CORONER'S COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Thomas Fulcher
Hearing dates:	2, 3, 4 May 2022
Date of findings:	24 June 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – s24 Coroners Act, death of a person in disability care group home; fracture sustained in a fall, whether failure by care workers to obtain medical assessment and treatment; responses of service provider since the death.
File number:	
Representation:	Mr Peter Aitken, Counsel Assisting the Coroner, instructed by Crown Solicitors Office Ms LP McFee Counsel for Ms Gorman, instructed by Colin, Biggers and Paisley Mr Timothy Ryan, Counsel for Ms Stevens, instructed by Shaddicks Lawyers Ms Gillian Mahoney, Counsel for Northcott Society, trading as Northcott Disability Services, instructed by Colin, Biggers and Paisley Lawyers

Findings:

I make the following findings pursuant to s81 of the Coroners Act 2009 NSW:

Identity	Thomas Fulcher
Date	21 January 2018
Place	Mount Druitt Hospital

Cause of death: hypovolaemic shock due to the consequences of his fractured femur

Manner of death - misadventure

Recommendations Nil

Non-publication orders: A non-publication order was made that the names of any residents of Northcott residential facilities, other than Mr Fulcher, not be published.

JUDGMENT

Introduction

1 This is an inquest into the death of Mr Thomas Fulcher, who had before his death been residing at Hartington Street Group Home ("the Home") administered by the Care organisation, Northcott Society, trading as Northcott Disability Services ("Northcott"). Mr Fulcher had a fall on 19 January 2018, was assisted to his bed to sleep after the fall and was observed the following morning to be seriously unwell. An ambulance was called on the morning of 20 January. Mr Fulcher died at Mount Druitt Hospital on 21 January 2018, at around 7.50am. As will be detailed below, the evidence supports a conclusion that on 19 January 2018 Mr Fulcher suffered a fractured femur, and there was subsequent internal bleeding leading to Mr Fulcher's death. The evidence suggests that if Mr Fulcher had received earlier medical attention his death may have been prevented.

2 As Coroner, I offer my condolences to the family of Mr Fulcher for their loss – he was a much loved brother of his many siblings, and particularly his sister, June, who was also his guardian.

3 The role of Coroner, under the *Coroners Act 2009* (the Act), is to investigate all reportable deaths. The investigation is conducted primarily to make formal findings as to the following five aspects of death (1) the identity of the person who died; (2) the date and (3) place they died, and what was the (4) cause and (5) manner of that person's death.

4 The inquest investigates the facts and circumstances of a death, places them on the public record, and may examine changes that could be made to prevent similar deaths in the future. In Mr Fulcher's case he was a person of some vulnerability given his disabilities and dependence on others for care, and it is particularly important for the Coroner to investigate the circumstances of his death and try to prevent similar occurrences in future.

5 The focus of the inquest was to inquire into Mr Fulcher's care on 19 January 2018, preceding his death at Mt Druitt Hospital on 21 January 2018, including whether there were deficiencies in that care. The inquest also examined the steps that have been taken by his care organisation, Northcott, to address issues identified subsequent to Mr Fulcher's injury and death.

6 Mr Fulcher reportedly dropped/fell to the ground, and was later assisted to the bathroom, and then to his room to sleep, by care staff. In the morning he was seen to have a swollen leg, and shortly after that observation, his health status deteriorated, an ambulance was called and he was transported to Mt Druitt Hospital where he later died. His death was a result of hypovolaemic shock due to the consequences of his fractured femur - in lay terms, internal bleeding following injury to a major artery or arteries caused by the fractured femur – which in turn led to a significant drop in blood pressure and apparent cardiac arrest some hours later, followed by brain hypoxia. In Mr Fulcher's case the fracture was a significant fragmented and spiral fracture of his thigh bone, as detailed below.

The issues

7 Because the cause of Mr Fulcher's death was not disputed, and because Northcott conducted a critical incident investigation into his death, and recommended and implemented a number of reforms, the focus of the inquest was on two areas. The issues for the inquest were:

(1) The circumstances, or manner, of Mr Fulcher's death; and

(2) Whether, in light of the reforms or changes made by Northcott, anything more needs to be done to help prevent similar deaths from occurring in the future.

Background of Mr Fulcher

8 Mr Fulcher ("Tom") was born on 6 September 1947. At the time of his death he was 70 years old. He was one of seven sisters and brothers who were

raised in Blacktown by his parents Frederick and Jean. He was educated until the age of 15 and began work in what was then called a sheltered workshop. His sister and guardian, June Mitchell, who was present at the inquest with her husband, Alan, noticed that Tom, who could read and write and talk, seemed to lose interest in those things about 19 years ago. However one of his regular carers, Margaret Crowley, has said that she had managed to coax Tom to say “goodnight” and “you” (for thankyou), but that he was otherwise non-verbal in the time that she knew him. Carer Beth Blacklaws recalled that Tom could say ‘no” if he didn’t want something. Tom suffered from various conditions, including an intellectual disability, moderate intellectual developmental delay, osteoporosis (a condition his sister suspected he may have had, and which was also suspected by a doctor who had attempted to have him assessed), schizoaffective disorder, high-arched feet that required corrective shoes, and depression and anxiety. He was largely non-verbal but was able to communicate certain aspects of his wishes or needs (as they related to activities of daily living) through means other than spoken language.

9 When he was about 19 or 20 years old Thomas was placed into care. In November 2015, following the devolution of institutional care, Mr Fulcher’s residence changed from the Marsden Large Residential Centre to the Hartington Street Group Home (“Hartington Street”), a supported accommodation residence and a purpose built facility, operated by the then Family and Community Services (“FACS”) (Vol 8: tab 161: TPA, p. 15). Mr Fulcher transferred to Hartington Street with 3 other residents and each of those residents continued to reside there with Mr Fulcher, up to Mr Fulcher’s death. On 3 November 2017, 10 weeks prior to Mr Fulcher’s death, Northcott assumed responsibility for Hartington Street. On that day, the staff transferred across from FACS to become Northcott employees, either as casual or permanent employees. The operations at Hartington Street continued, with the policies and procedures under FACS being relied upon. The process of moving across to Northcott policies and procedures began immediately and was a gradual process upon Northcott assuming control of the premises.

10 In accordance with an agreement reached prior to transfer, the same organisational structure was maintained for a 2 year period.

11 Tom was able to walk unassisted on even surfaces, but would reportedly seek the support of someone's arm on uneven surfaces or when stepping down from things like a kerb. He generally chose to walk unassisted, and walked with a shuffling gait. Care worker, Ms Garcia, described Thomas as someone who liked to be on his own. Ms Crowley said that when he was in pain, he would pace frantically.

12 His sister June was a regular visitor, including with her husband at times, and it is clear that she was deeply fond of and cared about Tom. Her statement also indicates that his death affected the regular carers at the group home. Tom was described by carer Sam Garcia as a "gentle, quiet, peaceful man" and by carer Beth Blacklaws as a placid man who would give her a big grin when she gave him nice things to eat. Staff member Jasleen Gill told the Northcott investigator that Tom loved music and dancing with the staff.

The evidence

13 The detailed police and coronial investigation provided nine volumes of documentary material which included the post mortem autopsy report by the forensic pathologist, post mortem CT scans; various medical and care records of Mr Fulcher, policy documents from Northcott; Northcott incident reports and a Northcott Critical Incident investigation into the death of Mr Fulcher; and FACS policies were also available to the Coroner. Dr Myles Coolican, Orthopaedic Surgeon, was engaged to provide a report to the Coroner, which was dated 31 March 2022.

14 A number of interviews with care staff were conducted by Northcott as part of its critical incident investigation; the police also interviewed witnesses and prepared statements and all of this material was included in the brief to the Coroner.

15 The witnesses who gave evidence at the hearing included the officer in charge of the police investigation, Detective Senior Constable James Cassar; care workers Ms Gorman and Ms Stevens; a medical expert retained as part of the coronial investigation, Dr Coolican; and witnesses from Northcott – Mr Chain and Ms Carpenter.

Mr Fulcher's support needs

16 Mr Fulcher's support needs were recorded in a number of plans. These were created during the period that Hartington Street was under the management of FACS and continued to apply upon Northcott assuming management of Hartington Street. The evidence discloses the following plans:

(i) On 19 November 2016, a "My Health and Wellbeing Plan" was developed. That plan stated Mr Fulcher will "demonstrate facial grimacing and vocalise a moaning sounds when I am experiencing pain. I will usually quite (sic) and just want to stay in my room" (V3: Tab 61: p. 5, 26)

(ii) In March 2017, a Behaviour Support Plan for Mr Fulcher was reviewed by Angie Zappala and a "Falls Prevention Strategy" for Mr Fulcher was prepared by Physiotherapist, Jenny Young (V3: Tab 61: p.250).

(iii) On 26 October 2016, a PRN Protocol for Mr Fulcher was developed by Jasleen Gill. V2: p. 67). On 15 November 2016. Mr Fulcher's sister, June Mitchell, consented to the PRN for Mr Fulcher (V2: p. 63). This was updated by Jasleen Gill on 28 March 2017 and consented to by relevant persons (V2: Tab 50: p. 69). This came about from Mr Fulcher's reluctance to engage in medical exams, pathology testing and imaging and (ADHC/FACS) staff concerns for their duty to care for Mr Fulcher's physical and mental health. On 26 June 2017, Thomas' sister and

guardian requested, subject to medical necessity, no further pathology or imaging for deceased due to significant anxiety and stress it causes for deceased (V2: Tab 50: p. 59). Accordingly, the PRN was ended due to the distress Mr Fulcher continued to endure in such assessments.

(iv) On 4 April 2017, a Physiotherapy Mobility Management Plan was created for MrFulcher.

(v) On 28 July 2017, Mr Fulcher's "My Safety Plan" was updated.

17 These documents remained with Mr Fulcher's file upon the transfer from ADHC/FACS to Northcott.

18 The key features of the Physiotherapy Mobility Management and Falls Prevention Strategy Plan were that:

(a) Mr Fulcher has a history of fractures.

(b) Mr Fulcher is able to walk short distances with support from staff due to fear of falling whilst walking on uneven surfaces.

(c) Mr Fulcher is at high risk of falls due to difference in leg length (right leg shorter than left leg) and foot length (left foot smaller than right foot).

(d) Mr Fulcher can transfer himself independently with standby supervision.

(e) Independent mobility whilst indoors with standby supervision; whilst outdoors standby supervision on even surfaces and one person to assist on uneven surfaces. Nil mobility aids used, hand on hand technique in place. Wheelchair to be used for

outdoors and long distances only preferably on even surfaces, rampsand kerbs.

(f) In the event of a fall, do not lift Mr Fulcher but assist (1-2 staff support whilst assisting from floor, verbal prompts and hold around hip area) by using the standard fall mobility techniques and in case of serious fall - call Triple Zero (000) and seek medical assistance.

Evidence of Mr Fulcher's injury

19 At post mortem, pathologist Dr Lorraine Du Toit-Prinsloo, concluded from the records, external autopsy examination and the results of a CT scan, that Thomas had died as a result of hypovolaemic shock (understood to generally include sufficient loss of blood preventing the heart from pumping enough blood, followed by organ failure) due to a fractured femur. Externally, the fracture and blood loss were indicated by marked swelling of Thomas' right thigh. She noted that spontaneous distal femur fractures in the setting of nursing homes are well reported and mostly occur in the elderly, associated with dementia, decreased mobility and osteopenia (a condition where the protein and mineral content of bone is reduced, but less severely than with osteoporosis). She noted that minor trauma can result in more severe fractures than might typically be expected. Dr Du Toit-Prinsloo recommended review by an orthopaedic surgeon.

20 Dr Myles Coolican, Orthopaedic Surgeon, Visiting Medical Officer in Orthopaedic Surgery at Royal North Shore Hospital, was engaged to provide a report to the Coroner, which was dated 31 March 2022. (Vol 9 tab 194). Dr Coolican confirmed a diagnosis of osteoporosis including very thin cortical bone (the outer layer of the bone). He noted that the fracture showed advanced osteoporosis. He described the fracture as

> "a spiral fracture of the right femur starting distally at the mid-femur and migrating proximally to the intertrochanteric region. Spiral fractures of this nature are caused by twisting injury. Given evidence of osteoporosis the

> fracture could have occurred with the described drop. It is clear that following this drop Mr Fulcher refused to walk and most certainly could not have taken any weight on his right leg following the fracture."

21 Dr Coolican also stated that the fracture could have occurred from a simple fall from standing height, but would have involved a twist of the femur.

22 Dr Coolican described a spiral fracture as occurring from a twisting injury. In his evidence at the inquest, Dr Coolican confirmed his view that a simple fall from height would produce the femur fracture, and clarified that the twisting or rotation that produced the spiral part of the fracture, could have resulted from the leg being in a turn when the fall occurred, with the twist being further twisted by the fall and hitting the floor.

23 Dr Coolican's evidence indicated that the fracture must have occurred subsequent to when he was last seen walking unaided on 19 January 2018. He also stated that it was extremely unlikely that Mr Fulcher would be walking around with an undisplaced spiral fracture of the femur, and the fracture most likely occurred during the drop to the floor, and he was seen to be unable to weight bear and walk after that. Dr Coolican stated that it was extremely unlikely that a significant injury occurred subsequently.

24 Separately, Dr Coolican concluded that the posited scenario of a simple undisplaced fracture occurring some time before the spiral fracture was extremely unlikely and he could not see any features to suggest a longstanding fracture with subsequent displacement. The fracture appeared fresh.

25 Dr Coolican also explained that bone fragments or spikes from a spiral fracture can penetrate an artery, causing the internal bleeding that was subsequently diagnosed, in circumstances where major arteries and branches were located near to the fracture site. Dr Coolican concluded that the cardiac arrest resulted in hypoxic brain damage whilst there was no cardiac output.

26 Dr Coolican concluded that the outcome would have been different if Thomas had received medical attention/ treatment on the evening of 19 January 2018.

Dr Coolican concluded that medical assessment would have revealed a shortened and externally rotated right leg with swelling around the fracture site and crepitus (a sound made by the movement of the fractured bone) when the leg was moved. Dr Coolican anticipated that physical signs of hypovolaemia would have been present over a period of 3-4 hours, including hypotension and tachycardia.

27 He clarified that the advanced osteoporosis that Thomas suffered in his femur would have likely resulted from not forming sufficient bone density in his twenties, particularly if he did not play sport or do other vigorous weight bearing exercise. He said that if the evidence was that Thomas was unable to get up, or could not get up after the initial fall or drop, that indicated that the fracture had already occurred by that point. Similarly, an inability to weight bear would indicate the fracture had already occurred. He expected that weight bearing would be painful after the fracture occurred.

28 Dr Coolican considered it most unlikely that there could have been an undisplaced fracture caused, and then some time later, a subsequent spiral and displaced fracture, for example by his leg subsequently being twisted during the 'leg check' later performed by Ms Stevens. Dr Coolican suggested that 'leg check' would have had to involve a twist with "violent force", and considered that what was described would not likely have caused the spiral fracture. He considered that a spike of bone visible on the CT scan had most likely penetrated one of the major arteries near the femoral artery, causing the blood loss. He said that the right foot would have appeared "turned out".

29 When asked to consider the scenario of the leg being checked and no fracture being detected, Dr Coolican clarified that crepitus may be something you would feel on examination rather than necessarily hearing a noise, that there may have been initial minor swelling. However the diagnosis of a fracture (from the combination of factors he expected would have been present and detectable) was a diagnosis he expected would have been made by someone medically trained, but not by someone without such training.

30 Dr Coolican was asked to review the post mortem CT scans of the rib fractures, given the reference in the Mt Druitt hospital records to recently healing fractures, and the pathologist's identification of rib fractures caused by CPR efforts. After such review Dr Coolican stated that there was no evidence of any recently healing rib fractures, either anteriorly or posteriorly, and, consistently with the view of the pathologist, Dr Coolican stated that the anterior rib and sternum fractures were likely a result of CPR.

31 Counsel Assisting submitted that "Prevention" was a key consideration in this inquest because, if Dr Coolican's evidence is accepted, on one view Mr Fulcher's death may have been preventable, because if policies had been followed he would in all likelihood have been examined by a paramedic or doctor, and thus his injury would have been detected and appropriately responded to.

Issue 1 – manner of death

32 The following is a summary of evidence taken from various witness statements and documentary evidence contained in the brief of evidence, and witness testimony at the inquest hearing. Given serious questions about how Mr Fulcher was injured a detailed summary of the evidence is required in these reasons for decision.

The events of 19 January 2018 – discussion of evidence

33 There were unanticipated staffing issues at the Home on 19 January because of a funeral - on 12 January 2019, a Northcott Disability Worker who worked at the Hartington Street Home died, and the funeral was on Friday, 19 January 2018. As a consequence, regular staff members were not available. Two staff members, Sandra Stevens and Maria Gorman, who did not regularly work at Hartington Street, were rostered to work. Both Ms Stevens and Ms Gorman had previously been inducted into Hartington Street, although some years before: Ms Stevens was inducted into Hartington on 30 November 2015; and Ms Gorman completed an induction sometime on 6 January 2016.

34 Both Ms Stevens and Ms Gorman had each worked a shift at Hartington Street in the days prior to 19 January 2018. Ms Gorman worked at Hartington Street on Thursday, 18 January, and Ms Stevens had worked a night shift on Monday, 15 January. The evidence indicates that neither worker read the files of Mr Fulcher during those previous shifts, or during the shift on 19 January.

35 On 19 January 2018, Mr Fulcher attended Sunnyfield at St Mary's between approximately 9.15am and 3.30pm – 4pm, at which time he arrived back at Hartington Street having been transported on the return journey by Ms Stevens.

36 Around 2.30pm on Friday 19 January 2018 Ms Gorman arrived and talked to Ms Stevens, who left shortly afterwards with the van to go and pick up Thomas and another resident from Sunnyfield.

37 At around 3pm, staff member Jennifer Dowd from Sunnyfield saw a female arrive to pick up Thomas and another male resident, on the evidence this was Ms Stevens. On being reminded by Ms Dowd that she was late, Ms Stevens allegedly said words to the effect "that's what happens when they employ fucking casual staff who can't drive". Sunnyfield is a separate NDIS provider organisation from Northcott.

38 Around 3.30pm Ms Stevens and Thomas returned to the Home, and Ms Gorman made Thomas a cup of tea and he ate some food. Another male resident was not in a good mood and was screaming at times. Thomas was observed to walk independently although Ms Gorman thought he was moving more slowly than how he presented the day before. Mr Fulcher was provided dinner at approximately 5.30pm.

39 Thomas ate some of his dinner while two other residents were yelling. Ms Gorman recalls being in the kitchen when Ms Stevens said she would give Thomas a shower.

40 Mr Fulcher was generally not showered prior to his dinner, so this was inconsistent with his routine. It appears to have been at the direction of Ms Gorman.

41 At about 6pm, Ms Stevens left the kitchen area for the purpose of showering Mr Fulcher who had walked towards his room. It is unclear what exactly happened but the evidence suggests the following occurred:

- Ms Stevens directed Mr Fulcher to the bathroom for the purpose of a shower.

- Mr Fulcher reportedly expressed reluctance and Ms Stevens took hold of him whilst he was standing in his doorway to physically redirect him to the bathroom.

- Mr Fulcher appeared to either intentionally or unintentionally drop towards the floor and Ms Stevens let go of Mr Fulcher and he landed on his bottom on the floor.

- Ms Stevens did not give Mr Fulcher time to self-regulate (assuming it was a behavioural response and not an unintentional drop or fall) then dragged, either in a pulling direction or a pushing direction, Mr Fulcher to the lounge, a distance of approximately 2 – 2.5 metres.

- Mr Fulcher was assisted by Ms Stevens to the edge of the lounge where, he apparently slid back to the floor.

- Ms Stevens then called Ms Gorman to assist in lifting Mr Fulcher off the floor and over to the bathroom for the purpose of being toileted and bathed in preparation for bed.

- Whilst placing Mr Fulcher in bed, in the presence of Ms Gorman, Ms Stevens looked over Mr Fulcher's legs and observed no swelling and no deformity. She also patted his leg (described as a "body check") and

felt nothing of concern and noted no reaction from Mr Fulcher to suggest he was in pain. Ms Gorman expressed similar observations.

- Mr Fulcher was then left in his bed to sleep until the following morning.

42 Ms Stevens evidence is that she called on Ms Gorman twice to assist in moving Mr Fulcher. There is a conflict in the evidence of Ms Gorman and Ms Stevens in relation to Ms Gorman's attendance. What is common on their evidence is that Ms Gorman did assist Ms Stevens to move Thomas a seated position on the floor of lounge area, to the bathroom to get him ready for bed; and then assisted to put him in bed.

43 Ms Steven's Incident report was prepared on 20 January 2018. The report stated:

> "Thomas kept trying to get up, staff was assisting, but Thomas's feet kept sliding on the floor. Staff by holding Thomas under the arms over to the lounge to assist Thomas on the lounge. Once on the lounge, Thomas slid to the floor." [In evidence Ms Stevens confirmed the reference to "staff" was a reference to herself]

44 On 21 January 2018, Samantha Garcia, Disability Support Worker, in a police statement reported that during handover Ms Stevens reported to her:

> "Tommy was refusing to have a shower. He was holding onto the door frame (of his room) and he dropped". I asked her what she meant by "dropped", and she told me he was pissed off and he was gripping onto the door frame and to me he was displaying behaviours".

45 At p. 4 of the Incident Report, it checks the box that there were no witnesses to the incident. An inference can be drawn from that marking that Ms Gorman did not witness any falls.

46 Ms Stevens made no mention of Mr Fulcher being moved to the lounge and suffering a slide off the lounge, in the handover to Ms Garcia. As noted by Counsel Assisting in his submissions, the absence of a detailed handover report was a loss of opportunity to ensure that Thomas's well being was monitored overnight, post fall.

47 On 30 January 2018, Ms Gorman in a police statement, reported that Ms Stevens reported to her “I was holding him and he just drop”.

48 Ms Gorman’s evidence was obtained from various sources – these included her oral evidence at the inquest; and her statement to police, and statements reportedly made by Ms Gorman to other Northcott staff. In addition other staff/ witnesses provided versions to Northcott and/or police. The following is taken from Ms Gorman’s police statement (tab 19 of brief). Ms Gorman was in the kitchen when she heard Ms Stevens call out “Maria, come here for a sec” and went and found Thomas sitting on a rug and Ms Stevens saying that she was holding him and he just dropped. In her statement Ms Gorman describes the two of them lifting Thomas by the back of his pants and then “helping him’ to the toilet. She then returned to the kitchen and was called back to the toilet where Thomas was sitting holding onto the rail, and she was told by Ms Stevens that he was refusing to have a shower. Ms Gorman watched Ms Stevens help Thomas stand while he held onto the rail, then they removed his pants and sponged him. This involved him being stood up and put back down twice.

49 Thomas was then ‘helped’ to his bed and had his legs lifted onto the bed by Ms Stevens who then performed a check of his legs, feeling the knee and then “twisting” each leg. Ms Gorman said she didn’t believe this was normal as “body checks” are only performed when something has happened. Ms Stevens is alleged to have then put the doona on and said “thank god you’re fucking going to bed now”. Ms Gorman told investigators that if she had seen Thomas fall, she would have been required to call an ambulance. She said she didn’t notice any injury to Thomas.

50 In her second statement dated 22 January 2020 Ms Gorman clarified that when she first saw Thomas on the rug he was holding one hand up and that they each assisted him to walk to the toilet. She said she didn’t know if Thomas would have been able to walk unassisted. He was walking at a slower pace than usual and taking small steps. She said she had never

received any training on how to assess a person for pain. She had never experienced Thomas refusing to stand or dropping to the floor.

51 Ms Gorman was interviewed for the purposes of Northcott's internal critical incident report, a copy of which is attached to the statement of Trevor Perry. This was a question and answer interview conducted on 15 March 2018 by Mr Ben Chain. In the interview Ms Gorman indicated that she had not read any of Thomas' support plans. She clarified that she had worked there 3-4 night shifts and about 3 afternoon shifts since 2016.

52 She said that as she had to leave the home on 19 January at 7pm she had spoken to management and arranged for the other workers to come earlier, at 8pm and 9pm respectively. After Ms Stevens had returned in the van with Thomas and the other resident (who didn't want to leave the van) she had given Thomas afternoon tea (a sandwich) and then the other resident came in from the van, saying "I hate you, I hate you" to Ms Stevens. She said Ms Stevens had taken Thomas for a shower and then called out to her 5-10 minutes later.

53 In her interview Ms Gorman recounted a similar version of assisting Thomas on the toilet and walking him to his room as had been told to police. When taken to the shift report entry that stated that "staff struggled to get Thomas upright, out of anger/stubbornness, Thomas refused to stand up", Ms Gorman denied that they struggled to get him up or that Thomas appeared angry.

54 In a second interview on 9 April 2018, Ms Gorman indicated that when she first saw Thomas, he was on the floor next to the lounge. She did not agree with the description in the incident report dated 21 January 2018 which referred to her and Ms Stevens assisting Thomas to the lounge, where he slid to the floor, and was then assisted back onto the lounge. She said they held onto him as he walked to the toilet after they had helped him from the floor where she initially saw him.

55 In her evidence at the inquest hearing Ms Gorman largely adhered to her previous accounts, but at times she did not recall specific matters. She was also very unclear about training received prior to Thomas's death and seemed unable to recall the content of any training. Ms Gorman acknowledged subsequently receiving training via the "no assumptions" campaign run by Northcott and that she attended a two day training program, the precise details of which she was unable to recall.

56 At the inquest, Ms Gorman was unable to recall what training she had received from ADHC/Family and Community Services ("FACS"), as it was then known, concerning the risks of falls with residents and what to do when there had been a fall. She could not recall seeing Thomas' Falls Prevention Plan dated March 2017. She said that she hadn't been aware of the recommended falls procedure - to use a chair to help the resident/client get up - and it didn't occur to her to use a chair at the time for Thomas. She agreed that if a resident had a fall, you check for injury, but couldn't recall any training on how to check. She suggested that it would be practice to take the resident to be seen by their GP.

57 Ms Gorman's evidence suffered from a substantial lack of memory or recall in a number of areas.

58 Ms Gorman said that she hadn't been aware of older people potentially suffering from osteoporosis; she knew that Thomas took calcium for his bones, but it didn't occur to her that he may have weakened bones. She hadn't previously had experience of seeing Thomas sick or in pain. Her understanding was that if a person couldn't verbalise, their facial expression may indicate pain, or they may make a noise. To her recollection, Thomas didn't make a noise or make a face.

59 Ms Gorman said that she didn't know Thomas' routine of a shower before dinner but agreed that it was important to maintain routines.

60 Ms Gorman said that her shift started at 3pm that day. She said that when Thomas arrived back from Sunnyfield he was not happy, and that when he was happy he would walk back and forth like a yo-yo and he wasn't doing that on this day.

61 Ms Gorman presented as someone whose attention - at the time she later came to assist Thomas to get up - was focused elsewhere, namely on the needs of the other three residents of the house, as she had been called away from those residents when she responded to Ms Stevens' call for assistance after Mr Fulcher dropped/fell. The evidence suggests that one of the other residents, TT, had been screaming immediately prior to the point at which Ms Stevens went to assist Thomas with his shower. There is also some evidence pointing to another resident exhibiting screaming behaviour at about this time (MM). Ms Gorman maintained that she needed to get back to the other residents because their medication was sitting out on the kitchen bench.

62 Ms Gorman said that when she went into the room Thomas was sitting on the rug, near to the lounge and the doorway to his bedroom, and raising his hand. He was facing across to the toilet. She thought that he was raising his hand because he needed help.

63 Ms Gorman's attention does not appear to have been focused on whether or not Thomas may have been injured as a result of whatever mechanism it was that had led to him being seated on the floor, raising his hand for assistance. She agreed that each disability support worker bore responsibility for the care of the residents, and now, if in a similar situation, she may need to call the on call doctor or the ambulance. Ms Gorman appears to have regarded Ms Stevens as responsible for whatever was occurring, in terms of managing it, and Ms Gorman appears to have neglected to pay attention to what she was dealing with or whether it indicated a need for seeking medical attention for Thomas.

64 Ms Gorman appeared to have no real recall of what she learned from any training. Ms Stevens had a better recall of training she received, and an

understanding of the role of training, policies, and behaviour management plans.

65 At one point in her evidence Ms Gorman appeared to concede that they may have been assisting Thomas to walk, such that he was not affectively weight bearing. However, at other points in her oral evidence, she seemed to be saying that her impression was that Thomas was walking on both feet and only being assisted by each worker with a hand under each elbow (for example when first taking him to the bathroom). This seems highly unlikely if Dr Coolican's evidence, both as to when the fracture occurred and how Thomas would then be unable to weight bear, is accepted.

66 Ultimately, Ms Gorman accepted during her evidence to the inquest that what she had said in her Northcott interview was accurate - that she didn't know if Thomas was capable of walking unassisted or not - and agreed that she must have been assisting him and he was not walking by himself.

67 The finding that I make on the evidence, is that Ms Gorman and Ms Stevens were assisting Thomas to weight bear. This raises concerns about the extent to which Ms Gorman made any effort to appraise the situation in her own mind and query whether Thomas may be injured. In her oral evidence she was asked if she was paying attention and said words to the effect; "No, I want to help Ms Stevens" and that she had other clients who needed medication. When asked if she thought Thomas may be hurt, she said words to the effect: "I didn't think of it". She didn't check for signs of pain.

68 When asked what she thought of Ms Stevens feeling Thomas' legs once he was in the bed, Ms Gorman said: "I ask myself why she did that". When asked: "what did you think?", she replied: "Nothing, I was wondering why she was feeling it [the leg]". However her evidence also indicated her understanding that a body check was something you perform when something has happened to a client.

69 Prior to the reported drop Thomas was seen to be walking normally. On 16 January 2018 Ms Blacklaws worked a ten hour day, on an evening shift at the home, and recalled that Thomas walked around the home as usual and did not appear injured. Other witnesses at Sunnyfield and the Home who saw Thomas throughout the day on 19 January, described him as walking normally.

70 Ms Garcia arrived at the Home at 9pm on 19 January 2018. She stated that Ms Stevens told her, when Ms Stevens came into the Home on the Saturday to complete the incident report, that Thomas 'fell forward off the couch when we were trying to get him on the couch from the floor'. She said she didn't see any injuries and had "padded down" his legs and he didn't indicate any pain for her to be concerned about. She said "he didn't flinch".

71 Ms Garcia was interviewed by the Northcott investigator on 15 March 2018. She said that she was aware of a manual handling guideline for Thomas - to monitor and supervise him on uneven or unsteady ground and that he was a 'shuffler'. When she started her shift Ms Garcia noticed that Ms Stevens appeared tired. Ms Stevens said that "Tommy was being a little shit today" and that all of the clients had been restless and that Tom refused to have a shower and she had never seen him act like that before and "he just dropped to the floor". Ms Stevens was asked if it was a fall and said no, it was a slow drop to the ground; that she had tried to get him back up by herself but he was too heavy, so she dragged him across the floor and had to move the rug as he was sliding, then she called out for other staff to help her and they helped her get him onto the couch, shower and then get him to bed.

72 Ms Garcia says she checked on Thomas during the night and thought he was sleeping peacefully. At 6.30am she saw him and he looked at her and pulled his blanket up to his face. She completed her shift and left the Home at 7am.

73 Ms Garcia maintained in her Northcott interviews that when Ms Stevens came back to the house to write the incident report she was adamant that Thomas didn't drop to the floor but was against the door frame and slid, and mentioned

he fell a second time off the couch, forward onto his knees and that must have been when he hurt himself. Ms Garcia recalled Ms Blacklaws being present when this was said. Ms Garcia in her statement said that she didn't recall being made aware that there was any concern that Thomas might have suffered an injury, or was checked for same.

74 Ms Stevens initially answered a number of questions when interviewed by police in 2018 but later in the interview exercised her right to silence. She also did not take part in the Northcott investigation. No criticism can be made of an individual's election to invoke the right to silence. She did answer a number of questions in the interview with police before exercising her right to silence, and the transcript of the record of interview with the police is in evidence. There is also some further evidence from Ms Stevens from 2018 - the overnight shift report from 19 January 2018 completed by Ms Stevens (tab 161.1 page138) and the incident report that she had completed on 20 January 2018, after Ms Blacklaws had alerted her to the fact that Thomas had been hospitalised (see tab 18).

75 Ms Stevens told police in her record of interview that she had worked in a role as a casual disability support worker since September 2014. She hadn't worked many shifts at the Home and in January had worked on the Monday as well as the Friday of the week that the incident happened. She said that at the end of a shift you do a verbal handover and that she thought you have 24 hours to complete an incident report. At each Home you work at you do an induction shift of 3-4 hours where you read files and do a walk through. She told police that her induction at the Home was about two and a half years ago (around 2016).

76 Ms Stevens said that the shift on 19 January became a ten hour shift - as a staff member had passed away and they were short staffed – but then it became even longer - she started at 8.30am rather than the 11am to 9pm shift, and was meant to leave at 7.30pm but left at 9pm.

77 She said the staff were not to prevent residents from dropping, as that could injure staff, but she would hold their hand if they put it out to be held. Thomas was able to walk to and get in the van by himself that day. She said she thought the other staff member would go to Sunnyfield that day to collect the residents but the other staff member (Ms Gorman) said that she would not, as she wasn't used to driving the van, and Ms Stevens said to police ""cause I do everything". She said TT (another resident) refused to get in the van but Thomas was "fine' and that he "shuffles". They arrived back at the home after 4pm. TT refused to get out of the vehicle for about 10-15 minutes. There were no issues with Thomas at that time. Thomas ate only half his dinner, and meanwhile TT and another resident's behaviours were getting worse. Thomas walked up the hallway by himself.

78 Ms Stevens told police in the interview in 2018, that some clients will have behaviour drops when they don't want to do something. She said there was no policy on this. Ms Stevens was shown photos of the rug and Thomas' room. She said that although the rug was a safety hazard, she wasn't saying it was the cause of Thomas' injury. Ms Stevens confirmed that the next day when she had to do an incident report, that Ms Blacklaws, Ms Garcia and Ms Crowley were at the Home. Ms Stevens states that she gave a "little bit colourful" handover to Ms Garcia.

79 In the incident report form completed by Ms Stevens, she says:

> "Customer Thomas, after dinner went to rest in his room, staff tried to redirect to bathroom to shower and change Thomas. Thomas grabbed onto door frame, when staff tried to release hand to give support Thomas dropped to the ground". [The report goes on to mention that] "Thomas kept trying to get up, staff was assisting, but Thomas feet kept sliding on the floor. Staff by holding Thomas under the arms over to the lounge to assist Thomas on the lounge. Once on the lounge Thomas slid to the floor. Both staff assisted Thomas back onto lounge. Two staff assisted Thomas to the toilet, changed Thomas's incontinence pad and put him to bed. Staff checked over Thomas's legs, Thomas seemed fine and alert".

80 At the inquest Ms Stevens provided the Court with a more detailed account of her recollection, and was cross examined by Counsel Assisting and by other Counsel, including Ms Gorman's Counsel.

81 Ms Steven's evidence at the inquest needs to be considered in light of the significant passage of time since the events of January 2018, as accuracy of recall can be impaired. Also where there are distressing past events there can be a tendency for witnesses to unconsciously shape recollections in a more favourable light, which may also impact on reliability. These matters effect the weight that can be given to the reliability of the account of Ms Stevens at the inquest, where that evidence conflicts with or differs from other evidence, including her earlier version as set out above in the incident report. The evidence was that after Thomas's death, Ms Stevens was unwell and on leave for a period of time, and this may also have affected her ability to accurately recall distressing events and impacted the reliability of her recollection.

82 Ms Stevens had last worked a shift at the home on the Monday 14 January 2018, and believed that it had been six months before that when she had last worked there. She said she spoke to Thomas that evening to redirect him to the bathroom, saying: "Can you go to the bathroom and go to the toilet and have a shower".

83 Ms Stevens described a 'drop' as when you were supporting [the client] "and they drop straight down". She could not recall if she had ever received training on how to deal with that. She had however been informally trained to put a wheelchair in front of the client and have staff put them in the chair. She said she had also been informally trained to put a chair in front of the client so they could use it to get themselves up, so that the worker doesn't injure their back performing the lift. She said she had not experienced anyone injuring themselves as a consequence of a drop.

84 Ms Stevens said that she was aware that Thomas was non-verbal and expected that expressions of pain might include facial expressions, moaning or screaming. She said most clients were non-verbal.

85 Ms Stevens said that she was aware of osteopenia in the elderly, but did not regard Thomas as elderly. She thought he was in his 60s. Elderly to her

meant aged 70-90 years. She said that usually the afternoon shift do the Sunnyfield pickup and she felt frustrated that afternoon; it had been a long day (that she was frustrated that Ms Gorman had not driven the van that afternoon to Sunnyfield, is supported by comments attributed to her by Sunnyfield worker Jennifer Dowd). Ms Stevens accepted that she had referred to Thomas as having been 'shitty" when she made the handover to Ms Garcia at 9pm on 19 January 2018.

86 As to whether Ms Stevens was familiar with Thomas' physiotherapy plan (which referred to risk of fractures) Ms Stevens said she didn't know but didn't think so; she didn't know if she had seen Thomas' Behaviour Support Plan, but accepted it was likely she would have seen it. She wasn't aware of his routine (shower before dinner), and it was Ms Gorman's idea to have dinner first.

87 When Thomas left the dining room the afternoon/evening of the injury, Ms Stevens said she had to rush down the hall after him, intending to get him to have a shower. She reached him at his bedroom door, he had his hand on the door frame and removed it and she took hold of it and then let go of his hand and he dropped. Ms Stevens also added that Thomas became wobbly and there was movement, before he dropped. She denied it was a rapid drop and referred to it as a "controlled drop". In the handover to Ms Garcia on the night, Ms Garcia recalled Ms Stevens referring to Thomas sliding down the door frame.

88 Ms Stevens initially said that she had taken Thomas' hand from the door frame but later denied that she had pulled his hand away from the door frame; she assumed he was angry when he 'dropped' but she thought he seemed fine. Thomas then put out his left hand for help and wanted to get up. She put her hand out to help him and didn't think of getting a chair. She said that Thomas tried to brace his right hand on the ground to get up and he "kept trying to get up". She said that when she helped Thomas up, he slipped or slid, so she dragged him under each arm a short distance to the lounge. She said she didn't think to call out for assistance at that point. She said that when

she got him to the lounge he also tried to get up and raise himself up but couldn't.

89 Ms Stevens said that Thomas didn't show signs of injury or pain and she assumed that he lacked the strength to get up. She claimed that Thomas managed to turn and put his bottom on the lounge but then he slid outwards, and landed on his bottom. She also alleged that prior to getting on the lounge Thomas was on his knees. Ms Stevens said she then called out for assistance from Ms Gorman.

90 Ms Stevens said that the 'leg check' involved running her hands down each side of Thomas' legs to see if there was a deformity. She was mainly concerned with his knee "because we were bearing a lot of his weight". She described the body check as a first aid-taught process, to look for swelling or bruising, as she was concerned he could have injured a cartilage or a ligament. Dr Coolican's evidence was that likely signs of injury, such as bruising and significant swelling, would not be expected to be immediately visible. Ms Stevens claimed that his feet looked ok.

91 Ms Stevens stated that Thomas looked ok and she thought he was ok. She did not check on him again that shift as she did not hold any concerns for him. She didn't think to ask him if he felt any pain. She couldn't recall telling Ms Garcia that Thomas didn't flinch when she felt his legs, but said in oral evidence that he didn't in fact flinch.

92 Ms Stevens was aware that there was an on-call officer from Northcott available, but didn't think a call was needed. She denied that she was minimising what must have been a fall by referring to it as a (controlled) drop. She disagreed that there was sufficient concern to justify seeking medical attention. She disagreed with the suggestion that she thought it was possible that he was injured, but didn't seek attention as she didn't want to get in trouble for the incident. She said that if a person couldn't weight-bear she would now call an ambulance.

93 Ms Blacklaws told police that she rang Ms Stevens after Thomas had been taken to hospital to ask what happened and was told that Thomas had "behaviour' and dropped to the ground in protest, as he wanted to go to bed but hadn't had a shower. When Ms Stevens came in to prepare an incident report, she told Ms Blacklaws that Thomas had hold of the door frame and dropped and that Ms Stevens had hold of his hand to break the fall. She said she dragged Thomas to the lounge so he could get up, but he fell a second time from the lounge.

94 To the Northcott investigator on 15 March 2018, Ms Blacklaws repeated these matters. Staff member Margaret Crowley told the Northcott investigator that Thomas did not usually have any behaviours in response to changes in his routine.

95 To police in her second statement Ms Crowley described Ms Stevens as good with clients and she had never seen her yell at them or manhandle them. Jasleen Gill told investigators that sometime if there was a change to routine Thomas might push a little bit or scream but if you gave him time he would rarely refuse, and told police in a statement dated 14 February 2020 that to his knowledge Thomas had never dropped to the floor. Ms Blacklaws told police in a statement dated 8 March 2021 that if Thomas did not want to do something, he used to walk away or pull away but he had not been known to 'drop' or refuse to shower.

96 Thomas' Behaviour Support Plan (Vol 8, tab161.6) identified that Thomas was unlikely to respond to unfamiliar staff and will say "no" but only when agitated and he doesn't want to do something, and that when agitated he would vocalise and scream.

97 On the basis of all the evidence detailed above, and considering the expert medical evidence as to Thomas's femur fracture, I find that by the time Ms Stevens and Ms Gorman were bearing Mr Fulcher's weight and assisting him to his bedroom, Mr Fulcher had suffered the fracture to the leg. The fracture is likely to have occurred at the time Mr Fulcher is reported to have "dropped" to

the floor. The evidence suggests that occurred at approximately 6.10pm, being the time that Ms Gorman says Ms Stevens called her to assist her with Mr Fulcher, following Mr Fulcher eating his dinner at 5.30pm and independently walking out of the kitchen area. It is unlikely that the actions following the initial drop carried sufficient force or pressures to cause a fracture.

98 However, it is unclear when the fracture displaced. There are four periods when displacement may have occurred, namely:

- In the process of the drop itself; or
- As a consequence of Ms Stevens moving Mr Fulcher (in either a pushing or pulling motion) from the doorway to his room (where he was reported to have dropped) to the couch some 2 – 2.5 metres away; or
- In the process of Mr Fulcher sliding from the couch to the ground following being moved from the doorway; or
- At some other time not observed by staff members.
- The evidence does not support the displacement occurred following Mr Fulcher being placed in the bed or as a consequence of being placed on the floor to commence CPR.

99 I note the evidence of Dr Coolican was that the bone fragment/spike into the artery had to occur before bleeding and cardiac arrest; and that when Mr Fulcher was sat up the following morning for the purpose of a shower, there was a postural drop (excessive fall in blood pressure) resulting in a faint (syncope) and a cardiac arrest. The loss of blood at that time is indicative of the damage to the artery being caused some period before that time, and is consistent with it happening the night before.

100 However, given that both Ms Stevens and Ms Gorman at all times deny seeing any abnormality in Mr Fulcher's presentation consistent with a displaced spiral fracture, the timing for the displacement is uncertain. Neither observed abnormal limb position or swelling. Further, neither observed facial gestures or sounds from Mr Fulcher consistent with expressing pain, although it is noted that a finding cannot be made as to the level of pain experienced by Thomas from the fracture.

101 There was no evidence of callus to suggest old healing fractures, and accordingly, no basis for finding that Mr Fulcher was subject to an earlier, unexplained injury.

The events of 20 January 2018 – discussion of evidence

102 Ms Garcia told Ms Crowley at the staff handover at 7am on 20 January 2018 that Tommy did not want to get out of bed and have a shower. Ms Crowley thought it was unusual, but let him sleep in. Ms Crowley said in her statement that Ms Garcia also mentioned that Thomas had had a fall or drop; Ms Garcia says in her statement that she mentioned this to Ms Crowley when Ms Crowley rang around 8.45am to ask if she knew anything about Thomas' leg and she told her about the drop to the ground reported by Ms Stevens.

103 After breakfast, Ms Crowley went into Thomas' room and formed the view that Thomas didn't want to get up and appeared scared to put weight on his feet. Ms Crowley called in Ms Blacklaws to have a look. They noticed his knee was swollen and called 000. Ms Blacklaws' recollection is that when she arrived at 8am she was told that Ms Garcia had mentioned that the previous evening Thomas had had a fall or drop but that it was just a drop and he was alright. After cooking breakfast they began showering residents and she was called into Thomas' room by Ms Crowley and noticed that Thomas was hesitant to put his feet on the ground and had a swollen knee. They called 000. After that first call Ms Crowley went to get Thomas' medication and then called Ms Blacklaws back into Thomas' room as he had become unconscious and

unresponsive. CPR was commenced. Ms Blacklaws' incident report form recorded that Ms Crowley first went in to get Thomas up at about 8.45am.

104 The ambulance Incident Detail Report records show a log of a call at about 9.08am, but a narrative shows that the two calls (one to report he was ok and responsive, and the second call to indicate he was not breathing) are included as part of the same narrative. Ms Crowley's estimate of the time she first went back in and saw Thomas was 8.15am. Given Ms Blacklaws' recollection of the time that Thomas was first noticed to be unwell (around 8.45am) and the time of the call to the ambulance, Ms Cowley's recollection of the time is likely to be a mistaken, and I find on the evidence that the time of the visit to Thomas' room is more likely to have been closer to 8.45am.

Findings – what happened to Thomas

Findings not in dispute

105 The following findings are made on the evidence and were not subject of dispute:

106 At the time of Mr Fulcher's death, there were four residents in the group home. Up until November 2017 the group home was managed by FACS but transitioned to Northcott in November 2017. Staff were retained under their previous employment conditions for a two year transitional period.

107 Ms Gorman received an induction at the home in 2017 where she was shown various communications books, medication, financials and the like. She did not read the customer files or if she had, she did not recall them.

108 Ms Gorman and Ms Stevens were not regular workers at the group Home although both had worked there before but not often, and had not previously worked together.

109 Thomas was seen by various people to be walking appropriate to his usual capacity, on the days before and on the day of the injury.

110 He arrived back at the home around 3.30pm or 4pm on the day of the injury, having been at Sunnyfield. Ms Stevens brought him back and Ms Gorman made Thomas a cup of tea and he ate some food. Another male resident was not in a good mood and was screaming at times, subsequently joined in this by a female resident. Later at dinner time (which appears to have been an early dinner, around 5pm or so) Thomas ate some of his dinner while the same two other residents were yelling. Ms Gorman was in the kitchen when Ms Stevens said she would give Thomas a shower. Thomas walked ahead of Ms Stevens down the hallway towards his room. He was still walking normally and unassisted at this point.

111 After Thomas had dropped or fell to the floor Ms Stevens called for Ms Gorman to come and lend assistance. The two of them eventually assisted Thomas to get to the bathroom and subsequently he was sponged and assisted to his bed, where Ms Stevens performed a check of his legs.

112 Ms Gorman finished her shift early, at about 7pm. Ms Stevens was relieved at 9pm by Ms Garcia. Ms Stevens had by that time worked a 12.5 hour shift.

113 Ms Garcia arrived and spoke to Ms Stevens, after Ms Stevens had worked a 12.5 hour shift, which appears on the evidence to have been difficult around dinner time, with at least two of the residents yelling. It is also noted that the evidence at the inquest disclosed that Ms Stevens had been the only staff member present from the time that Ms Gorman departed to Ms Garcia's arrival.

114 Ms Garcia checked on Thomas the next morning at 6.30am, that he didn't want to get up, and that he was next checked on some time later, after staff thought he wanted to sleep in and left him alone. It appears from the evidence that this next check was most likely after 8.45am, and the ambulance records suggest contact with the ambulance operator around 9.08am.

115 A finding that Thomas appeared to go into cardiac arrest when he had been assisted to a seated position on the bed is consistent with Dr Coolican's oral

evidence to the effect that this would have put more pressure on the heart and its reduced capacity to pump blood given the internal blood loss by this point.

116 Staff noticed that there was something wrong by the swollen appearance of Thomas' leg and his apparent reluctance to put his feet on the floor. There is no evidence that Thomas vocalised what would likely have been his significant pain and possible distress at that point. However it is difficult to determine the extent to which this particular fracture caused Thomas to suffer pain, although it is a reasonable probability that it caused pain.

117 I agree with the submissions of Counsel Assisting that an unfortunate combination of circumstances came together on the night when Thomas suffered his grievous injury, which can be seen with the benefit of hindsight to have created a situation where the potential for sub-optimal and ultimately deficient care was increased. These factors included:

(i) No permanent staff members were present in the home at the time that Thomas suffered his injury, but rather two staff members with little familiarity with his routines and communication style including how he might express pain, and therefore may have missed cues that regular workers would have picked up;

(ii) The two staff members were not familiar with recent support plans developed for Thomas;

(iii) There was no supervisor on site that day who might also have been familiar both with Thomas and his need for a particular routine;

(iv) Thomas' regular routine (shower before dinner not after) was disturbed, possibly causing the difficulty described by Ms Stevens – that he grabbed the door frame of his bedroom when asked to go to the bathroom for a shower.

However, this may have been because (as suggested by family, in a family statement), Thomas wanted to go to the peace and quiet of his own room, given that other residents were making some disturbance;

(v) Northcott had apparently not yet been able to roll out all of its training/ policies to all of its staff which were transitioning from being FACS staff, including casuals and permanent part-time, having taken over this home and some others as at 1 November 2017;

(vi) the (Family and Community Services) training that Ms Stevens and Ms Gorman had received either did not appear to have emphasised the need to seek professional assessment where an injury was suspected as having possibly occurred, or if it did, such training was forgotten/overlooked;

(vii) Other residents were requiring attention at the time, which appears to have been a distraction for Ms Gorman at least;

(viii) Ms Stevens had worked a long shift and was apparently tired, and decided to herself inspect and assess whether Thomas might be injured or not, notwithstanding that she was not a trained medical professional, nurse or paramedic;

(ix) The injury was not visible to the untrained eye at the time it initially occurred (at least the fractured bone);

(x) An injury of that degree was not suspected by the care workers Ms Stevens and Ms Gorman, as likely to result

from a fall or drop from standing height; and the risk of exsanguination does not appear to have been expected;

(xi) A ‘drop’ was not regarded by either Ms Stevens or Ms Gorman as an accident or injury needing medical attention/inspection

(xii) What lessons that had been learned from training or instruction were not appropriately employed. In this case Ms Steven’s evidence of appropriate care practices that she would ordinarily use – namely using a chair to allow clients to get up from a fall; and allowing a resident time to settle when they were upset or refusing something – these were not followed on this day. Instead, Ms Stevens took Thomas’ hand off the door frame, whereupon he either dropped or fell;

(xiii) Thomas was put to bed, and the night shift staff member was not instructed that he may have been injured from a fall, nor advised to check on his wellbeing during the night. As Thomas was in bed for the night there was no opportunity to further assess him physically or his ability to weight-bear until the morning;

(xiv) Ms Stevens did not inform Ms Garcia on handover that Thomas may have been not weight-bearing when he was helped back to his bed nor that he had had a ‘leg check’ for possible injury;

(xv) Ms Gorman did not independently consider the need for medical assessment when Ms Stevens checked Thomas’ legs in bed;

(xvi) The workers did not know or suspect that Thomas may suffer from osteoporosis and that he might therefore be more vulnerable to injury; and did not have knowledge of his Falls Management Plan, and did not follow the plan.

118 All of these factors would appear to have come together to create the circumstance that an assumption was made, that Thomas was fine and the possibility that he was injured and required medical assessment was not considered.

119 I need to make very clear that these factors do not exclude the individuals, or service providers involved, from failures of care, however they are important to understand as the backdrop to what occurred.

120 Importantly these factors highlight the need for team work in group homes, and for staff to have knowledge of the needs/behaviours, routines, communication modes, of residents who are being cared for. The issues of communication and teamwork were a focus of inquiry during the inquest.

Findings – how Thomas was injured

121 The evidence indicates that Thomas took hold of his bedroom door frame, possibly because he was used to going to bed after dinner, possibly because he was not happy to co- operate with Ms Stevens at that point, or potentially because he wanted the peace and quiet of his room given the agitation and disturbance being caused by other residents at the time. The subsequent action of Ms Stevens trying to release Thomas' grip from the doorframe, and her subsequent release of his hand, may have caused him to lose balance and fall or drop to the ground, whether sliding down the door frame or not. The fact that she was redirecting him to the shower at a point when he was entering his bedroom could account for the twisting motion of his leg in the fall (that is, he was in the motion of turning when he fell). Ms Stevens' evidence that he began to wobble supports that conclusion.

122 There is no suggestion that Ms Stevens deliberately caused Thomas to fall, but rather her account of a slow, controlled drop (if it means some kind of gentle lowering to the ground) is inconsistent with the evidence and opinion of Dr Coolican, and does not satisfactorily account for Thomas suffering the fracture.

123 Why might Ms Stevens offer this account of a controlled drop? The simplest explanation is that she is mistaken or, as a result of the trauma and PTSD that she said she subsequently suffered, she has genuinely convinced herself that Thomas dropped or fell in a controlled manner. She was not prepared to concede that she was mistaken in her recollection.

124 I make the finding that the actions taken by care staff after Thomas's fall were inadequate. Firstly, Ms Stevens took it upon herself to make a rudimentary assessment of Thomas for injury, rather than to make a call for a medical assessment to occur after the fall. It appears she did not ask Thomas any questions. Ms Stevens made assumptions about his wellbeing, without the training necessary to be able to rely on those assumptions as accurate.

125 Yet Ms Stevens was squarely on notice that

(i) Thomas had either dropped or fallen to the floor,

(ii) had attempted to get up but could not,

(iii) had further difficultly getting up onto the lounge and possibly slipped again near the lounge, and

(iv) was not weight bearing when he was being moved to his bed, despite being able to walk only minutes earlier.

(v) On the evidence these indicators must have caused her to suspect an injury because she undertook the 'leg check'. I note her oral evidence that a cartilage or ligament injury was a possible issue.

126 Ms Gorman also failed to independently assess and report Mr Fulcher's fall and to seek medical review.

127 The care workers, Ms Stevens and Ms Gorman, failed to make adequate reports of the fall – Ms Stevens in particular had this obligation having witnessed the fall. This obligation included reporting the possibility of injury in the entry in the communication or shift book. Ms Gorman had seen Thomas on the floor requesting assistance with a raised hand, she had assisted to bear his weight and had observed the leg check, so she had an awareness of potential injury which she was also obligated to report.

128 Whilst the entry in the communication book refers to Thomas needing two staff to assist him, it does so in the context of stating that Thomas had refused to stand. It is notable for what it does not clearly set out, namely that Thomas was unable or unwilling to weight-bear, and was then checked in a rudimentary way for suspected possible injury. Had such information been passed on, including in writing and verbally at shift handover, it was possible that the assessment that was eventually conducted around 8:45am, may have occurred earlier;. Perhaps if this had been adequately reported to Ms Garcia when she arrived at 9pm on 19 January, it may have caused her to seek attention for Thomas overnight or at least more actively monitor his well-being.

129 The tragedy of Thomas' death is only amplified by these missed opportunities for medical assessment and treatment.

130 Disability care workers are not trained medical professionals or paramedics, and this should be factored in to all training and policies. As Northcott itself identified, there was a need to train workers (i) that they should not make assumptions; and (ii) that the appropriate steps in appropriate situations required third party consultation and advice, including, where relevant, medical assessment.

131 The importance of reporting all concerns, and seeking medical review, and ensuring full information exchange at shift handover, is highlighted by what occurred to Thomas. The need for team work and information exchange among staff in group homes is a paramount matter to be addressed in organisation of staffing, shift allocation and processes within each home. The issue of appropriate length of shifts, of staff rosters which avoid long hours of work, is also highlighted.

132 What emerged, at least from Ms Gorman's evidence, is that there is potential for ambiguity as to what is meant by a "fall". Ms Gorman said that a fall and a drop are almost the same, but also said that a scenario where the client refuses to do something, and then drops, is not a fall.

133 For the reasons detailed above I find that the careworkers, Ms Stevens and Ms Gorman failed to adequately care for Thomas by seeking medical review and assessment after the fall; and by reporting the circumstances of the fall to other workers in an adequate fashion. Further, they failed to comply with the Northcott 2017 Falls Management Procedure which was in place for Thomas.

134 The evidence of Northcott's two representatives (Ms Carpenter and Mr Chain), at the inquest, indicates that Northcott has treated Thomas' death with appropriate seriousness and responded in a way that aims to minimise the risk of such an event occurring again. It has also taken appropriate disciplinary measures against Ms Gorman and Ms Stevens

Northcott policies as at January 2018

135 The policies in January 2018 are contained in volume 4 between tabs 62-68 and in Volume 8 at tabs 167-170. At tab 62, the November 2017 on call and escalation contact numbers information sheet, identifies scenarios when an on call officer may be contacted, including incidents that have caused harm to a customer.

136 The manual handling policy (tab 63) set out Northcott's minimal lift approach and prohibited unassisted lifts of customers weighing more than 20kg. At

page 7 (brief p 1199) it sets out that in the event the customer falls or ends up on the ground and it has been identified that workers cannot safely assist, then emergency services should be contacted. The policy is silent as to whether the assistance of a second worker might obviate the need to call emergency services. The Northcott first aid policy at the time (tab 65) does not assist with the scenario of a drop or fall but rather is aimed at compliance and roles. The Northcott after hours guidelines (tab 66 p 1224) identifies that staff may use the line where there is a customer illness or injury and staff are unsure what to do.

137 The incident management policy from 2017 (tab 67) required that incident forms be completed within 24 hours and submitted to the supervisor, or 48 hours if access to a system called 'Riskman' was available to the staff member. Relevantly, an incident report form needed to be completed for customer behaviours of concern whether identified previously in a behaviour support plan or not (p 1234). Thomas' reported drop would appear to fall within this requirement, but the 24 hour reporting period applied. Incidents are defined at page 12 of the policy. It includes an event which could have led to injury and an incident may or may not result in injury.

138 Northcott's 2017 policy concerning allegations of abuse and neglect is set out behind tab 68. A flowchart for reporting is set out at p 1259. "Abuse" and "neglect" do not appear to be defined in the policy but indicators of possible abuse and neglect are set out at pps 1264-1265.

139 The most important document from 2017 for this inquest is perhaps the Northcott Falls Management Procedure (tab 167). *It defined a fall as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.* By contrast, the current policy exchanges the word 'accidentally' for "inadvertently".

140 The *2017 policy set out under the heading 'procedure details' for a fall including calling for an ambulance if serious injury is, relevantly, suspected, to perform an initial assessment (which appears to apply to any fall), including*

observing bruising, swelling, ask and observe the patient for new pain associated with the fall, ask the client to move each limb, check if there is shortening or rotation of each leg. These last two aspects were identified by Dr Coolican as indicators that might have revealed a fracture. The procure also recommends GP review with 48 hours (presumably in those matters where an ambulance is not required).

141 The 2017 policy also provides that if in doubt about whether the client can be safely coached from the ground (as set out in the appendices to the policy), the worker should not assist the client without a mechanical aid. If a mechanical aid is not available and the client cannot be safely assisted from the ground, emergency services can be contacted. The policy was silent about whether another staff member may assist and did not set out ways in which pain may be assessed where the resident is unable to articulate it or express it in the usual way.

142 As indicated above it is clear that the workers, Ms Gorman and Ms Stevens did not comply with the Falls Management Procedure. If the Falls Management Procedure had been followed strictly then the policy would indicate that Thomas be medically assessed following his fall. It is also the case that the processes in place at that time, did not ensure that casual workers, called upon at short notice, familiarised themselves with management plans and needs of residents when working at a Group Home where they were not familiar with the residents, or where they had not worked for a significant period of time.

Northcott submissions in relation to Issue 2 - the adequacy and appropriateness of the staff response to and subsequent management of Thomas'sreported 'drop'

143 Northcott concedes that the response of both Ms Gorman and Ms Stevens to the "drop" of Mr Fulcher was inadequate and inappropriate. Northcott submits that on this issue, the following factors came into play.

144 The policies inherited from FACS did not include one for fall management and that was a deficit. That deficit has since been addressed.

145 Northcott accepts that the use of two casuals who had limited exposure to the Hartington Street premises, in the absence of staff experienced in the support needs of the residents of Hartington Street, contributed to the circumstances of Mr Fulcher's injury. (It is stated that the present use of casuals or staff unfamiliar with a particular residence in Northcott homes, no longer reflects the practice that occurred on 19 January 2018).

146 Neither Ms Stevens nor Ms Gorman, on commencing either of their two shifts at Hartington Street, took steps to update themselves as to Mr Fulcher's file/read any part of his file. located at the house. (However I note that there is a responsibility on Northcott to make provision for updating of casual staff on the needs of residents, and the evidence at the inquest was that this has now been better provided for. In addition, house supervisors, and training have assisted in this regard).

147 Both Ms Stevens and Ms Gorman failed to comply with the falls management strategy for Mr Fulcher, being a document available to them; and did not act to escalate the situation to experienced workers, notwithstanding the presence of On Call posters being displayed in the house.

148 Northcott submits that Ms Stevens, based upon her evidence, prior to Mr Fulcher's death, did not take the steps of logging on to Northcott's induction training, its policies and its procedures, and connecting to her allocated email, between 3 November 2017 and 22 January 2018 when she was stood down and later terminated. It is submitted Ms Stevens did not contact Northcott HR when she discovered her required email link had expired. (However, as noted during the inquest, this was during the initial weeks of transition of the staff and homes to Northcott, and communication systems may not have smoothly transitioned, especially for casual workers).

149 Northcott submits that the response of Northcott in immediately suspending both Ms Stevens and Ms Gorman and conducting a formal investigation into Thomas's death was appropriate and undertaken in a comprehensive and diligent way. The recommendations following that investigation were implemented and it is submitted have resulted in real and continuing improvements to the operations of Hartington Street and all Northcott facilities

Evidence as to Current and new Northcott policies

150 The current policy is at tab 161.5 and also at 173. It includes a new section identifying that the impact of falls includes hip and thigh as the most common fall related injuries, and that falls are one of the leading causes of death for people in residential care. It stresses that it is vital to guide rather than lift a customer after a fall. It stresses that it is important that the customer does all the work in getting back up and provides a procedure similar to the superseded policy, involving the use of a chair. Perhaps oddly, the new policy no longer sets out, under procedures, the detail of the old policy concerning examination of limbs and possible rotation or shortening, although it does identify that a deformed limb or the customer being unable to move the limb is an indication of a severe fall or injury.

151 The new policy (and the related Falls Risk Assessment Form, tab 174) similarly does not offer guidance on assessing or enquiring about pain. It does however provide that indicators of a severe fall or injury include the customer not attempting to get up, and requires the calling of an ambulance immediately. In Thomas' case in the incident form he was described as 'kept trying to get up', so this new guideline would assist staff to identify that medical review would be required if presented with a similar fall as experienced by Thomas.

152 As for the assessment of Thomas the next morning at 7am, Northcott have introduced a document called 'Health and Wellbeing Procedures', (tab 176) which notes at page 6 the various symptoms of illness. Relevantly, for Thomas, they may have included a change in behaviours (not getting up or

wishing to), facial expressions (pulling the blanket up to his face), change of toilet pattern (no evidence of urination nocturnally), and change of sleep pattern. A scenario/example of how this worked in practice is produced at tab 183.

Has Northcott implemented changes to reduce risk?

153 Northcott has provided those assisting the Coroner with a series of materials that were generated as part of a staff awareness campaign in August 2018 by the witness, Mr Chain (see tab 185 page 11), which appears to have been promoted through the Northcott 'Noise' staff newsletter (see also Trevor Perry statement, tab 161). They include the 'no assumptions' flyers, which relevantly include (tab 179) a page setting out the decision-making tools to use to help decide if assistance needs to be sought for a customer. They also include guidance on when to seek assistance if there are changes with a customer's health and wellbeing, and include to call a line called HealthDirect before calling the Home Doctor service.

154 The evidence supports the conclusion that Northcott has implemented changes since Thomas's death and continues to review and reform their processes to achieve improvements.

155 Changes introduced by Northcott include: (i) introduction of the 'no assumptions' training programme involving the newsletter and staff meetings, (ii) roll-out of its own policies and procedures and training in those policies and procedures to existing and new staff, (iii) creation of an induction programme and handbook for new staff, (iv) implementation of supervisors at on-site locations during weekday business hours, (v) promotion of regular staff meetings where issues can be discussed and training lessons reinforced, including through scenario-based learning, (vi) developing a rostering process that tries to ensure that staff familiar with the clients are used as much as possible when there is an emergency vacancy, (vii) refinement of the Falls Management Procedure and creation of the Falls Risk Assessment Sheet, (viii) development of the DBAS instruction sheet, (ix) ongoing assessment of

individual client needs by a health professional such as a speech or occupational therapist, including development of individual client pain profiles and pain index sheets for staff to refer to, to help identify when a client may be in pain, (x) reinforced emphasis through the 'no assumptions' campaign on the need for staff to consider behavioural change, (xi) roll out of an incident management procedure which requires notification of behaviours of concern via the electronically filed incident reports, (xii) monitoring of those incident reports by a specialist team and (xiii) current ongoing rollout and refinement of the 'no assumptions' campaign.

Steps taken by Northcott since Thomas' death to improve its processes and training and possible recommendations

156 As indicated above, Northcott have implemented a number of changes since Thomas's injury and death. The inquest received evidence of a number of important changes introduced by Northcott in response to Thomas' death, and in streamlining and improvement of its processes more generally. It also received evidence of a critical incident investigation conducted by Northcott, which sought to identify how Thomas' death could have occurred.

157 The disability care sector employs workers whose principal job is to care for and support and clients in group homes but not (other than where qualified clinicians may be engaged as workers) to administer medical care and assistance beyond basic first aid. Whilst there is a risk that a conservative approach to suspected injury may lead to some unnecessary requests for medical assessment, including ambulance calls, the greater risk is that a client may suffer injury and pain that is not detected and treated appropriately.

158 That risk is amply and tragically illustrated by the trauma that Thomas Fulcher no doubt endured during the night of 19 January 2018 and early hours of 20 January.

159 The inquest identified that there is a risk where disability care workers are caring for vulnerable, non-verbal clients, that those workers may well lack appropriate skills to assess and determine if a client is in fact injured or not,

and may act on assumptions, and ignore what may seem to be indicators of concern. That this may be so has been recognised by Northcott in the conduct of its 'no assumptions' campaign.

Northcott's submissions on Issue 2(iii) - As at the date of the inquest, the adequacy and appropriateness of staff training and staff policies as to first aid, seeking medical assessment (including where a resident is non-verbal or has difficulty reporting pain), reporting to on-call managers and reporting suspected sub-standard handling of a resident

160 Northcott submits:

- In addressing this issue, it is useful to consider the environment at the time, and the environment now, to reconcile the significant changes in respect of Northcott's training of staff. The time of Mr Fulcher's death presented a unique and challenging experience for Northcott and the disability sector as a whole. There had been, and at that time was continuing to be, a significant transition from State government funded centres to the Commonwealth NDIS individual model of care.

- The transfer of Hartington Street to Northcott was but one element of that changing environment. The process of that change was challenging – Northcott had no access to the existing staff, which consisted of both agency workers and FACS employees, and no access to the premises, until the changeover date.

- Northcott was required to work with existing frameworks, policies and practices, that the staff had already been trained in by FACS. The evidence of Aleta Carpenter was that Northcott proceeded on the basis that all staff had been inducted and understood the policies and procedures of the houses, and then Northcott proceeded to refine inductions for staff to allow them to understand and meet the particular needs of the clients with whom they were working.

- Northcott commenced measured roll out of its policies and updating and meeting training needs of the staff. It was a process that took time

and was far from complete, 10 weeks into the transition. The fact that the existing staff, such as Ms Stevens, were not engaging in matters such as logging onto computers and completing induction training, speaks of the difficulties faced by Northcott in the early days of the transition.

- Following Mr Fulcher's death, there was a significant change in the governance of NDIS approved providers providing services to NDIS participants. In July 2018, the NDIS Quality and Safeguarding Framework was put in place by the National Disability Insurance Agency (NDIA) to protect the safety of National Disability Insurance Scheme (NDIS) participants and the quality of the services participants receive under the Scheme. Practice Standards and a Code of Conduct were introduced which applies to all providers including Northcott and their employees. Training is provided on those matters and it is a requirement of the NDIA and Northcott that all employees undertake that training. Further NDIA registration requires proposed providers to pass a Third Party Verification (TPV) process to qualify for NDIA registration. TPV is an essential part of the Quality Framework Reporting that ensures Providers meet quality safeguards.

- These matters, which all lead into risk mitigation and enhanced safety for both recipients and staff of NDIS providers, did not exist at the time of Mr Fulcher's fall. In that regard, whilst the NDIS remains part of the infrastructure of disability care and support, the period between 3 November 2017 and July 2018 was a moment in time unlikely to repeat itself.

- Northcott has provided detailed information to the Coroner that sets out how Northcott staff are trained to respond to a first aid incident in the workplace as at the present time. It is submitted that Northcott's timely roll out of the "No Assumptions" campaign, created and delivered in direct response to the death of Mr Fulcher, is an important risk minimisation initiative. The evidence is that campaign is ongoing

and is adapted to ensure that it remains responsive and current to both the needs of the residents and the operational level of the staff. In this regard, Northcott have also looked at their staff message delivery and have incorporated SMS for message delivery to take into account the level many staff operate at, in terms of technical savviness, and their engagement with computers and emails.

Northcott submissions - No Assumptions campaign

161 On 23 July 2018, the Communication & Stakeholder Engagement "No Assumptions" 2018 was prepared. On 30 July 2018, the No Assumptions campaign rolled out its Communication Action Plan, following which the following were delivered to Northcott staff via its intranet platform, then known as Nigel (see: V8: Tab 161: p. 9)

- August 2018 - Introduction
- September 2018 - Risk Factors followed by the Common health issues affecting people with disability
- October 2018 - Detecting early warning signs followed by Decision Tools
- November 2018 - Seeking timely medical Treatment followed by Culture Change

Mr Benjamin Chain, Clinical Practice Lead, Northcott, gave evidence at the inquest that the contemporary No Assumption campaign deals with falls management and references the need to seek urgent medical advice where there is an actual or suspected head injury or where the person is over 60 or where the person has an underlying condition such as osteoporosis

Northcott Submissions - Relevant policies

162 On 21 September 2021, Northcott's Falls Management Procedure was issued, followed by 21 December 2021, the Falls Risk Assessment Form and the Incident Management Policy and Procedure was re-issued.

163 Mr Chain gave evidence as to the various tools applied in Northcott residences and responded to questions from Counsel Assisting about the Stop and Watch Tool developed by the NSW Agency for Clinical Innovations and the Pain Index Chart, MFIA and DISAB. Of note, the DISAB tool was created by Northcott in collaboration with the NSW Ambulance Service. Mr Chain believed that tool, which is designed to identify when a paramedic needs to be called and provides assistance in ensuring all relevant information to assist with transfer of care is provided to the paramedic, and then to the hospital, has made its way into the Paramedic handbook.

164 Mr Chain also identified how the needs of the workforce are taken into account. He considered that the Health Watch Tables, which were included in the first version of the No Assumptions campaign, were too clinical for support workers, and that assessment resulted in its removal, and replacement with a more streamlined continuing campaign looking at trends and internal risks.

Northcott submissions -Training

165 The training of Northcott staff is monitored, and essential training, such as first aid, is electronically monitored to ensure that staff remain current in their first aid accreditation.

166 Upon taking over Harrington Rd from FACS, Northcott has improved staff consistency. It was noted by Ms Stevens that in the three months she worked with Northcott, she observed greater staffing levels. Ms Gorman spoke of consistency in her residential placements during the period she continued to work for Northcott.

167 Mr Chain gave evidence of the use of Video webinars, information held on Nula (the new Nigel, Northcott intranet), the texting of messages to staff by

SMS based on observations that support workers are most engaged with that platform and the creation of case studies and information packs that are explored at team meetings.

168 Ms Carpenter gave evidence of the role team meetings have in sharing information, updating staff and ensuring staff are across developments and policy changes.

Northcott submissions -Staff Consistency

169 Ms Aleta Carpenter gave evidence of the process now applied for staffing. There is a clear and known hierarchy. There are regular staff appointed to work in a specific residence. Where a regular staff shift cannot be filled, the process is to first look to additional hours and then overtime of workers in the house. Staff are informed as part of their induction that they may be required to do overtime in those circumstances. If the absence cannot be filled the usual way, then a worker from outside the residence will be sought. Where that occurs, the worker must have previously undertaken all the training requirements for that home, noting that some types of care require specific training. Upon commencing the shift, the replacement worker is provided with an induction into home by the service coordinator. If the service coordinator is unavailable, which only occurs on rare occasions and is an unplanned event, that induction is conducted by a staff member who knows house and can provide that information. It may result in that worker going into overtime to provide the induction.

170 The evidence of Aleta Carpenter was that the Rostering team is able to see the last time a person was rostered into a house. In circumstances where that person has been absent for a period, an induction will be arranged for their return shift.

171 Ms Carpenter gave evidence that the induction involves reintroducing the staff member to the residents, going through documented material, the admissions / discharge folder, key documents, documents on the system, an introduction

to office including the location of relevant posters and signs, a general review of home and its operations and the customers documents such as their profiles and plans, and that the profile information includes information around routines and specific times residents need to attend programs. Staff are also directed to consider the communication book which may set out a particular reason as to why a routine needs to be changed for the day.

172 Northcott submits that in this regard, the consideration identified at [73] of Counsel Assisting's submissions, namely the "Court may wish to consider whether some comment in the findings directed to Northcott could be made, about the desirability of emergency replacement staff familiarising themselves with the clients' Behaviour Support Plan and Physiotherapy Plan if starting a shift at a home after many months absence" is a matter already required for such staff.

Northcott submissions -Safeguarding

173 Mr Chain, when asked about the hotline for staff to report complaints where they cannot or are not comfortable reporting it to their supervisor, detailed the internal safeguarding team at Northcott that sits within the Quality and Risk Team. Mr Chain gave evidence that the function of that team is to review incident reports as they come in and to pick up on cases of alleged abuse and neglect. Those reports are submitted directly to the NDIS Quality and Safeguards Commission through its online portal. The Quality and Risk Team were said to be presently working on a campaign to raise greater awareness of alleged cases of abuse and neglect.

Recommendations proposed by Counsel Assisting and Northcott response

174 Counsel Assisting the Coroner in submissions suggested possible recommendations which could be made to Northcott. In written submissions Northcott has engaged with those recommendations and made changes as follows.

(i) Proposed recommendation (i) - That Northcott make a refinement to the current Falls Management Procedure (tab 173) and the Falls Risk Assessment Form (tab 174) to include reference to the possibility of osteoporosis in ageing clients as a risk factor/matter for assessment;

Northcott Response to proposed recommendation (i):

Page 2 of Tab 173, the "Northcott Falls Management Procedure" has been amended to include osteoporosis as an identified chronic medical condition in the column under the heading "Example of Internal Risk Factors". The entry will now read

"• Chronic medical conditions (eg Epilepsy, osteoporosis)".

The fifth question on page 1 of Tab 174 of the "Northcott Falls Risk Assessment Form" has been amended to include "osteoporosis" so the question will read:

"Underlying medical condition affecting balance, strength or cognition (e.g. epilepsy, osteoporosis**,** confusion or disorientation), underweight or low appetite."

(ii) Proposed recommendation (ii) - That Northcott re-cast or re-frame the definition of a fall in the current Falls Management Procedure to include a point of clarification (to the effect that a resident dropping from a standing height to the ground, even if deliberate, may inappropriate circumstances meet the definition of a fall)

Northcott Response to proposed recommendation (ii):

Page 1 of Tab 173, the "Northcott Falls Management Procedure" has been amended to add the following under the heading "What is a fall?":

"• A fall can be a drop. If a person, intentionally or unintentionally, drops to the ground (from a standing or sitting position), due to the possibility of injury, you should treat the drop as if it was a fall and respond in accordance with this policy."

(iii) Proposed recommendation (iii) -That Northcott consider clarification of the Falls Risk assessment Form at 'Step 4'

to make it clear that if the client is unable to get up unassisted, to consider the possibility that he or she may be injured, even if no visible injury is apparent, and to seek appropriate assistance.

Northcott Response to proposed recommendation (iii)

Page 4 of Tab 173, the "Northcott Falls Management Procedure" can be amended to add the following under Step 3:

"Step 3. Check for injuries. If you believe the customer may be badly injured (eg a fracture), or the customer is unable to get up without assistance, encourage the chair method by placing a chair in front of the customer to see if they can pull themselves up onto the chair. This can assist in determining if someone can hold their body weight post fall and any potential injuries that may not be visible…"

Further the following has been added under Step 3 in the Red Text Box:"• The person is unable to get up unassisted."

(iv) Proposed recommendation (iv) - That Northcott consider the inclusion in the Falls Management Procedure of a clarifying note to the effect that the dual purpose of self-mobilisation is to avoid injury to staff and to identify if there is a possible physical problem or injury with the client;

Northcott Response to proposed recommendation (iv):

Page 1 of Tab 173, the "Northcott Falls Management Procedure" has been amended to add as the (new) 2nd dot point, the following under the heading "What is the Purpose?":

"• This procedure aims to prevent staff hurting themselves when assisting customers who have had a fall and also to assist staff in identifying whether the customer who has had the fall may have an injury."

(v) Proposed recommendation (v) - that Northcott consider whether staff training on falls management needs to spell out that even where 2 or more staff members are available to lift the client, that is not an appropriate,

method of assistance and the correct procedure should be followed in all cases.

Northcott Response to proposed recommendation (v):

> Page 3 of Tab 173, the "Northcott Falls Management Procedure" under the heading "Standard falls response strategies", can be amended as follows:
>
> "It is vital for you (either alone or with the assistance of another staff member) ~~and the customer~~ that you do not simply 'lift' the customer if they have fallen. Lifting instead of guiding a customer after a fall can cause an injury to you or cause further damage to the customer if they are injured.
> In the first instance, staff should always refer and follow directions set out in the customer's individualised plan or their individual Falls Prevention Strategy.
> Not every customer will have their own Falls Prevention Strategy. However, it is important to note that anyone can be subject to a fall.
> After assessing the customer for injury, where it is determined the customer is not injured, but where the customer is not able to get totheir feet due to pre-existing mobility issues, use special equipment
> such as hoist, to assist the customer back to their feet or onto amobility chair.
> If you are supporting a customer who has a fallen, but they do not have a Falls Prevention Strategy, you should follow these steps below to prevent further injury to the person and yourself. This should be followed including where there is more than one staff member present and assisting the customer following the fall: **Step 1.** …"

Findings on proposed recommendations

175 Noting that Northcott has already amended their policies and publications, in accordance with the recommendations proposed by Counsel Assisting, then I am of the view that no further formal recommendations are required. I am also of the view that Issue 2 of the inquest has been addressed by Northcott through the changes it has implemented, and these changes significantly reduce the risk of a similar occurrence occurring in the future.

176 I also observe that the landscape for disability care providers and workers has evolved since Mr Fulcher's death, with the Code and Standards implemented under the NDIS. This provides further accountability for services provided to those who have disabilities, and for the quality of services. Following Mr Fulcher's death, there was a significant change in the governance of NDIS approved providers providing services to NDIS participants. In July 2018, the

NDIS Quality and Safeguarding Framework was put in place by the National Disability Insurance Agency (NDIA) to protect the safety of National Disability Insurance Scheme (NDIS) participants, and the quality of the services participants receive under the Scheme. Practice Standards and a Code of Conduct were introduced which applies to all providers including Northcott and their employees. Training is provided on those matters and it is a requirement of the NDIA, and Northcott, that all employees undertake that training. Further, NDIA registration requires proposed providers to pass a Third Party Verification (TPV) process to qualify for NDIA registration. TPV is an essential part of the Quality Framework Reporting that ensures Providers meet quality safeguards.

Formal findings

177 I make the following formal findings pursuant to s81 of the Act.

Place and time of death

178 Thomas died on 21 January 2018 at Mt Druitt Hospital at about 7.50am.

Cause of death

179 I find the cause of death, having regard to the medical evidence set out above, is hypovolaemic shock due to the consequences of his fractured femur.

180 The evidence at the inquest, including the evidence of Dr Coolican, in combination with the findings of the pathologist, supports a finding that the injury to the femur was a consequence of a fall or drop to the floor at the Hartington St residence in Rooty Hill on 19 January 2018.

Manner Of Death

181 I find for reasons detailed above, that there was no deliberate act of harm by any third party to Mr Fulcher to cause the injury which led to his death. Nor was there deliberate neglect of his injury. Rather there were assumptions

made that he had dropped as a behaviour, and that this would not cause serious injuries. I have made the findings, as set out above, about the inadequacies of actions of the careworkers. Whilst there were inadequacies, I am not satisfied on the evidence that these amount to a level that they could support a finding of death by neglect.

182 Therefore for all the reasons set out above I find the manner of death is misadventure.

183 I note the family's concerns that Thomas not be seen as a cause of, or contributor to, the circumstances leading to his death – the inquest did consider aspects particular to Thomas, including him being non-verbal and/or the role of any reported behaviours. It was important, for proper examination of the manner of his death, that Thomas's ability to communicate his needs be considered. However, there is no suggestion that this contributed to the manner of his death – an awareness of the communication modes used by residents, and their care needs and responses, is essential for those providing care to residents of group homes, and the inquest has for this reason focused on how such awareness, and consideration of individual resident's needs, can be better met through policies, as well as through the training of care providers.

In Closing

184 I acknowledge and express my gratitude to Counsel Assisting, Mr Peter Aitken, and the instructing solicitor from Crown Solicitors Office, Ms Avani Khandar, for their assistance both before and during the inquest. I also thank the investigating Police Officers, and in particular the Officer in Charge, Detective Senior Constable James Cassar, for his work in the Police investigation and compiling the evidence for the inquest.

185 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Mr Fulcher's family.

186 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales