed with this position. This then raises the question of what happens when this degree of reliance is unavailable to the Public Guardian.

14.39 The Public Guardian accepted that if a person who was the subject of a guardianship order did not have anyone able to provide such service proposals, the Public Guardian would then find services or a case manager to perform that task. However, such a case manager would not usually be appointed without seeking the views of the person under guardianship. The role of a case manager is to seek information as to what services exist, what support the person is being provided, and what options are available. A case manager may be a registered NDIS Provider or in the aged care sector. However, no steps were taken in Mrs Chrupalo's case to identify or appoint an alternative case manager.

14.40 In Mrs Chrupalo's circumstances Lourdes was not able to assist and no proposals had been received. Therefore, another approach was appropriate. Ms Binny understood that her obligation

was to "*try and find alternative services that may be available to provide support"* once she was aware that Lourdes was no longer providing services. However, Ms Binny took no steps to find alternative services. She could have asked Ms Green what other service providers there were, or sought assistance from the ACAT assessor.

Information should have been sought as to the availability and willingness of other service providers and case managers

14.41 After 2 December 2015 the Public Guardian took no steps to ascertain the availability of other service providers to provide services to Mrs Chrupalo, or alternative case managers. Such information was relevant to the making of accommodation and services decisions by the Public Guardian under the existing order, and was relevant to assisting the Tribunal to understand the utility or otherwise of a decision extending the guardianship orders on 7 January 2016.

14.42 The Public Guardian accepted that Ms Binny appeared to lack appreciation of the obligation to find another case manager. Both the Public Guardian and Ms Binny accepted that attempts should have been made before 7 January 2016 to try to find other service providers.

14.43 The Public Guardian stated that enquiries were not made with nursing or aged care providers, and attempts were not made to organise or implement a high-level Home Care Package, because it understood from Ms Green that Mrs Chrupalo was resistive to outside help. However, the Hospital records indicated that Mrs Chrupalo and Mr Clee were interested in accepting services at home. It was for the Public Guardian to seek Mrs Chrupalo's views regarding what care might be acceptable, and if it was seen to be necessary, to consider applying for a coercive order.

14.44 **Conclusion:** By 2 December 2015 the Public Guardian was aware that Lourdes was no longer providing services to Mrs Chrupalo. Despite this awareness the Public Guardian took no steps to identify a potential case manager to assist with seeking of proposals of services relevant to Mrs Chrupalo's health and welfare needs. The failure to take such steps was inappropriate, a fact recognised by the Public Guardian, and by Ms Binny, in hindsight.

14.45 It is accepted that information available to the Public Guardian suggested that Lourdes was unable to assist Mrs Chrupalo, and that Mrs Chrupalo had expressed a reluctance to engage with external service providers. However, the Public Guardian ought to have interrogated the information available in order to independently verify whether it was correct, and to determine whether other service providers might be available to assist Mrs Chrupalo, and whether Mrs Chrupalo and Mr Clee were prepared to engage with in-home services. Again, the failure to undertake such enquiries was inappropriate.

A police welfare check should have been requested

14.46 On 2 December 2015, when Ms Binny became aware that Mrs Chrupalo had not been receiving assistance, Ms Binny did not consider requesting police to conduct a welfare check. Ms Binny had no prior experience being unable to contact a person under a guardianship order, and had not previously requested a police welfare check. Ms Binny gave evidence that she would now give consideration to such a check.

14.47 The Public Guardian conceded that a request for a further police welfare check was a reasonable action that could have been taken, stating that this:

(a) could have determined if the living situation had further deteriorated and if Mrs Chrupalo and Mr Clee were in need of further care; and

(b) given the Tribunal and the Public Guardian further information regarding the need for a coercive function.

14.48 **Conclusion**: The Public Guardian did not make relevant enquiries, perform any risk assessment or make any attempt to arrange alternate support services or to appoint a case manager for Mrs Chrupalo. The Public Guardian accepted that no assistance could be provided to Mrs Chrupalo without, in fact, making any attempt to do so. As Ms Robinson noted, only very limited attempts were made to exercise the Public Guardian's function under the order, no guardianship decisions were ultimately made for Mrs Chrupalo.

Tribunal hearing on 7 January 2016

14.49 On 7 January 2016 the Tribunal reviewed the previous guardianship order made concerning Mrs Chrupalo and decided that the order should lapse and not be renewed.

14.50 Ms Binny was asked for her views as to whether the order should be extended. Ms Binny provided the following responses:

(a) Ms Binny stated that the "*biggest difficulty*" was that all the services had "*indicated that they're not willing to work with them because of the situation and all the threats that have been made to people there*". However, as noted above, there was no information available to Ms Binny that anyone besides Lourdes was unwilling to provide services to Mrs Chrupalo. Significantly, the lack of an order's utility was one matter considered by the Tribunal in reaching its decision not to renew the order.

Ms Binny accepted that she was not in a position to make any submission about the availability or lack of availability, or willingness or unwillingness, of other service providers to provide services to Mrs Chrupalo. Despite these concessions, Ms Binny repeated in evidence that there were "*no other services possibly wanting to provide input or assistance*".

(b) Ms Binny stated that Mrs Chrupalo and Mr Clee were "*not wanting to, you know, speak to anybody or have anybody come over or even, you know, approach the property and things like that*". There was no information available to Ms Binny that anyone besides Lourdes had been refused entry, and no evidence that objection had been taken to approaching the property.

(c) Earlier, although not in response to questions as to whether the order should be extended, Ms Binny stated that Mrs Chrupalo was "*refusing all the services and won't allow staff or any of the*

nurses into the property anymore". It is not clear whether she was referring to Lourdes or to any services.

Ms Binny also stated that Mrs Chrupalo was "*quite resistant to everything as well*". There was no information available to Ms Binny that Mrs Chrupalo had refused community services from anyone besides Lourdes.

14.51 It was submitted on behalf of the Public Guardian that Ms Binny was providing as much information as she could to the Tribunal and acting in good faith. This is because Ms Binny informed the Tribunal that all of her discussions had been with Ms Green, who had provided her with "*a pretty comprehensive update*" as to Mrs Chrupalo's views regarding acceptance of services. In this regard, it was submitted that the Tribunal also confirmed with Ms Green the information that Ms Binny provided, and that Ms Binny's contact regarding Mrs Chrupalo had largely or entirely been through Ms Green.

14.52 Accepting the above, it is noted that both Ms Binny and Ms Osborne gave evidence that an assumption should not have been made that the information provided by Ms Green was correct, and that it was for Ms Binny to test the accuracy of the information provided to her. Further, Ms Osborne accepted that if Ms Binny did not have information as to the lack of availability or willingness of other services providers, or of threats to the wider community, it was concerning and very serious if she provided that information to the Tribunal.

14.53 **Conclusion:** At the hearing on 7 January 2016, the Public Guardian relied on information provided by Ms Green that was assumed as being accurate, and not tested, by the Public Guardian. This resulted in Ms Binny making submissions to the Tribunal which were not supported by objective evidence and which did not provide an entirely accurate picture of the availability and willingness of services to assist Mrs Chrupalo. In these circumstances, without supporting information, such unqualified submissions should not have been made. However, it is accepted that the submissions were made in the context where the Tribunal sought Ms Green's confirmation regarding the information provided by Ms Binny.

14.54 It can be accepted that the Public Guardian is unable to independently check every piece of information that might be provided relevant to a guardianship order, and that it is necessary for the Public Guardian to rely upon information provided by an applicant for such an order. However, in Mrs Chrupalo's case, the submissions made by Ms Binny were central to the Tribunal's consideration of whether the guardianship order should be extended. In such circumstances, it was inappropriate for the Public Guardian not to have tested the information provided by Ms Green in order to independently determine its accuracy.

14.55 It is of concern that whilst Ms Binny initially accepted that she was not in a position to make the unqualified submissions described above, Ms Binny later reverted to the view that there was no other service willing or available to provide assistance to Mrs Chrupalo.

An application should have been made by the Public Guardian to extend the order

14.56 Ms Binny did not express a clear view to the Tribunal as to whether the order should be extended. However, she did indicate that if the order were extended, the Public Guardian might be able to visit Mrs Chrupalo.

14.57 At the Tribunal hearing on 7 January 2016, Ms Binny had no information available to her that the urgency of Mrs Chrupalo's circumstances had changed, or that the risk to her safety had abated. Ms Binny accepted that she should have provided the following information to the Tribunal at the hearing on 7 January 2016:

(a) that other avenues were available to the Public Guardian to attempt to find alternative ways contact Mrs Chrupalo, which had not been attempted;

(b) if steps had been taken to ascertain what services were available in the area, the availability of those services;

(c) that to the extent there was any resistance to services by Mrs Chrupalo, it was with respect to one provider, Lourdes; and

(d) that to the extent there were any threats made by Mrs Chrupalo or her son, that information had been provided by Ms Green and did not relate to other service providers.

14.58 The Public Guardian accepted that the Tribunal should have been informed: (a) of the limitations of information in relation to Mrs Chrupalo's resistance to assistance of outside services; and (b) the Public Guardian could have attempted to find any other service providers.

14.59 Ms Binny indicated that the main basis for seeking discharge of the orders was that there were no services on the ground to provide support. However, it should be remembered that Ms Binny had no information available to her that other services were unavailable to provide support, and had made no enquiries in this regard.

14.60 The Public Guardian accepted that a submission should have been made on 7 January 2016 for the order to be extended. Ms Binny stated that, with hindsight, she would have advocated for the guardianship order to be extended. She accepted that, now, such a submission would be made until attempts had been exhausted to contact the person the subject of the order. Ms Binny also accepted that she "*possibly*" should have advocated for an extension in order to ensure that a welfare check was undertaken.

An application should have been considered for a coercive order

14.61 The Tribunal's orders of 8 October 2015 did not include any coercive powers, such as a coercive accommodation function or power to override a person's objections to medical treatment. The Tribunal indicated that it was not in a position to assess those authorisations given that Mrs Chrupalo had not had a full capacity assessment, the Tribunal did not have thorough reports about the current situation, and had not spoken to Mrs Chrupalo. The Tribunal anticipated that after 3

months, the Public Guardian might let the Tribunal know if stronger powers were needed. However, this transcript was not provided to the Public Guardian.

14.62 The Public Guardian's evidence is that it will not seek or use a coercive function unless it can be clearly demonstrated that the person has refused, or is very likely to refuse, an accommodation decision. It says that it would need to be satisfied that there is known health, welfare and safety concerns, and the person is at serious risk. The Public Guardian stated that given what little was known about Mrs Chrupalo's circumstances, and since no accommodation decision had been made due to the inability to contact Mrs Chrupalo, it would not have been appropriate to seek an enforcement function. Ms Robinson states that to make a coercive order, the Tribunal would need to be satisfied that all reasonable efforts had been made otherwise to facilitate the move, and that the best interests of the person required this approach.

14.63 There were known concerns for Mrs Chrupalo's health, welfare and safety, and she may have been considered a person in serious risk. It was known that Mrs Chrupalo had previously refused to enter an aged care facility and had discharged herself against medical advice. It was therefore appropriate for the Public Guardian to consider making an application for coercive orders. However, the appropriateness of this order could not be assessed without further steps having been taken by the Public Guardian in advance of the hearing of 7 January 2016. The information available to the Tribunal by that time was three months out of date, and Mrs Chrupalo had not been contacted by the Public Guardian. In such circumstances it is unlikely that the Tribunal would have made a coercive order in relation to Mrs Chrupalo when such an order was not made on 8 October 2015. The outcome may have been different if the Public Guardian had taken adequate steps in relation to Mrs Chrupalo.

Police welfare check

14.64 On 7 January 2016, both Ms Green and Ms Binny discussed with the Tribunal the possibility of a police welfare check. As noted above, Ms Green considered that it was not her responsibility, and the Tribunal expressed the view that it was a matter for the local service providers. The Public Guardian considered that Lourdes were going to pursue a welfare check through the police. It is apparent that there was no clear statement as to who, if anyone, would or should organise such a check. Notwithstanding, either the Public Guardian or Ms Green could have requested that police undertake such a check.

14.65 Ms Binny gave evidence that once the order had been discharged, it was not her role to request police to perform a welfare check. Similarly, the Public Guardian's position is that once the order had lapsed, it could take no further action as it was no longer appointed with any legal authority. However, Ms Osborne indicated that whilst she was unaware of processes in 2015, there is nothing now that would stop the Public Guardian making such a referral to the police. It is not apparent why there would be any relevant difference in the authority of the Public Guardian to make such a referral between 2015 and the present date. Therefore, such a referral should have been made.

14.66 **Conclusion:** The evidence establishes that there were a number of steps that Ms Binny should have taken in relation to Mrs Chrupalo that she did not take. Ms Binny did not seek to identify alternate means to contact Mrs Chrupalo, did not seek to identify a case manager once it became apparent that Lourdes were no longer providing services to Lourdes, and did not seek to obtain information from sources other than Lourdes, all of which would have given effect to the plan originally formulated on 23 October 2015.

14.67 It is noted at the time this plan was formulated in consultation with a Principal Guardian, Ms Binny was under supervision within the Office of the Public Guardian. The available evidence does not identify the nature and extent of the supervision of Ms Binny between November 2015 and January 2016. The inquest did not consider in any detail Ms Binny's current role and the extent to which she has received adequate supervision and training. As noted above, the evidence has identified an apparent lack of appreciation by Ms Binny regarding the urgency of the situation, the need for her to act promptly and issues concerning the accuracy of her submissions to the Tribunal. These are matters for the Public Guardian to consider further in the context of Ms Binny's current role. As submitted on behalf of the Public Guardian, this is an issue which is beyond the scope of the Inquest.

14.68 In addition, there is no evidence that the Public Guardian conducted a case review of this matter to identify appropriate measures to be adopted in the future. This issue is in part answered by improvements which have been made by the Public Guardian since 2015, which are discussed below.

Improvements made by the Public Guardian since 2015

14.69 Since 2015, the Public Guardian has introduced a number of improvements to its systems and processes. It is acknowledged that these improvements go some way to addressing steps that the Public Guardian should have taken, but did not take, in relation to Mrs Chrupalo.

Triage system

14.70 Since 2015, the Public Guardian has introduced a "triage" process to the Western Guardianship Team, which front-loads the gathering of information relevant to a guardianship order. It is intended to "*ensure initial information gathering and analysis of files occurs in a systematic, efficient and timely manner as the officer gathers initial case information, makes initial contact and conducts an analysis on each file*".

14.71 The triage process follows a number of steps:

(a) As soon as the Public Guardian is aware that an order has been made, on the same day or the next day, the triage team will read the background papers, make contact with the Applicant or service providers, and seek to ascertain what information and decisions need to be made.

(b) The triage team can make inquiries, seek information and reports, and can make simple decisions such as seeking a person's medical and dental consent prior to allocation to a

guardian. Ms Osborne stated that there are clear follow-up steps that are triggered if the triage team does not receive an answer after a certain time.

(c) A more complex file would have been allocated to a principal guardian. Ms Binny stated that if Mrs Chrupalo's case was brought to the attention of the triage team, it would have been reviewed more quickly.

14.72 Ms Osborne stated that the triage process addresses concerns, such as arose in Mrs Chrupalo's case, regarding not seeking information from others as to alternative service providers that may be available.

14.73 The Public Guardian does not have a policy that applies when a person under a guardianship order cannot be contacted, nor does the triage process have any specific guidance as to the procedure for that circumstance. However, in such a situation, Ms Osborne stated that gathering information from other sources would become critical.

14.74 The triage process, if properly implemented, will assist with the information gathering steps that were not taken by Ms Binny in a timely manner in relation to Mrs Chrupalo.

The Health Guardianship Project

14.75 The Health Guardianship Project is a collaboration between NSW Health, the Tribunal, and the Public Guardian. It is focused on orders made by the Tribunal in relation to persons who are in hospital, and is intended to expedite decisions in order to ensure that persons do not remain in hospital for longer than is necessary. The Public Guardian explained that the implementation of the Health Guardianship Project has reduced the average length of hospital admissions from the time a guardianship application is made. The Public Guardian also stated that the project has improved relationships between the Public Guardian and NSW Health.

14.76 Ms Binny stated that if someone such as Mrs Chrupalo had been identified by the Hospital as a person in need of a guardianship order, the Public Guardian may have sought coercive orders at the point the person sought to discharge against medical advice. Ms Osborne stated that if the Public Guardian had been appointed, she would have worked with the Hospital to ensure that Mrs Chrupalo stayed within the Hospital. If Mrs Chrupalo was still determined to self-discharge, a coercive function could have been sought. However, Mrs Chrupalo's case may not have fallen within the Health Guardianship Project, as it does not apply to a person who has been discharged (including by way of self-discharge) before appointment of a guardian.

14.77 The Key Performance Indicators for the Health Guardianship Project include 21 days from the time of application for the Tribunal to list the matter for final hearing, and 14 days for the Public Guardian to make an accommodation or services decisions once appointed. It was also apparent during the hearing that Dr Hardacre and Ms Bickerton were both previously unaware of the Health Guardianship Project.

14.78 While the Health Guardianship Project seems to be a helpful and important development, it may not have applied to Mrs Chrupalo's circumstances, unless an application was made for a coercive

function sufficiently in advance of Mrs Chrupalo's self-discharge to enable the Tribunal to consider the application and make such an order.

Other changes at the Public Guardian

14.79 A number of other changes at the Public Guardian may be summarised as follows:

(a) Regional allocation of files: Between 2018 and early 2019, the Western Guardianship team adopted a "regionalisation approach" to the allocation of client matters, where guardians cover a particular geographical region within the Western area. This allows guardians to be familiar with local services and build relationships with service providers.

(b) Additional oversight and allocation: The Public Guardian is also revisiting how files are reviewed to ensure additional oversight, and has introduced full allocation of matters to ensure that matters are allocated to a single, dedicated guardian.

(c) Complex case mechanism: The introduction of this mechanism brings together subject matter experts from across the organisation to find solutions or a way forward. Complex case reviews monitor case progress and allow a multidisciplinary approach and "whole of organisation" approach to complex cases. This information will form part of the information that is provided to the Tribunal. Mrs Chrupalo's case would have fallen within the complex case mechanism.

(d) No increased training for staff on Tribunal hearings: It does not appear that any specific additional training has been introduced since 2016 regarding the provision of information to the Tribunal. Ms Osborne referred to staff induction training, regular supervision of junior staff and the building of abilities through attending hearings. She also referred the work that had been done with the Tribunal as to the information that was provided on review, the role of the Public Guardian (and its limitations).

(e) Elder abuse policy: On 1 April 2021, Ms Osborne gave evidence that the NSW Trustee and Guardian (**NSWTG**) is in the process of developing a new policy for responding to allegations of abuse, neglect and exploitation. On 27 August 2021, the NSWTG's Abuse Policy was released internally to all staff but was not publicly released. The Abuse Policy states that the NSWTG has a duty of care to protect customers from neglect, abuse and exploitation pursuant to section 39 of the *NSW Trustee and Guardian Act 2009* and section 4 of the *Guardianship Act*. It provides that where the NSWTG receives information relating to allegations of violence, abuse, neglect or exploitation of a customer, the organisation has a responsibility to respond appropriately and quickly to ensure the safety of the person. It sets out NSWTG's framework for responding to allegations, including escalation and referral pathways.

The Abuse Policy provides guidance on the types of abuse and associated indicators. Neglect is recognised as a form of abuse and defined as follows:

> Neglect is the failure of a responsible person to provide the necessities of life, such as adequate food, shelter, clothing or medical care, to another person. This may also include preventing others from providing this care. Neglect can be intentional or passive. Signs of neglect include:

- Inadequate nutrition, malnourishment or unexplained weight loss
- Poor personal hygiene
- Being left alone or unattended for periods of time
- Lacking in social, cultural, intellectual or physical stimulation.

Under the Abuse Policy, a staff member is to immediately escalate concerns or allegations of violence, abuse, neglect or exploitation to their manager and perform a risk assessment. An indicator that a person may be at "*immediate risk*" includes "*trying to contact a customer on multiple occasions and not being able to reach them directly or through a service provider*". Where there is an immediate risk to the welfare and safety of the customer, the manager will report concerns to emergency services such as the NSWPF and request a "*welfare check*". The Abuse Policy states that where the NSWTG is appointed as Public Guardian, concerns/allegations of abuse are looked into and weighed up against the risk/benefits of a decision for the represented person

14.80 The NSWTG is considering whether to incorporate the Abuse Policy into a training package. The NSWTG induction process identifies key policies that new staff are to be aware of, and this will include the Abuse Policy. It is therefore desirable to make the following recommendation.

14.81 **Recommendation 9:** I recommend that the NSW Trustee and Guardian provide training to staff within the Office of the NSW Public Guardian in relation the *Policy: Recognising and responding to allegations of violence, abuse, neglect and exploitation of customers*.

14.82 Ms Osborne gave evidence that the Public Guardian had not had a change to its funding since 2010, despite increasing demand for NSWTG's services as a result of the ageing population, the impact of the Disability and Aged Care Royal Commissions and the introduction of the National Disability Insurance Scheme. Staffing numbers remained the same and guardians carried a high caseload. In a further statement provided after giving evidence, Ms Osborne stated that the NSWTG was granted an additional $41.5 million in funding over the next four years in in the recent NSW State budget, announced on 22 June 2021, to address the increased demand for guardianship and financial management service.

Ageing and Disability Commission

14.83 The NSW Ageing and Disability Commission (**Commission**) was established on 1 July 2019. Its functions include responding to allegations of abuse, neglect and exploitation of adults, including by providing advice, making referrals and conducting investigations. It may, for instance, make a referral to NSW Health to conduct an assessment or to NSW Police. The NSWTG and the Commission have a Memorandum of Understanding, which operates as an information sharing agreement.

14.84 Ms Osborne stated that the Public Guardian would now likely refer Mrs Chrupalo's matter to the Commission, noting the Commission's wide ranging investigative powers. Kathryn McKenzie, Director, Operations at the Commission, stated that there were a range of actions the Commission

could have taken to assist the Public Guardian, such as putting forward options in relation to decisions to be made.

14.85 However, there is not a clear delineation between the roles of the Commission and the Public Guardian. Ms McKenzie stated that if a matter was referred to the Commission in respect of which the Public Guardian had been appointed, the Commission would engage with the Public Guardian at an early point to determine what actions had been taken or were to be taken, so that there was no duplication.

14.86 Ms McKenzie also stated that if the adult at the centre of the report or referral did not want the involvement of the Commission, and there was no indication of impaired capacity, then the Commission would typically respect their wishes. Subject to certain exceptions, such as the level of seriousness or risk, the Commission is required to have the consent of the adult concerned to conduct an investigation.

Preventing and Responding to Abuse of Older People (Elder Abuse) NSW Interagency Policy

14.87 The NSW Interagency Policy for Preventing and Responding to Abuse of Older People (Elder Abuse) (**Interagency Policy**) was updated in June 2020. The Interagency Policy sets out the approach to preventing and responding to abuse of older people for NSW Government agencies. The Interagency Policy states:

> This policy applies to all NSW agencies; however, details additional requirements for agencies with significant interface with older people through the services they deliver.
>
> The policy has a higher expectation of response and accountability for agencies that have a higher likelihood of identifying abuse or a role in assisting the response to abuse. Responses will be calibrated according to service type and nature, particularly where there is a professional duty of care.

14.88 The Interagency Policy defines abuse as:

> A single or repeated act, or lack of action, occurring within a relationship where there is an expectation of trust, and which causes harm or distress to an older person.

14.89 The Interagency Policy recognises neglect as a form of abuse and defines neglect as:

> The failure of a responsible person to provide the older person with the necessities of live – such as adequate food, shelter, clothing, medical or dental care – or to prevent others from providing them. It can also include failing to take reasonable actions to assist the older person to access necessary aged care or other supports. Neglect can be intentional or passive.

14.90 Signs of neglect include:

> […] inadequate nutrition, malnourishment and unexplained weight loss; inappropriate clothing (such as for the season); poor personal hygiene, unkempt appearance; poor skin integrity; hypothermia or overheating; being left alone, abandoned or unattended for long periods, or lacking in social, cultural, intellectual or physical stimulation; injuries that have not been appropriately cared for; exposure to danger or lack of supervision; absence of required aids.

14.91 The Interagency Policy refers to the enhancement of police resources in 2019 to include Aged Crime Prevention Officers (**ACPOs**) in each Police Command across NSW. The primary responsibility of ACPOs is preventing, disrupting and responding to the exploitation, abuse and neglect of vulnerable people, including older people and people with disability. The ACPOs receive training in working with people with dementia, Trustee and Guardian Services and identifying carer stress.

14.92 The Interagency Policy also states that non-government and private services that provide support services to older people should familiarise themselves with the signs of elder abuse and have clear response protocols

15. Findings pursuant to section 81 of the *Coroners Act 2009*

15.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Elizabeth Raper SC, Counsel Assisting, and her instructing solicitor, Ms Tracey Howe of the NSW Crown Solicitor's Office. The Assisting Team has provided invaluable assistance and demonstrated exceptional professionalism in preparing for, and during the conduct of, the inquest. I am also extremely grateful for the sensitivity that they have shown throughout the course of this particularly distressing matter.

15.2 I also thank Detective Senior Constable Anthony Armour of Orana Mid Western Police District for conducting a comprehensive investigation and compiling the initial brief of evidence.

15.3 The findings I make under section 81(1) of the Act in relation to **Judith Chrupalo** are:

Identity

The person who died was Judith Chrupalo.

Date of death

Mrs Chrupalo died sometime between about 16 February 2016 and 2 March 2016.

Place of death

Mrs Chrupalo died at Dubbo NSW 2380.

Cause of death

Due to the effects of decomposition the postmortem examination was unable to ascertain the cause of Mrs Chrupalo's death. Therefore, the limited available evidence does not allow for any finding to be made as to the cause of Mrs Chrupalo's death.

Manner of death

Mrs Chrupalo died of natural causes.

15.4 The findings I make under section 81(1) of the Act in relation to **Christopher Clee** are:

Identity

The person who died was Christopher Clee.

Date of death

Mrs Clee died sometime between about 16 February 2016 and 2 March 2016.

Place of death

Mr Clee died at Dubbo NSW 2380.

Cause of death

Due to the effects of decomposition the postmortem examination was unable to ascertain the cause of Mr Clee's death. Therefore, the limited available evidence does not allow for any finding to be made as to the cause of Mr Clee's death.

Manner of death

Mr Clee died of natural causes.

16. Epilogue

16.1 It is a disheartening fact that many reportable deaths to the Coroner occur in situations where persons are found deceased in their homes, alone, and without a concern for their welfare having been raised for a significant period of time. Sadly, the inquest, and the entire coronial process, occurred without the involvement of any family member or loved one of Mrs Chrupalo and Mr Clee. This inquest, perhaps more than others, has emphasised the need to protect older persons, and the members of our community who are most vulnerable and socially disconnected, from potential harm.

16.2 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
23 December 2021
Coroners Court of New South Wales

Inquest into the deaths of Judith Chrupalo & Christopher Clee

Appendix A

Recommendations made pursuant to section 82, *Coroners Act 2009*

To the Secretary, New South Wales Health:

Recommendation 1: I recommend that NSW Health review *The Guardianship Application Process for Adult Inpatients in NSW Health Facilities (GL2017_013)* in relation to the requirements for making an application under the *Guardianship Act 1987*, particularly in relation to the concept of disability, including physical disability, and the Health Guardianship Project.

To the Chief Executive, Western New South Wales Local Health District:

Recommendation 2: I recommend that Dubbo Base Hospital introduce procedures and provide training to staff in relation to guardianship applications that set out:

(a) the circumstances in which it is necessary and appropriate to make an application;

(b) who is responsible for coordinating such an application;

(c) the requirements for guardianship applications, including the reports to be provided to the NSW Civil and Administrative Tribunal and appointed guardian to support the application and guardianship process (whether a private guardian or the Public Guardian is appointed); and

(d) coordination with the Office of the Public Guardian in relation to the Health Guardianship Project.

Recommendation 3: I recommend that Dubbo Base Hospital introduce procedures and provide training to staff for capacity assessments that:

(a) set out the appropriate circumstances where such assessments should be undertaken;

(b) identify who the appropriate health practitioners and/or clinicians may be depending on the nature of the assessment;

(c) identify the appropriate range of assessment tools are available;

(d) require early referral for capacity assessments, pre-discharge, to ensure adequate time for undertaking an assessment;

(e) identify the available options for a capacity assessment or other negotiator pathways that are available where there is a possibility of discharge without medical advice;

(f) ensure that, if there is a referral to a clinician for assessment, the purpose(s) of such assessments are clearly identified and documented and all relevant information is made available to the clinician conducting the assessment;

(g) ensure that ultimately the assessment is undertaken within a multidisciplinary framework; and

(h) require documentation of any assessment, including any tests undertaken.

Recommendation 4: I recommend that Dubbo Base Hospital review procedures for discharge against medical advice and advance discharge planning to ensure that the health and welfare of patients is protected with adequate post-discharge support that is consistent with the Hospital's duty of care.

Recommendation 5: I recommend that Dubbo Base Hospital introduce written procedures and provide training in relation to elder abuse, neglect and exploitation of patients, which provides guidance on the indicators, the means of responding, and the duty of care and responsibilities of staff. Such procedures and training would refer to the procedures relating to appointment of the Public Guardian or a hospital guardian, the availability of assistance from the Ageing and Disability Commission and the operation of the Health Guardianship Project.

<u>To the Chief Executive, Lourdes Hospital and Community Health Services:</u>

Recommendation 6: I recommend that Lourdes Hospital and Community Health Services (**Lourdes**) review procedures for discharge, including against medical advice, to ensure that the health and welfare of patients is protected and consistent with Lourdes' duty of care, including ensuring that Lourdes has:

(a) received a direct communication from the patient that he or she no longer wishes to receive care (a communication from a carer being insufficient) before discharge;

(b) liaised directly with the patient's general practitioner regarding the possibility of discharge; and

(c) has before discharge, informed the patient of the possibility of discharge and what other services are, or are not, available.

Recommendation 7: I recommend that Lourdes Hospital and Community Health Services introduce written procedures and provide training to staff in relation to guardianship applications that set out:

(a) the circumstances in which it is appropriate to make an application;

(b) the requirements for guardianship applications;

(c) the information and support to be provided to the NSW Civil and Administrative Tribunal and appointed guardian to support the application and guardianship process (whether a private guardian or the Public Guardian is appointed)l;

(d) the role of the Public Guardian once appointed; and

(e) co-ordination with the Office of the Public Guardian in relation to the Health Guardianship Project.

Recommendation 8: I recommend that Lourdes Hospital and Community Health Services introduce written procedures and provide training in relation to elder abuse, neglect and exploitation of patients, which provides guidance on the indicators, the means of responding and the duty of care and responsibilities of staff. Such procedures and training would refer to the procedures relating to appointment of the Public Guardian or a hospital guardian, the availability of assistance from the Ageing and Disability Commission and the availability of the police to assist in providing welfare checks.

To the Chief Executive Officer, New South Wales Trustee & Guardian

Recommendation 9: I recommend that New South Wales Trustee & Guardian provide training to staff within the Office of the NSW Public Guardian in relation the *Policy: Recognising and responding to allegations of violence, abuse, neglect and exploitation of customers*.

Magistrate Derek Lee
Deputy State Coroner
23 December 2021
Coroners Court of New South Wales