CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kelvin Forrest
Hearing dates:	1 November 2021- 5 November 2021 Ballina Local Court
Date of findings:	11 March 2022
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Accidental fall from height; wandering in a patient with behavioural and psychological symptoms of dementia; "social admission" to hospital; Provision of disability services through NDIS; Discharge planning
File Number:	2018/23305

Representation:	Counsel assisting: Ms R Mathur instructed by Ms L Burgoyne of Crown Solicitor's Office Northern Area Local Health District and NSW Ministry of Health: Mr P Rooney instructed by Makinson d'Apice Lawyers National Disability Insurance Agency: Mr N Swan instructed by HWL Ebsworth United Disability Care (formerly AccNet21): Mr C Eberhardt instructed by Behlau, Murakami, Grant RNs Brooke, Dunsmore, Johnson, Newlands, Smith and York: NSW Nurses and Midwives' Association
Non publication orders	Pursuant to s74 of the *Coroners Act 2009* (NSW) there is to be no publication of the name of a young co-patient at Byron Central Hospital who had significant behavioural and cognitive issues.

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Introduction

1. This inquest concerns the tragic death of Kelvin Forrest. Kelvin was a patient at Byron Central Hospital at the time of his death. In the early hours of 28 July 2018 a staff member found him lying on the concrete of a ground level hospital loading dock. His position was directly below a small veranda situated at the end of the inpatient unit where he had been admitted. Kelvin appeared to be in shock and was hypothermic and hypoxic. He was immediately taken to the Emergency Department for treatment.

2. Tragically Kelvin went into cardiac arrest and despite attempts at resuscitation, he died shortly afterwards. Later it was confirmed that he had multiple injuries including fractures to his pelvis and lower vertebral column. He also had extensive pelvic and retro-peritoneal haemorrhages which were consistent with having been caused by a fall from the first floor of the building.

3. Kelvin was only 53 years of age. At the time of his death he had been accommodated at the Hospital for 11 days.

4. Kelvin's brother, John Forrest graciously told the court about his younger brother Kelvin. He painted a picture of a remarkable man born into a remarkable family. He explained that Kelvin's life may have begun in an era where harsh attitudes existed in relation to children born with Down Syndrome but that their mother's absolute refusal to accept the beliefs of the day meant that Kelvin was able to transcend those negative and limiting expectations. When Kelvin's mother was told to place baby Kelvin in an institution and "get on with her life", she resolved to ensure that her son had the greatest life he could. In that she succeeded.

5. John Forrest told the court that Kelvin initially attended the local infants school and later attended a special school where he learnt "the reading, writing and cash handling abilities that he would need to become a functioning and contributing member of society." His family's quest to encourage his independence was rewarded and Kelvin went on to live in his own unit at Byron Bay. He worked with Liberation Larder, Meals on Wheels and at the Salvation Army store. He always wanted to contribute and enjoyed being part of a team. He loved movies, dancing and dining out. He got involved in all kinds of activities such as ten pin bowling, horse riding, surfing, swimming and going to the gym. He travelled with his family and was enveloped in their love, never missing a family function. He was also loved and respected in his local community and by those he touched with his friendly and outgoing nature. The court had the opportunity to view photographs of his extraordinary and often joyful life. I thank Kelvin's family for their generosity in sharing these memories.

6. I was greatly moved by the family statement and acknowledge that families such as Kelvin's have helped change the way we think about inclusion in the community. I have enormous respect for their ability to support Kelvin and provide him with the tools he needed for independence. It is clear to me that Kelvin was greatly loved by many and that the circumstances of his death have caused enormous grief and sadness to his family and friends. I offer my heartfelt condolences.

The role of the coroner and the scope of the inquest

7. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may also make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

8. In this case Kelvin's family were keen to shine a light on the barriers they experienced during Kelvin's last months in the hope that their experience could be a catalyst for change. Kelvin's hospitalisation was inextricably linked to their quest to access greater support for Kelvin as his cognition and functional ability declined. There is little doubt that Kelvin's death was a wholly preventable tragedy. Kelvin's behaviour, from the time of admission, at Byron Central Hospital indicated a need for closer supervision than he received.

The evidence

9. The court took oral evidence over five hearing days. The court also received extensive documentary material in nine volumes. This material included witness statements, medical records and expert reports. The court heard oral evidence from Kelvin's brother, John Forrest, NSW Police officers involved in the investigation, staff involved in his care at the hospital, and staff involved in the provision of disability services. The court also heard from two independent experts, Dr Jennifer Torr, a psychiatrist with a particular interest in treating patients who experience intellectual disability and Professor Julian Trollor, a neuropsychiatrist with specialist expertise in the field intellectual disability and mental health.

10. It is important to state at the outset that the scope of these findings does not extend to a wide-ranging assessment of the functioning of the National Disability Insurance Scheme. Similarly, while Professor Trollor provided broad information about the need to reframe

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).

many aspects of medical care for people with intellectual disability, some of that information goes beyond the proper scope of this inquest. Nevertheless I commend the expert reports to senior executives of both the NDIA and the NNSWLHD.

11. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

12. A list of issues was prepared before the proceedings commenced. It is as follows:

    i. The manner and cause of Kelvin Forrest's death on 28 July 2018.

    ii. the circumstances surrounding how the deceased came to be in the loading dock;

    iii. the knowledge of staff in relation to the deceased's propensity to wander external to the ward;

    iv. the care, treatment and hospital's policies and procedures for dealing with wandering patients and the allocation of 1:1 nursing;

    v. the adequacy of the handover between the nurses so far as Kelvin's wandering was concerned

    vi. the management of a hospital ward when consideration is given to the individual needs of each patient and any internal conflict arising amongst individual patient needs/management

    vii. Whether the events of 27 and 28 July 2018 reveal inadequacies or deficiencies in NSW Health policies in relation to the management of a medical patient labouring under an intellectual disability and/or dementia

    viii. Whether Kelvin Forrest's death was preventable, having regard to the adequacy or otherwise of the National Disability Insurance Agency's (NDIA) response to the application for a review of the NDIS funding for Kelvin Forrest, in particular whether any delay on the part of the NDIA contributed to Mr Forrest's admission or unnecessarily extended his admission as a social patient at Byron Central Hospital.

13. These issues directed the focus of the evidence presented in court. In short, the inquest centred on understanding the safety systems in place at the time of Kelvin's death and assessing whether his safety was adequately managed. It also considered whether there are ways of preventing future tragedies of this sort. This included understanding why Kelvin's stay at Byron Central Hospital extended for over ten days.

Fact finding and chronology

14. In her submissions, counsel assisting provided a very detailed review of the evidence before this court. I rely on that document to set out the chronology of events and to outline some

of the expert evidence received. I accept counsel assisting's summary of the evidence as accurate and reproduce much of it below.

Background to the events leading to Kelvin's hospitalisation

15. Kelvin had been raised to lead an independent life and was supported in this by his family and community. He lived with his parents until his early twenties and enjoyed a busy life. Later he moved into an assisted living residence and lived in community housing homes, always maintaining close contact with his family. His mother in particular would call him multiple times a day and he would visit the family home and go on outings with relatives.

16. In October 2017 Kelvin's aging parents moved into care. The transition was difficult as a delay in getting a landline installed meant Kelvin and his mother were for the first time restricted in their ability to talk frequently. Her death in January 2018 was a terrible blow for Kelvin. I accept John Forrest's evidence that the effect on Kelvin was substantial and that it seemed to "rock his very existence". Kelvin's father was suffering the effects of dementia by this time and it fell to other family members, in particular to John Forrest, to provide the family support Kelvin needed.

17. Members of Kelvin's family noticed that after his mother's death, Kelvin commenced to wander more frequently. By March 2018, John Forrest was developing serious concerns about Kelvin's capacity to live by himself. The family received reports that he had been seen wandering at night, seemingly unaware of the traffic or the potential for danger.

18. On 6 June 2018, Kelvin's general practitioner (GP) considered that it was likely that Kelvin was developing dementia.

19. During June and July there were a number of incidents which demonstrated Kelvin's growing confusion. On one occasion he refused to leave a clothing store, mistakenly believing a staff member was his carer. Police and ambulance were called. On other occasions he became confused in situations where he had previously been comfortable. He attended the local club requesting a meal, without money and when he had already eaten. He was seen in the town in a dazed state. A family member noticed him at the beach park seemingly unaware that his carer would be arriving at his home. It became clear that his cognitive function was deteriorating and his family and members of the community became increasingly concerned for his welfare.

20. On 9 July 2018 he was examined by a geriatrician, Dr Mohammed Khateeb. Dr Khateeb confirmed that aside from his background of intellectual disability and Down Syndrome, Kelvin had severe cognitive impairment with features of behavioural and psychological symptoms of dementia as well as possible agitational depression (OCD). He recommended that Kelvin's level of care be increased and that it may need to involve 24

hour supervision if there were “night time behaviours and safety concerns”.[3]

21. Kelvin’s family had been extremely concerned about Kelvin for some time. John Forrest remained in close contact with Kelvin’s carers and worked very hard to increase his support.

Kelvin’s admission to Byron Bay Hospital

22. On 17 July 2017, Kelvin was brought by ambulance to the Emergency Department of Byron Central Hospital. One of his carers had found him on the floor of his home, in pain and cold. It is not known how long he was on the floor. He presented as hypothermic with abdominal tenderness.

23. Hospital records disclose a medical impression that Kelvin had experienced a deterioration in self-care with “likely increased needs”. Abdominal distention from bowel gas was noted. Kelvin was admitted to the hospital for a planned full “Allied health review” to be conducted for an appropriate level of care to be arranged prior to discharge.

24. Kelvin’s carer reported to medical staff that his memory and communication had declined, that she had found faeces and urine around the house, and that Kelvin had been seeking and begging for food in the community, seemingly unable to regulate his oral intake. She reported that Kelvin had not previously been incontinent and it appeared that he now needed more assistance with every day activities and care at night.

25. Kelvin was transferred from Emergency to the Inpatient Unit later that evening.

26. The Inpatient Unit at Byron Central Hospital has a total of 43 beds, but not all are available for use. The court heard that the Inpatient Unit has a working maximum capacity of 26 beds. Kelvin was admitted to bed 4 in the unit.

27. An Adult Nursing Care Plan created on 19 July 2018 identified that Kelvin was confused and wandering, incontinent and needing assistance with activities of daily living. The plan, (which was reviewed but not significantly altered later during the admission) was to conduct observations on Kelvin every eight hours or three times a day, toilet him every two hours, and to monitor and supervise him as an additional fall prevention strategy.[4]

What was known about Kelvin’s propensity to wander?

28. It is clear that from the moment of his admission, medical staff were advised by Kelvin’s carer and family about their concerns in relation to Kelvin’s ability to remain unsupervised

[3] Exhibit 1, Tab 32
[4] Exhibit 1, Tab 37

at home during the night. A social work note from the afternoon of 18 July 2018 indicates that there was an awareness that “he wanders and gets into difficulty when not adequately cared for.”

29. Clinical records indicate numerous references to wandering behaviour after his admission, including the following

- On 18 July 2018 at 0511, it is noted that Kelvin was up and wandering the corridor.
- On 18 July 2018 at 2042, it is noted that Kelvin was wandering off the ward and wanting to go home, with security having to redirect him back from out near the café.
- On 19 July 2018 at 0633, it was noted that Kelvin had woken at approximately 0100 hours and was wondering the corridor. It was not immediately possible to gently guide him back to bed and the Health Services Assistant (HSA) was called and managed to assist him back to bed.
- On 19 July 2018 at 1030 the Adult Nursing Care Plan records Kelvin was confused and wandering as well as requiring monitoring as an additional fall prevention strategy.
- On 19 July 2018 at 1344 it was noted that Kelvin was wandering that day and required supervision as he was at risk of leaving the ward.
- On 19 July 2018 Kelvin was found by Assistant in Nursing (AIN) Mortlock in another patient’s room. (This was not included in the clinical notes but is a matter raised in his statement and in oral evidence). AIN Morlock says that he found Kelvin in room 18 after hearing the female patient calling out. He found Kelvin wearing a gown over a T-shirt with disposable pants around his knees. He was pulling on the woman’s leg trying to remove her from her bed. An unnamed nurse arrived and AIN Mortlock states that he asked this person to call security to assist him in redirecting Kelvin out of the room. It appears that Kelvin may have been looking for the toilet. Kelvin was helped back to his bed.
- On 25 July 2018 at 2019, Kelvin was seen wandering, needing one-to-one care and reassurance. Kelvin was found attempting to go through the doors to another patient’s room and was gently redirected.
- On 26 July 2018 at 0434 hours it was noted that Kelvin was awake and wandering the ward twice during the night needing to be redirected back to his room.
- On 26 July 2018 at 1202 hrs, it is recorded that Kelvin was found on the road outside the hospital and needed to be brought back by security staff. This was a very significant incident and should have been given considerable attention in any risk management. A medical review, at the very least, was required.

- On 26 July 2018 at 1527, it was noted that Kelvin was again wandering and needed one-on-one care and a special nurse was put in place.
- On 26 July 2018 at 2056, it was noted that Kelvin is prone to wander but is easily re-directed to his room. The nurse noted in the clinical records that Kelvin was being "specialled" due to his absconding earlier in the day.
- On 27 July 2018 at 1949, it was noted that Kelvin required constant supervision, however the reason for this is not stated in the clinical records.
- On 27 July 2018 at an unknown time but presumably later than 2030 hrs. It is noted that Kelvin had left his room and walked towards the front of the ward and was redirected by RN Johnson back to his room.

30. Other clinical records note Kelvin's dementia, confusion and his need for supervision. HSA Robert Belcher specifically recalled seeing Kevin standing at the balcony door saying "I want to go home" in the days before his death. He reported that it took 20 minutes for Kelvin's carer to get him away from the door.

31. Given that Kelvin could usually be redirected, in my view it is most likely that staff may not have recorded *all* the instances of wandering. Nevertheless, the notes disclose a clear pattern of wandering, including at least one incident where the behaviour caused considerable risk to Kelvin. I do not accept that his propensity to wander ever ceased. There may have been times where he was more settled or asleep, but in my view the risk remained for the entire admission.

32. I accept the expert opinion that Kelvin's wandering may have been a form of "home seeking" behaviour commonly seen in people with dementia. He may also have been experiencing acute delirium.

How did the Hospital manage Kelvin's wandering?

33. It was crucial for the court to carefully examine how the hospital managed Kelvin's propensity to wander.

34. In my view there was a failure to properly understand the nature and causes of Kelvin's wandering. This led to inadequate management of the risks involved in his care. A number of factors contributed to this situation, including

35. **"A Social Admission"** – A number of medical and allied staff appeared to regard Kelvin as a "social admission", that is a patient without acute medical needs who was present in the hospital while a discharge plan was facilitated or suitable accommodation found. RN Smith gave evidence that she understood Kelvin to be a "social admission". When asked what that meant, she replied, "[t]here's no acute medical need and that usually it's around

discharge planning or finding suitable accommodation. It's around that journey when they leave the hospital."[5]Others characterised Kelvin's admission in a similar way. In my view this demonstrated a failure to even properly consider his wandering either as a behavioural symptom of dementia that required ongoing management or as a possible symptom of delirium.

36. Professor Trollor gave compelling evidence about home seeking behaviour and delirium. He explained that a person who comes to hospital with worsening cognitive impairment will struggle to settle into a new environment and will look for an escape to find comfort and familiarity. He stated, "It's one of the triggers for someone seeking an exit from wherever they are. The person coming into hospital with cognitive impairment that may have worsened will struggle to accommodate the environment that is unfamiliar to them and naturally be wondering where they are and how do they get back to a place of comfort and familiarity. So it is a well-known trigger for seeking one's own home, so to seek an exit."[6]

37. Professor Trollor described the term "social admission" as "unfortunate and misguided"[7] He explained that it can be barrier to care and is frequently a contributor to extended stay. I accept his view that the term is the "unfortunate legacy of the compartmentalisation of health and other social care."

38. In my view the characterisation of this admission as "a social admission" meant that medical staff lacked sufficient curiosity in relation to Kelvin's ongoing behaviour and the risk it posed in a non-secure unit. This resulted in an inadequate understanding of his condition and sub-optimal management of his personal risk.

39. I accept the submission put to me by the legal representative of the nurses involved in Kelvin's care that it was not the role of nursing staff to "assess the genesis" of Kelvin's wandering and that this kind of inquiry or assessment would normally fall within the domain of a medical practitioner. The evidence does suggest that Kelvin was cleared early in his admission and was not comprehensively reviewed by a doctor during the following period. However, there were missed opportunities for escalation or medical review, particularly after Kelvin's wandering took him outside and onto the road.

40. **Difficulties in managing competing needs of patients in the Unit** – There was no systematic analysis of the competing needs of patients within the unit. A number of witnesses gave evidence that there was another patient on the ward who had been diagnosed with autism and who had significant behavioural and cognitive issues. The court heard that he was a young man who had difficulty regulating his behaviour and appeared

[5] 2/11/2021 T34.43-45
[6] 4/11/2021 T62.49 – T63.4
[7] 4/11/2021 T54. 24

to have a particular focus on checking and unlocking doors. For this reason the door to veranda was frequently kept unlocked. The court heard that this young man's behaviour could become violent and agitated if he found the veranda door locked. Unfortunately, the clear risk to a patient such as Kelvin was not factored into the decision to leave the door unlocked, especially at night. Further it is unclear precisely who made this decision and whether they had the authority to do so. While I acknowledge the difficulty in housing various patients in a single medical unit, the apparent informality of the decision-making processes around the door lock indicate the issue was not given sufficient or explicit consideration.

41. **Limited use of a "special"**- Kelvin was predominantly managed within the usual staff provided to the inpatient ward. On one occasion he was "specialled". The special was implemented on the afternoon of 26 July 2018, after Kelvin was found to be on the roadway outside the hospital. The special was not continued for the evening of 27 July 2018 seemingly because he was not wandering and had been "settled" during the day. However, Kelvin was found to be wandering again on the evening of 28 July 2018 and the special was not reinstated.

42. The evidence of Keryn York, executive director of nursing was that it is expected that a special would last 24 hours, but an assessment would be made each shift about whether it was required. The continuation of a special was also dependent on ward acuity and staffing. RN Brooke said she would rarely, if ever, deny a request for a special. RN Newlands noted that the decision to implement a special can be affected by the existence of other available staffing resources such as an assistant in nursing, an HSA, registered nurse or external security.

43. The NNSWLHD in submissions, accepted that there were sufficient staff for a special to have been provided for Kelvin had it been deemed necessary. The NNSWLHD also accepted that the relevant policy[8] in place at the time states that a request for a special only needs to meet one of six criteria, with 'wandering behaviour due to acute delirium or dementia' being one of them. Kelvin's behaviour clearly met this criterion.

44. I note that Dr Torr told the court that in all likelihood Kelvin should have been specialled for the entire period of his admission. In evidence, Dr Torr said that she was impressed by the efforts of staff and carers to keep Kelvin engaged and to prevent him from wandering, but in order to *actually* prevent him wandering off the ward, "he probably should have been specialled the whole time."[9] I accept her opinion on this issue. In my view and I accept that I have the benefit of hindsight, the provision of a special could have saved Kelvin's life.

[8] Northern NSW LHD Clinical Policy NC_NNSW-PRO-7623-15 Individual Patient Special Policy.
[9] 4/11/2021 T71.20-34

45. **Handover between shifts** – The court was concerned that Kelvin's wandering and the associated risks may not have been adequately communicated between shifts so as to build up a more complete picture of his mental state. A good example of this is that even after the incident where he had been found on the roadway and briefly "specialled", Kelvin was described as "settled" on the evening of 27 July 2018. This appears to have been based on a brief period where he had fallen asleep and did not adequately consider the pattern of his night waking.

46. I accept the evidence of Professor Trollor[10] that it is possible that Kelvin was experiencing a subacute delirium on a background of his Down Syndrome and dementia. He gave compelling evidence that it is often the case that for a person with a disability, the underlying health issues are masked or obscured by the presence of the obvious disability. Delirium can result in a fluctuation of symptoms and there may be periods where a patient appears more settled and a period where the confusion is more obvious. It does not appear that this possibility was brought to the attention of a doctor

47. In these circumstances a single brief period where he appeared "more settled" should not have immediately indicated a special was no longer required, especially when he had frequently woken at night and moved about the ward over the last week.

Hospital Discharge Planning and liaison with NDIS

48. The medical records disclose that Kelvin was kept at the Hospital because there were ongoing concerns about his living arrangements and his capacity to care for himself without increased supervision. The court was keen to understand the role Hospital staff could have played in ensuring that a timely and appropriate discharge plan was devised.

49. The court heard from Chloe Dunsmore, a registered nurse who was working at the time of Kelvin's admission as the discharge planner. Her position was a part time role. She explained that her job was to "work in collaboration with the multidisciplinary team to coordinate and facilitate the discharge process."[11] She explained that the multidisciplinary team involved working with "the patient, their family, carers, occupational therapies, social work, physiotherapy, the GPs and the admitting doctors". Given that it became clear that it was apparently critical that Kelvin obtain an occupational therapy report, her assistance was likely to have been potentially very useful to the family.

50. Chloe Dunsmore told the court that Kelvin had been reviewed by "our Allied Health team" on the first day of admission. Her primary involvement appears to have been in assisting in arranging a family meeting with John Forrest, but she was never aware of the need to

[10] 4/11/21 T.61
[11] 2/11/2021 T 8427

escalate any issue. Surprisingly Chloe Dunsmore told the court that she was not aware that NNSWLHD employed someone in the role of Health Disability Inclusion Manager (HDIM). She was also not aware that at the time of Kelvin's admission, the position was known as NDIS Transition Manager. Paul Todoroski, who occupied the position - then and now - attended the Hospital several times in 2018 to attend patient-specific meetings with nursing management and to conduct training sessions. The purpose of the role was, in part, to "discuss the management of, and possible discharge options for, particular patients with complex care needs, who were a participant in the NDIS."[12] It is clear that an important resource was not properly harnessed in Kelvin's case.

51. Ms Dunsmore was not the only staff member who, even now, had no knowledge of the existence of the HDIM. It is noted that during the course of the inquest, an all-staff memorandum was circulated by the CEO of the NNSWLHD alerting staff to the position and the services provided.

How did Kelvin come to be in the loading dock?

52. Kelvin's tragic fall was unwitnessed and not recorded by any of the CCTV that was operating in the hospital.

53. Following extensive inquiries and investigation, Detective Senior Constable Sheehan, the officer in charge of the investigation, told the court, that in his opinion it appeared that Kelvin had left his room within the inpatient unit, sometime between 1 AM and 5:15 AM on 28 July 2018[13]. Having left his room Kelvin turned right into the hallway and made his way to the glass door at the rear of the ward which leads to a veranda directly above the loading dock where he was discovered on the morning of 28 July 2018.

54. Detective Senior Constable Sheehan explained that by taking this path Kelvin remained undetected by any of the CCTV cameras located on that level of the hospital. It appears most likely that Kelvin was able to exit an unlocked door onto the veranda and then climb directly onto the railing. He appears to have stood on top of railing.

55. Examination of the roof area directly below the veranda showed sliding finger marks on the northern roof edge in direct line with where Kelvin was found below. DNA analysis of blood spots located on the aluminium railing confirmed as the blood was Kelvin's.

56. While the veranda is designed with safety slats, Detective Senior Constable Sheehan concluded that Kelvin was able to squeeze his body between two of the aluminium slats that run the full length of the open space between the floor and the ceiling of the first floor.

[12] Exhibit 7
[13] I accept the submission that further investigation makes it likely to have occurred between 3-5.15 am

He was then able to climb down onto the flat roof of the loading dock area. While these slats are narrow, it is noted that Kelvin was of small stature and records suggest he weighed only about 60kg.

57. The court heard evidence that indicated that the door to veranda was most likely to have been unlocked that evening. In particular AIN Craig Mortlock gave evidence that on the evening of 27 July 2018 and into the morning of 28 July 2018, he was supervising another patient in the unit on a one-on-one basis. Twice during that period, he went to the door with his patient and confirmed that the door was unlocked. He also told the court he heard the balcony door open on another occasion during the night and that left him feeling scared and frightened. He said that he did not see Kelvin wandering around the Impatient Unit at any time that night. He accepted that he had experienced microsleeps during his shifts before, but never anything more than a microsleep.[14]

58. HSA Robert Belcher gave evidence that the balcony door was left unlocked overnight to accommodate the needs of the young autistic patient who became upset if he found the door to be locked."[15]

59. I accept it is most likely Kelvin left the unit through an unlocked door and climbed onto the roof. From this point it is hard to know exactly what happened. Kelvin may have been confused and disoriented and not realised that he was high off the ground. He may have tripped or fallen accidently in the dark. It is likely that he was "home seeking" and had little idea of the dangerous position he was in.

60. I was informed that the balcony door is now kept locked.

61. For the record I accept, without reservation, Dr Torr's view that Kelvin's death was an accident and that he did not have the capacity to ideate, plan and carry out a suicide attempt. I accept Dr Torr's view that there is no compelling evidence that Kelvin was in such a state of despair that he would wish to end his own life[16]. There is absolutely no evidence of prior self-harm or self destructive behaviour. Kelvin's death was a tragic and preventable accident.

What was the medical cause of Kelvin's death

62. Kelvin was immediately taken to the Emergency Department where he was seen by medical staff. He was pale and disorientated with some blood around his mouth. He was found to have low blood pressure and was hypothermic. He was administered oxygen, but he was agitated and tried to pull the equipment off himself. An intravenous line was

[14] 2/11/2021 T99.3 – T101.31
[15] 2/11/2021 T6.4 – T6.40
[16] Exhibit 1, Tab 73, [183] – [184]

established after several attempts and tests showed abnormal blood gas results and high lactate levels. Emergency staff believed that he may have suffered some form of internal bleed, but before further investigations could be completed, Kelvin suffered a number of cardiac arrests. He could not be revived, despite extensive resuscitative efforts.

63. An autopsy was conducted on 2 August 2018. Dr Allan Cala, forensic pathologist documented significant injuries which were consistent with a fall from height. These included extensive buttock and lower limb bruising, a fractured pelvis and lower vertebral column, extensive pelvic and retro-peritoneal haemorrhage (back of abdomen).

64. I accept that the medical cause of death was "multiple injuries" sustained in his fall from the first floor.

Changes made by the Northern New South Wales Local Health District (NNSWLHD) after Kelvin's death

65. The court heard from Kylie Wilman, the current Executive Officer, Director of Nursing (DON) at Byron Central Hospital. Ms Wilman outlined a number of changes that have been implemented at the hospital since Kelvin's death.

66. In 2019 a multidisciplinary safety huddle system was introduced. The safety huddles occur on the floor of the Inpatient Unit three times a day, bringing together a team including the Deputy DON, the Nurse Unit Manager (NUM), Health and Security Assistants (HSA) and maintenance staff. A risk matrix form is completed, with staff identifying and recording patients at risk of wandering, falls or any other risks.

67. Patients the subject of a "special" are now reviewed every 24 hours at the morning huddle. This ensures that specials are in place for a minimum period of 24 hours.

68. In June 2019 a new policy directive concerning clinical handovers was released by NSW Health, the purpose of which was to enhance patient safety by ensuring a consistent approach to handovers. In evidence RN Newlands confirmed it to be her experience that since 2019 the hospital has emphasised that attention should be drawn to risk factors such as wandering during handovers.

69. In 2019 a form was produced containing a visual prompt about the ISBAR method of handover (Introduction, Situation, Background, Assessment, Recommendation). Wandering is clearly identified as a risk factor. The document is displayed prominently around the Inpatient Unit, it also appears as a prompt on computer screens and is reproduced in a lanyard worn by nurses.

70. Since Kelvin's death, the NNSWLHD's Observations-Minimum Standards document has been updated. A flow chart summarising the requirements for patient observations is

displayed in three areas around the Inpatient Unit. The chart reveals that Kelvin as a "maintenance care" or "social" patient required – both then and now - observations at least every 24 hours. The chart also states that staff may increase the frequency of observations at any time if there are any concerns.

71. In 2020, the 5-4-5 initiative was introduced at the hospital. Nurses gather together at the nurses' station for five minutes twice every shift to discuss five key factors, one of them being patient risks including wandering.

72. I accept the submission that NNSWLHD has demonstrated that it is committed to addressing the risks to patient safety through wandering and has been able to provide some solutions to the safety gaps identified in the management of Kelvin's inpatient stay.

Examination of issues related to his NDIS funding

73. In reviewing the management of Kelvin's participation in the NDIS, it is important at the outset to keep in mind that the system was relatively new at the time of his death and that some changes have already occurred to streamline communication for family members.

74. Prior to the rollout of the National Disability Insurance Scheme (NDIS), funding for Kelvin's care was co-ordinated by the NSW Department of Aging Disability and Home Care (ADHC). Kelvin was deemed eligible for the NDIS on 10 July 2017 and a 12 month plan was approved on 18 July 2017.[17] The first NDIS plan allowed for 41 hours support per week. No formal assessment of Kelvin was required for the funding to continue under the NDIS.

75. The court heard from Lisa Short, General Manager, Service Delivery and Performance at the National Disability Insurance Agency (NDIA), the statutory agency tasked with implementing the NDIS. Ms Short explained the difference between the NDIS and the previous scheme, saying *"… the NDIA is an insurance based approach (as compared to a welfare directed supports approach) which means that the NDIA provides funding which pays for reasonable and necessary supports for people with disability support needs so they can live an ordinary life and reach their full potential and achieve their goals."* She noted that the predecessor welfare scheme allocated block funding, paid to providers, who in turn provided services to those meeting specific criteria. Ms Short stated that the NDIS differs because the participant receives the funding and they can exercise choice and control to determine what support they receive, when they receive it and by whom they receive it.[18]

76. Professor Trollor believes one problem with the new system is that providers under the

[17] Exhibit 1, Tab 34 [1]
[18] 4/11/2021, T85.39

NDIS are many and varied. Under the old system, funding for services was largely coordinated by one government organisation.[19]

77. A network of disability support providers liaise directly with participants to implement their NDIS support plans. Kelvin's disability support provider was ACCnet21, now known as United Disability Care. Ms Short told the court that the NDIA received no paperwork or monitoring reports about Kelvin from ACCnet21 between July 2017 and March 2018.

78. John Forrest's primary contact at ACCnet21 had been Day Program Team Coordinator Lisa Barbour, and Kelvin's primary carer Geraldine Crumpton. On 9 March 2018, John contacted Ms Crumpton outlining some concerns about Kelvin's behaviour in recent times. He mentioned that he had a meeting scheduled with Ms Barbour for 3 April 2018 to prepare for Kelvin's NDIS review.

79. On 12 March 2018 he again emailed Ms Crumpton explicitly stating that he was seeking an increase in support hours and attaching a proposed roster he had drafted. He asked for her input. In evidence John Forrest explained that whilst Kelvin's funding under the new system was comparable to what he had received under the old system, their mother's death in January 2018 and their father's move to a nursing home meant that the funding had to be stretched further, because Kelvin was no longer spending significant periods of time at their home on weekends. By reply email Ms Crumpton told John, *"I totally agree with you that we need to increase Kelvin's support"* and offered some suggested changes to the draft roster.

80. On 13 March 2018, John Forrest emailed Ms Barbour in preparation of their meeting to discuss the upcoming NDIS review. John was also seeking clarification of when the NDIS review would take place. He was under the impression that there was a date set in April 2018, but he had noticed on the NDIS portal that the date was now appearing as 13 July 2018. He put forward to Ms Barbour a case for increased funding to allow more support to Kelvin in his own home. He also noted that a trial in June 2017 which saw Kelvin living part-time at a supported living facility had been "a disaster." John attached the proposed new roster and asked that it be costed.

81. From March 2018, Angela Hartley was Kelvin's NDIS Supports Coordinator at ACCnet21. I accept that up until Ms Hartley's recruitment into the role, there was no one formally occupying the position, but that other staff may have undertaken tasks associated with the role. In evidence Ms Hartley stated that her primary role was to assist clients to obtain sufficient funding from the NDIS.[20]

82. On 14 March 2018, Ms Barbour replied to John. She confirmed that the review with the

[19] 4/11/2021, T56.32
[20] 3/11/2011 T24.11

NDIA to discuss the NDIS funding was scheduled for 16 April 2018. I note that it did not in fact occur until late June. In this email, Ms Barbour also informed John of the existence of Ms Hartley and explained that her role was "to support carers and customers with change in circumstances and updates for the NDIS plans." Ms Barbour enquired whether he was happy for his emails to be passed on to her. He agreed. John continued to contact Ms Barbour directly from time-to-time and assumed the information would be shared with Ms Hartley[21]. This did not always occur. In evidence, Ms Hartley spoke of her belief in a "conflict of interest" that prevented her from accessing Ms Barbour's records. To my mind this was never satisfactorily explained.

83. On 14 March 2018, Ms Hartley emailed John to introduce herself. Later that day, Ms Crumpton emailed John to report further concerns about Kelvin's behaviour, including that she had arrived at his home to find the kitchen floor wet and all the kitchen drawers full of water.

84. On 20 March 2018, Ms Hartley first made contact with the NDIA sending an email introducing herself and seeking confirmation that Kelvin's review would occur on 16 April 2018.

85. Over the coming days there was further email contact between Ms Hartley and John, with John pressing for costings to be prepared for his proposed care roster and also asking for detailed information about existing expenditure of funding.

86. On 23 March 2018, Rebecca Cook from the NDIA replied to Ms Hartley, explaining that Kelvin's current plan expired 13 July 2018 and that a review was to take place within 12 weeks of the expiry date, the first date of that 12 week period being 16 April 2018. Ms Cook said contact would be made after 16 April 2018 to confirm the date for the review. Importantly, Ms Cook also stated the following, *"[y]our quarterly monitoring reports will be an important contribution to the scheduled review process. If you have not yet submitted monitoring reports could I please encourage you to do this at your earliest convenience."* In oral evidence, Ms Hartley agreed that she did not submit any quarterly reports in support of Kelvin's funding review.[22] She was not aware that any had been conducted prior to her coming into the role. She agreed that she did not inform Ms Cook that she had just come into the role and didn't have any quarterly reports for Kelvin to date. She also told the court that she believed that submitting the quarterly reports would not have made any difference in securing an increase in funding. When asked about the source of that belief, Ms Hartley said it was based on her own experience in the past of receiving no response from the NDIA and also that she had been told by NDIS workers that the reports were not read.[23] I

[21] 4/11/2021, T6.3- T7.12
[22] 4/11/2021, T32.48-T33.21
[23]4/11 /2021 T34.18

do not accept that this assertion is an adequate explanation for her conduct.

87. On 27 March 2018 Ms Hartley and John exchanged emails, confirming their meeting on 3 April 2018.

88. On 28 March 2018 Ms Crumpton emailed John, copying Kelvin's other carers and Ms Barbour to report a further deterioration in Kelvin's condition, namely his difficulties toileting independently. She also reported another incident of the kitchen taps being left on, filling the drawers with water.

89. On 29 March 2018 Ms Barbour and John exchanged emails preparing for the 3 April 2018 meeting and John again pressed for detailed information about NDIS expenditure on Kelvin.

90. On 3 April 2018, John Forrest met with Ms Hartley and Ms Barbour to prepare for the upcoming NDIS review, which John still believed was imminent.

91. On 4 April 2018, John emailed Ms Crumpton with his recent observations of Kelvin indicating further concerns about his decline, including a soiling incident and the fact that the kitchen drawers needed to be replaced as Kelvin continued to leave the tap on.

92. On 9 April 2018, Ms Crumpton emailed John, copying Ms Barbour to report further behavioural issues. Kelvin was now taking dirty clothes from the washing basket and putting them in his wardrobe. He had also been taking wet clothes from the line and putting them away.

93. Ms Hartley completed an NDIA Plan Review Report[24] indicating that Kelvin was seeking an increase in funding at the next review. In her statement Ms Hartley says that she submitted the review plan to the NDIA in April 2018 because she wanted to get in early and give the NDIA plenty of notice of Kelvin's situation ahead of the annual review. In evidence however, she said she probably did not submit the Plan Review Report until she submitted the Change in Circumstances form, which wasn't until June[25]. I do note that Ms Short says the NDIA received it on 16 April 2018[26]. The form itself is not dated, so the NDIA must have obtained that date from its own records. I therefore accept that it is likely that it was submitted by Ms Hartley on 16 April 2018.

94. As to the Review Plan itself, the instructions on the form itself state, "[t]his pro-forma is to be used by Support Coordinators to support participants to review their current NDIS plan and prepare for their next plan." The review plan is not supported by any report from Kelvin's General Practitioner or a specialist such as an occupational therapist. The report states that Kelvin's support network has been reduced following the death of his mother

[24] Exhibit 1, Tab 34-27
[25] 3/11/2021, T35.30-T36.39
[26] Exhibit 1, Tab 34 [2]

and his father's move to a nursing home. It states "*[r]eduction in supports over the plan have left Kelvin unsupported and led to wandering and placed him at risk"* and *"Kelvin's awareness and capacity is reducing leading to possible safety risks and changes to behaviour and function."*[27] However, it also records *"Kelvin lives independently, supported living was trialled, however this was detrimental to Kelvin's health and wellbeing and maintaining his current living situation is more appropriate to Kelvin's health and needs."* In evidence, John Forrest agreed that as at 13 March 2018 (when he referred to the 2017 supported living trial as a "disaster"), his preference was for an increase in funding to provide more hours of care to Kelvin in his own home, rather than pursuing Supported Independent Living (SIL). Given Kelvin's history the approach at that point is easy to understand. The position changed as Kelvin's condition deteriorated.

95. On 19 April 2018, Ms Barbour emailed John, copying Ms Hartley. She reported that on two occasions, the transport service had arrived at Kelvin's home, which was unlocked, to find him standing confused and undressed beside his bed. Staff tried to support him by laying his clothes out for him, but even after doing that, they had arrived to find him confused, undressed and not knowing what to do. Ms Barbour also raised concerns that he was not locking doors and could not follow normal routine such as dressing, making his bed or putting away his teddies. She wrote, "I feel that Kelvin's safety could be at risk if he is not locking his door of an evening."

96. On 20 April 2020, John's reply email to Ms Barbour included, "*We are well aware that Kelvin's independent living carries great risks. However, we regard this as an acceptable trade-off for the many benefits. We also accept that the risks are increasing as his abilities decrease with age and that a point will come where the trade-off will be no longer acceptable."* There were further emails between them offering suggestions to address Kelvin's behavioural issues.

97. On 2 May 2018, Ms Hartley wrote to John, suggesting they submit a 'Change in Circumstances' form because the NDIS review could still be weeks away. She said the form would be best supported by evidence and documentation and asked whether Kelvin had visited a doctor or specialist. Mr Forrest replied suggesting that Kelvin's care worker Ms Crumpton (who ordinarily accompanied Kelvin to medical appointments) could contact his GP. Ms Hartley's reply on 3 May 2018 was supportive of that suggestion, but she did not provide John with any clear direction about precisely what was required, that is, a specialist opinion as to cognition and an occupational therapist's opinion as to functional capacity. In evidence, Ms Hartley agreed that a specialist opinion was more or less mandatory if there was to be any hope of a successful application for an increase in funding

[27] Exhibit 1, Tab 34-37

and she also appeared to accept that she could have provided John with more information at this point[28].

98. Kelvin's family were keen to do anything they could to assist his case for increased support. John Forrest had worked tirelessly on this mission. I have no doubt that if clear direction had been given at this stage these expert reports would have been expedited.

99. On 22 May 2018, Kelvin had an appointment with his GP Dr Bettie Honey, which had been arranged by Ms Crumpton at John's request. Dr Honey emailed John the same day with her concerns, saying that Kelvin's dementia was worsening and that in her opinion, it could be dangerous for him to be left alone at night. Dr Honey informed John that she was referring Kelvin to a geriatrician to ask for behaviour management, particularly at night. John replied the same day emphasising that the purpose of the visit today was to obtain evidence in support of an application for increased NDIS funding, *"[t]he purpose of Kelvin's visit with you today was to obtain your medical opinion and confirmation of Kelvin's slowly declining abilities. We need this to support our case for additional support funding from NDIS. I am happy to support whatever referrals you consider necessary to support this case for Kelvin. Specifically we need evidence to support the fact that Kelvin's care needs have increased in the last 12 months, due to a decline in his abilities. The decline is quite apparent, but non-medical opinions are not accepted by NDIS as evidence, and rightly so."* Dr Honey, by return email, asked John if the NDIS had conducted any assessments of Kelvin's functioning.

100. On 23 May 2018, John explained to Dr Honey that the NDIS conducts no such assessments and it is for them to do so and that ACCnet21 was trying to apply for an increase in care, particularly on weekends. The same day, John forwarded his correspondence with Dr Honey to Ms Hartley.

101. On 25 May 2018, Ms Barbour reported to John and Ms Hartley further concerns about Kelvin's behaviour, as observed by his carers.

102. On 31 May 2018, Ms Barbour reported to John and Ms Hartley that when the bus arrived to collect Kelvin, he was found standing in the middle of the road. John replied to Ms Barbour expressing some frustration that he still did not have the documentation required to support the application for increased funding and was hopeful that would be provided at Kelvin's next GP visit on 6 June 2018.

103. On 31 May 2018, Kelvin was not at home when transport staff arrived to collect him. He was eventually found at the pub. Ms Barbour conveyed this information to John in an email and copied in Ms Hartley.

[28] 3/11/2021 T31.29 and 4/11/2021 T32.32

104. On 5 June 2018 John Forrest inspected a Supported Independent Living (SIL) home at Ocean Shores and considered it to be a suitable location for Kelvin to live.[29]

105. On 6 June 2018 Kelvin had another appointment with his GP. A letter authored by Dr Honey the day before confirmed his Down Syndrome diagnosis and stated that Kelvin now most likely had dementia, had been found frequently wandering, including standing in the middle of the road unaware of the traffic and dangers. She noted that she was 'trying to increase his care level with care also needed overnight'. Ms Crumpton provided this letter to Ms Barbour and Ms Hartley. She also confirmed that at the appointment on 6 June 2018, Dr Honey completed the referral to geriatrician Dr Mohammend Khateeb.

106. 10 June 2018 was the day that police were called to remove Kelvin from a boutique in Byron Bay and ended up taking him to Byron Central Hospital. He was returned home later that day. In evidence, John Forrest agreed that it was this incident that confirmed in his mind that Kelvin required 24/7 supported living, not just an increase in funding to provide more care in his own home.[30] John alerted Kelvin's carers and also Ms Hartley. John also made several attempts to get documentation from police about the incident, so that it could be provided to the NDIA, but was denied access until after Kelvin's death.[31] Given John's official role in Kelvin's life this approach appears overly restrictive.

107. On 12 June 2018, Ms Barbour emailed John Forrest and Ms Hartley with more concerning reports from Kelvin's carers. He was no longer locking the house, he was wandering aimlessly to the Beach Hotel, he rarely answered the phone and when he did answer he just said "yeah yeah yeah" and did not appear to comprehend what was being said. Ms Barbour suggested the information to be included in NDIS review.

108. On 12 June 2018, Ms Hartley emailed John to say she had requested all incident reports from the organisation and that she would submit the 'Change in Circumstances' form requesting funding for SIL as soon as she received those details. The 'Change in Circumstance Form'[32] is signed and dated 12 June 2018. In her statement, Ms Hartley says she submitted it to the NDIA on 13 June 2018[33]. Ms Short says the form wasn't lodged with the NDIA until 26 June 2018 following the meeting in Ballina and that it had been lodged by Ms Lynne Reynolds[34]. However, Ms Short also explained that Ms Reynolds wasn't a direct NDIA employee but an NDIA "external" or contractor. The NDIA records only include emails and contact with an external that has personally been attached to the file by them. I accept that Ms Hartley lodged the forms on 13 June 2018. This view is

[29] Exhibit 1, Tab13 [12]
[30] 4/11/2021 T9.36-45
[31] 4/11/2021 T10.16-37
[32] Exhibit 1, Tab 34-39
[33] Exhibit 1, Tab 33 [12]
[34] Exhibit 1, Tab 34 [4]

strengthened by the fact that John Forrest received a phone call from Ms Reynolds the very next day to make arrangements for the review meeting in Ballina.

109. As to the Change in Circumstances form itself, in evidence Ms Hartley was asked why no details had been included under the heading "Why disability support needs have changed?" Her evidence was, *"I guess from experience we had found that not all reports had been thoroughly read so we found we were getting more, you know, outcome having those discussions at the planning meeting."*[35] I do not accept this as an adequate explanation for her conduct.

110. Around this time, Ms. Hartley also submitted an Application for Review of a Reviewable Decision, stating that the decision to be reviewed was made on 1 June 2018 and that Kelvin was seeking increase in funds to fund SIL accommodation[36]. In evidence, Ms Hartley could not recall filling out that form, but having looked at it, believed that she had done so. When it was pointed out that the NDIA's decision to grant an interim increase in funding (but not SIL approval) did not occur until 12 July 2018, she could not recall what decision she was seeking a review of when completing that form.

111. On 25 June 2018, ahead of the NDIS review meeting, Ms Barbour emailed another update from Kelvin's carers to John and Ms Hartley. It contained reference to an incident of faecal incontinence, concerns about his physical health (gout, poor eating habits) and reports of him becoming vague when on outings.

112. The long-awaited NDIS review meeting occurred on 26 June 2018 in Ballina. Beforehand, John Forrest met with Ms Barbour and Ms Hartley to go over everything that had occurred in recent months and to confirm that they were going to advocate for Kelvin to receive funding for SIL. However, when the meeting with Ms Reynolds commenced, it was apparent to John that she was not in a position to deal with an application for SIL. The meeting was terminated within ten minutes and Ms Reynolds promised to escalate the matter within the NDIA. John was told to expect to hear from the NDIA by the end of the week. NDIA records confirm that Ms Reynolds updated Kelvin's file that same day, requesting the NDIA re-stream him from 'Supportive' to 'Intensive.' Ms Short explained that streaming is an internal process used to predict the level of support a participant requires. Ms Reynolds recorded on the file that John hoped SIL would be recommenced and Kelvin provided 24/7 care.[37]

113. On 27 June 2018, Ms Hartley and John exchanged emails about a SIL vacancy at Binya, the group home at Ocean Shores, with John confirming that he would like to accept the position for Kelvin.

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[35] 3/11/2021 T40.5-50
[36] Exhibit 1, Tab 34-51; 3/3/2021 T.36.23
[37] Exhibit 1, Tab 34 [4]-[7]

114. On 29 June 2018 Ms Hartley emailed Ms Reynolds indicating that she was able to source a SIL vacancy at Ocean Shores and sought advice regarding whether Kelvin could transition now or await approval from the NDIS[38].

115. On 3 July 2018, John emailed Ms Hartley expressing concern that he had heard nothing from Ms Reynolds or the NDIA. Both Ms Hartley and John also emailed Ms Reynolds directly requesting an update. Ms Reynolds replied to John the same day apologising for the delay. She said that she would contact the NDIA the following day.

116. On 5 July 2018, still with no word from the NDIA, John emailed Ms Hartley, saying that he was hoping to move Kelvin into the care home around the 19-23 July 2018, but without any response to the funding question, he was reluctant to commit. The same day, John emailed Ms Reynolds, copying Ms Hartley, again requesting a response so that the move into Ocean Shores could proceed.

117. On 6 July 2018, Ms Hartley emailed Ms Reynolds and John, seeking a response to the SIL funding request so that arrangements could be made to move Kelvin into the group home.

118. On 9 July 2018, Ms Barbour emailed John with further reports from Kelvin's carers about his deteriorating condition. On the evening of the 6 July 2018 Kelvin attended the Byron RSL and experienced urinary incontinence. Kelvin had no money to get home, but a taxi driver who knew him agreed to take him home without charge.

119. On the 8 July 2018 Kelvin again attended the Byron RSL, with no money, asking for food. The RSL provided him with a plate of food free of charge. The RSL contacted his carers requesting in-home care for Kelvin, but as Ms Barbour pointed out, he was not funded for support during those hours.

120. John replied to Ms Barbour and Ms Hartley the same day, expressing his understandable frustration, *"I don't know what I can add to what has already been said in relation to Kelvin's increased support requirements. We have all agreed (including Lynne Reynolds at the NDIS review) that the solution lies in Kelvin moving into 24/7 supported accommodation. Angela has been told, by Lynne, not to make any move in this direction until the funding outcome is known. Both Angela and myself are actively (almost daily) contacting Lynne for updates, but we are getting either no response, or responses promising to follow up, with no subsequent advice on what, if anything, these follow-ups reveal about the delay in reaching a decision. In any case, we know nothing more than we did when we all left Kelvin's review meeting two weeks ago, when we were told to expect an outcome that same week. I am as powerless as you are to do anything to help Kelvin, until this funding*

[38] Exhibit 1, Tab 34-19

issue is resolved. I can only suggest that you pass the information regarding Kelvin's diminishing abilities and increased support needs on to NDIS as it comes in, in the hope that they can be provoked into making their funding decision. I remind you also that Kelvin's plan expires mid next week, and he will (presumably) be totally without ACCnet21 support from July 18, unless NDIS approves a new budget by then". John again emailed Ms Reynolds requesting an update.

121. On 9 July 2018, Kelvin was seen by geriatrician Dr Khateeb. Kelvin's carer advised John was that Dr Khateeb would send his report to Kelvin's GP when it is completed. I note that Dr Khateeb's report was not received until 16 August 2018, well after Kelvin's death.

122. On 10 July 2018, Ms Barbour emailed John and Ms Hartley with more reports from Kelvin's carers. Kelvin had broken his phone off the wall and removed pieces of a modem, placing them in a box. He was now without a telephone service. John replied, indicating that the situation was becoming so dire that he wanted to move Kelvin into the care home ahead of any decision on funding.

123. On 10 July 2018, Ms Reynolds emailed Ms Hartley, saying she has been off work, but she had submitted Kelvin's 'Change of Circumstances' form to the NDIA and had marked it urgent. She said that she had also advised the NDIA of the possible placement in the group home. Ms Hartley decided to start transition planning in the hope that funding would be approved. She contacted John to make arrangements for Kelvin to visit the group home and meet the other residents.

124. On 11 July 2018, Ms Reynolds returned to work and informed John, Ms Barbour and Ms Hartley that she had received feedback from the NDIA and was working through it with senior staff. She said she would provide a further update by the end of the day.

125. On 12 July 2018 an interaction record of the NDIA records 'Restream to intensive'[39] John logged onto the portal and saw there was an interim plan increasing total funding by 26.8%. He emailed Ms Hartley asking whether this meant he could start the move into the group home on the 16 July. In the meantime, NDIA LAC partner Ms Gemma Hill wrote to Ms Hartley noting that the restreaming to intensive was on the basis of 'anecdotal' information' that Kelvin does not have capacity to live independently without 24/7 support but that this has not been 'clinically verified'. She stated that a three month interim plan had been approved given there was insufficient information to confirm a 12 month plan. The three month approval of funds was insufficient to pay for the SIL living proposal. The NDIA informed Ms Hartley that before SIL could be approved it needed to be demonstrated that no other cost effective option was effective or suitable, confirm the dementia diagnosis, provide a detailed functional assessment recommending SIL level of support; and that "no

[39] Exhibit 1, Tab 34-18

moves should take place until approval is given."[40] This document was provided to John.

126. On 13 July 2018, one of Kelvin's carers reported that he had attended the Byron RSL on the night of 11 July 2018 and staff were extremely concerned about him.

127. On 14 July 2018, Kelvin's niece Mandi happened to be in the park near Byron Bay Beach and noticed Kelvin sitting on the swing. She went up to him and gave him a hug, but Kelvin was unable to recall her name. He also could not answer Mandi's questions about when his carer was due to arrive at his home. Further, Kelvin was wearing mismatched shoes on the wrong feet. He had food smeared on his face and was bleeding from a fresh cut to his chin. Kelvin was unaware of the injury. Mandi contacted Kelvin's carer who came and collected him. John provided Mandi's email to Ms Barbour and Ms Hartley asking them to ensure it was included in the supporting evidence for the funding review.

128. On 16 July 2018, Ms Hartley emailed John updating him about communications she had had with the NDIA. Ms Hartley informed the NDIA's Gemma Hill that she was very concerned about the three month interim plan which did not appear to provide adequate funding to obtain all of the reports said to be required to support the SIL funding application. Ms Hartley did however suggest to John that an Occupational Therapy (OT) report be obtained. In oral evidence, John Forrest said that until he received this email, he had no idea that an OT report was required. In her evidence, Ms Hartley explained that one of the reasons an OT report had not been arranged earlier is that there were long waitlists[41]. This explanation is in direct contrast with her email of 16 July 2018, which includes, "I do suggest we engage with an OT who can conduct the assessment and reports asked for from the planner. I can recommend Barbara Underwood. I know her waitlist is not to too long and she is taking new clients." Ms Hartley also offered another reason for her failure to alert John to the need for an OT review from the outset. She said that the allocation of NDIS funding for such reports has been exhausted by the time she came into the role.[42] In my view there is no adequate reason given for not advising John Forrest about the critical need for an OT report before this point. John Forrest was passionate about assisting his brother. He was engaged, capable and motivated, he just needed to be told what was required and I have no doubt he would have made it happen.

129. I note Ms Short's evidence was that the requirement for an OT functional assessment was in existence as of March 2018 with respect to anyone who wished to seek funding for supported independent living.[43]

130. On 16 July 2018 John emailed Kelvin's GP Dr Honey chasing up the geriatrician's report.

[40] Exhibit 1, Tab 34-17
[41] 3/11/2021 T69.10
[42] 3/11/2021 T43.40-T44.5
[43] 4/11/2021 T86.34

He also contacted Barbara Underwood, the OT recommended by Ms Hartley, requesting a consultation and report. An appointment was arranged for 24 July at Kelvin's home. This was later moved to Byron Central Hospital following Kelvin's admission.

131. On 16 July 2018, Ms Crumpton took Kelvin to the group home at Ocean Shores to meet the other residents. She reported that it all went well.

132. On 17 July 2018, Kelvin was admitted to Byron Central Hospital after he was found non-responsive at his home. John Forrest the set about trying to inform the NDIA of these very worrying developments. Ms Reynolds suggested to him that he try contacting Ms Hill directly (being the NDIA representative based at Lismore and the person who had advised Ms Hartley that more documentation was required to approve SIL funding). However, the only number John had was the NDIA's national call centre number. He phoned it and was informed that he could not be transferred directly to the Lismore office. John had travelled from his home some hours away to go to the Hospital. He experienced poor mobile phone coverage in Byron Bay and was concerned that any return call from the NDIA would not get through. He also did not have access to the original communications between Ms Hill and Ms Hartley and therefore did not have a direct email address for Ms Hill. I have no doubt that John Forrest's frustration was extreme by this stage.

133. I pause here to note that Ms Short in her evidence accepted that John would have faced difficulty getting through to the NDIA on the national hotline and email address. At the time it was staffed by the Department of Human Services and "*they were taking a long time to answer the phones."* The national hotline has now been outsourced to Serco. Apparently there is a matrix in place involving levels of escalation. Any general enquiries that come through the phone line or the general email address have a response time of 48 hours. If a matter is escalated to tier 2, that means that the participant is at low risk of harm, and there is a 24 hours response. Tier 3 is medium risk of harm or medium to high risk of harm, and that carries a two-hour response. Ms Short's evidence was that had John Forrest contacted the national phone line or the general email address under the current system, he could have expected to receive a reply within two hours.[44]

134. On the same day, John decided to contact the NDIA through their general enquiries email address regarding his request for an urgent review of Kelvin's plan. He also attached the email from his niece Mandi documenting the recent incident at the park. He wrote "*You can see we are making every effort to obtain the better proof of Kelvin's situation, however, the need for 24/7 support is urgent and waiting any longer for documentation is posing a serious threat to Kelvin's safety. It would be no exaggeration to say that even his life could be in danger if he must remain in the community without support with the vast majority of*

[44] 4/11/2021 T91.36-T92.44

the week due to a lack of NDIS support funding. I am seeking an urgent review of Kelvin's planning fund so that SIL component is included and we can place him in an existing vacancy at group house in Ocean Shores where he will have 24/7 support and live with established friends"[45].

135. On 17 and 18 July 2018, John was in contact with a social worker at the hospital discussing plans to have a full review of Kelvin conducted while he was a patient, to obtain the necessary documentation for the NDIS. This did not occur.

136. On 19 July 2018 John obtained a letter from Kelvin's GP Dr Honey confirming Kelvin's diagnoses with Down Syndrome and Dementia and reporting a need for 130+hrs of care to keep him safe, saying he needed 24/7 care[46]. Dr Honey also noted that Kelvin could not even reach a blanket to keep himself warm when he fell at home, and that he would be best suited to a disability supported living arrangement.

137. On 19 July 2018 John Forrest told Ms Hartley that the family would be prepared to fund SIL pending evidence being gathered to enable the NDIS decision[47], *"Is it possible for Kelvin to fund his own additional support until NDIS review his plan whenever that might be?": "If we are forced to choose between draining Kelvin's life savings versus keeping him alive and safe this is the option we might have to accept."* Ms Short's evidence was that Ms Hartley never communicated to the NDIA that Kelvin's family was prepared to pay for the group home[48]. Ms Hartley in her evidence, offered the following explanation, *"[w]e wouldn't inform them that the family were willing to pay for something because they would allow them to do that and it would alleviate them of having to."*[49]

138. On 19 July 2018 Ms. Hartley emailed the NDIA stating that Kelvin is in crisis mode having been admitted to Byron Central Hospital. She did not raise with the NDIA that Kelvin's family were prepared to fund SIL on an interim basis pending the assessment by the NDIA.

139. On 19 July 2018, John called the Hospital Discharge Planner RN Chloe Dunsmore regarding the difficulties Kelvin was having accessing extra funding to facilitate a move to a group home and 24-hour care. John was not agreeable to a suggestion by her that Kelvin be discharged into an aged care facility[50] . John urged the hospital to provide information about Kelvin's condition to the NDIA. Following the phone call, a family meeting with Dr Honey, ACCnet21, John, the social worker and discharge planner was organised for

[45] Exhibit 1, Tab 14-93
[46] Exhibit 1, Tab 34-75
[47] Exhibit 1, Tab 14-110
[48] 4/11/2021 T84.43-47
[49] 3/11/2021 T49.12
[50] Exhibit 1, Tab 26 [7]-[10]

Tuesday 24 July 2018[51].

140. On 20 July 2018 Ms Hartley provided the NDIA with Dr Honey's letter confirming the diagnosis of dementia[52].

141. On 23 July 2018 Ms Hartley emailed the NDIA expressing concerns regarding a lack of funding. On that same day Ms Hill from the NDIA informed Ms Hartley that as per her email of 12 July 2018, the NDIA required confirmation of a diagnosis of dementia, provision of a report informed by related assessments, particularly a detailed functional assessment recommending SIL level of support and details about why each option is/isn't suitable for the participant. It also stated "It is important that moves do not take place until it is agreed to by the NDIA. A move to a new place will require a plan review for the participant and a new SIL quote for the new and other participants living in the household. This will ensure that the appropriate SIL line item is included in the participant's plan and the quote can be implemented."[53]

142. On 23 July 2018, John received contact from someone who was directly involved in the approval of funding, when Sam Collins from the NDIA Lismore office emailed him offering a phone conference to discuss Kelvin's change in circumstances. It was scheduled for 26 July 2018 and would include Mr Collins, John, Ms Barbour and Ms Hartley.

143. During this period John continued to try and gather documentation supporting the application for SIL. Eventually he received a report from the OT Barbara Underwood. The report proved to be inadequate, requiring the NDIA to request further information. In evidence John Forrest recalls the consultation, which took place while Kelvin was in hospital, "during my discussion with Ms Underwood, Kelvin's carer and he popped their head in the door, and you know a brief exchange of conversation took place but I did not observe Ms Underwood actually doing any form of physical assessment on Kelvin, no." There should have been clearer guidance both to John Forrest and Ms Underwood about what was actually required to support an application for SIL funding.

144. On 24 July 2018, John attended the meeting with the hospital where it was agreed they would provide a letter to be used in support of the SIL application.

145. On 25 July 2018 John received a two-line letter from a doctor at Byron Central Hospital stating that Kelvin was unsafe in the community under the current plan and required 24 hour care.[54].

146. On 26 July 2018 there the telephone conference between John, the NDIA's Mr Collins and

[51] Exhibit 1, Tab 26 [7]-[10]
[52] Exhibit 1, Tab 34-75
[53] Exhibit 1, Tab 34-14
[54] Exhibit 1, Tab 13 [18]

ACCNet21 occurred. The outcome was that the NDIS required further documentation from ACCnet21, stating that "Kelvin's Support Coordinator needs to organise functional assessment for Kelvin as a matter of urgency so that the NDIS can assess whether he is eligible for SIL". It was John understands that the NDIA would negotiate directly with NSW Health about the timing of Kelvin's discharge from hospital.[55]

147. On 26 July 2018, John emailed Mr Collins from the NDIA reporting Kelvin's wandering (this being the incident where he was found on the roundabout outside the hospital and led to a 1:1 special being implemented). Mr Collins replied as follows, *"I had a chat earlier today with Chloe. Thanks for providing her details. Chloe mentioned Kelvin absconding today. Chloe also mentioned that the hospital is not intending to release Kelvin tomorrow, unless you are there to pick Kelvin up. The Hospital will continue to accommodate Kelvin in the (very) short term while the NDIS considers short term alternatives, and while Kelvin's Support Coordinator arranges more evidence. In summary: Kelvin can stay in Hospital until at least mid-next week; In the alternative you are welcome to pick Kelvin up tomorrow, or consent to Kelvin going into aged care accommodation; Kelvin's Support Coordinator needs to organise functional assessments for Kelvin as a matter of Urgency, so that the NDIS can assess whether he is eligible for Supported Independent Living; and the NDIS is exploring urgent accommodation in the interim, noting that a finalised SIL placement may take more time. Next Steps: If you do not consent to aged care nor pick Kelvin up from Hospital at a time of your choosing, I will provide a further update as the matter progresses - most likely early next week. I suggest encouraging Kelvin's support coordinator to arrange for the evidence required so that the NDIS are in a position to assess Kelvin's eligibility for NDIS-funded supported independent living."*

148. On the same day, John emailed Ms Hartley to ensure she was aware that the NDIA required OT Ms Underwood to conduct functional assessments of Kelvin as a matter of urgency. Ms Hartley provided this information to Ms Underwood.

149. On the afternoon of the 26 July 2018 John again emailed Mr Collins, stating "*just had a call from the hospital. They claim that NDIS had told them that it will take a couple of weeks for them to arrange for Kelvin to be discharged and moved into SIL. They have again confirmed that they require a definite plan for Kelvin's discharge to be in place by this time tomorrow. Please follow up with them and keep me informed."*

150. Later still on 26 July 2018 John emailed Mr Collins again, seeking clarification of what was required by the OT, stating *"we were all under the impression that the assessment provided by Barbara Underwood would meet your needs and have heard nothing to the contrary until this email from you."*

[55] Exhibit 1, Tab-14-140

151. Not long after, the OT emailed John saying that her report covered Kelvin's function and asked him to get the NDIA to call her directly if they wished to discuss.

152. On 27 July 2018 John called Mr Collins regarding approval to use Kelvin's entire 90- day plan funding to move him to the share house inspected on 25 June 2018. He planned to attend the hospital to have Kelvin discharged and moved to the home at Ocean Shores over 29 and 30 July 2018[56]. In an email to Ms Hartley John summarised his call to Mr Collins, saying *"I am advised that NDIS are (unofficially) prepared to apply all funding in Kelvin's current plan to fund a move into Binya, pending their completion of a full review of Kelvin's plan for the coming year."* He emphasised that Mr Collins detailed a number of items required from Ms Hartley before the assessment could proceed.

153. On 27 July 2018 Ms Hartley emailed John to say she was preparing a housing report for the NDIA and asked for permission to have Kelvin seen by a psychologist to assess him and provide strategies to address wandering off from the SIL home, particularly given that there would be times where there would be four residents to one carer. John replied agreeing to the psychologist appointment but noting he was under the impression there was ample funding for 1:1 support during his short transition period. He pressed for an answer as to when Kelvin could move into the Binya group home as he needed to provide the hospital with a firm discharge date by the end of the day.

154. On 27 July 2018 Ms Hartley submitted the form to the NDIA, a document titled 'Determining Need - Identifying Suitable Housing Solutions[57] and a completed form titled "Support Coordination End of Service Report and Advice[58]. I note that page one of the 'Determining Need' document states, under the heading "What is the Role of the Support Coordinator", that the support coordinator is required to coordinate the required assessments and perform a number of tasks including:

a) Work closely with the participant and their support network to identify their housing and accommodation objectives;
b) Refer the participant to suitably qualified specialist assessors that have been recommended by the Agency to inform the Planner of their physical/cognitive/functional support needs for Specialist Disability Accommodation;
c) Refer the participant [where the need for a Planner if identified] to a Support Coordinator with the skills to strengthen their ability to implement NDIS funded supports and monitor obligations from a variety of funded, mainstream, informal and community interfaces.

[56] Exhibit 1, Tab 13 [20]-22]
[57] Exhibit 1, Tab 34-74 read in conjunction with Tab 34[23]
[58] Exhibit 1, Tab 34-84

155. Ms Hartley gave evidence that it was not her role to determine who was best to provide a diagnosis, prognosis and reports in relation to Kelvin's cognitive capacity. However, she said she understood that "[w]ork[ing] closely with the participant and their support network to identify their housing and accommodation objectives" was part of her role at the time.[59] I further note that the document submitted by Ms Hartley stipulates *that '[t]he support that is identified as being required to assist a person in their home is generally assessed by an Occupational Therapist'*. Under the heading Monitoring and Review it states, *"[o]nce the participant has successfully completed all required assessments, the Support Coordinator will be responsible for collating the required information and providing recommendations and advice to the Agency."*

156. In respect of delays caused as a result of action or inaction by ACCnet21, I accept the submission advanced by counsel assisting that Ms Hartley, who had worked with the organisation for 15 years, failed to advise John Forrest from the outset, in a clear and direct way that expert evidence from specialists carries great weight when seeking an increase in funding. In particular, she failed to communicate the need for a functional assessment by an Occupational Therapist when John Forrest first decided on 10 June 2018, to seek Supported Independent Living (SIL) for Kelvin.

157. I accept that the NDIA has implemented some changes that now provide for the streamlining of urgent reviews. However it is likely that more can be done to assist participants where there is a need to correct or change funding levels urgently. Dr Torr pointed out that more should be done to prevent this kind of urgent situation developing. Kelvin's functional decline was wholly predictable at his age and forward planning, including annual assessments for someone such as Kelvin may have prevented the crisis that occurred. It is clear that for many years Kelvin's family were able to offer him much of the support he needed, but when it became apparent that he needed more, the process was difficult to navigate. In Dr Torr's view Kelvin's NDIS plan was always inadequate, it just became more obvious as his cognitive ability declined. I accept her opinion on this issue.

The need for recommendations

158. Section 82 of the Act confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that

[59] 3/11/2021 T52.7

may be learnt from the circumstances of each death.

159. Counsel assisting put forward a number of recommendations arising out of the evidence for the court's consideration.

160. I intend to deal with each of the proposed recommendations in turn.

Recommendations proposed by Counsel assisting the Coroner

To Northern New South Wales Local Health District (NNSWLHD)

That consideration is given to a tick box on the NNSWLHD admission form indicating whether the patient:

a. identifies with a disability

b. identifies whether they are funded by the NDIS

c. if a disability is identified an automatic referral to the health disability inclusion manager for assessment and review regarding support in the community

d. if a disability is identified and automatic referral to the NDIS health liaison officer

161. Counsel assisting was concerned to craft a recommendation which might trigger better management in the care of hospital patients who face barriers to care related to their experience of disability. Professor Trollor told the court that people with intellectual disability are high users of health services. Their admission rates are high and their length of stay is typically twice that of the general population. At the same time research indicates that staff often feel ill prepared and under skilled in this area.

162. Professor Trollor gave compelling evidence about the utility of establishing, at the time of hospital admission, whether a patient has a disability and the nature of the support that will be required, including whether NDIS services are involved. He explained that this could assist the health service to provide appropriate care and if necessary, service adjustments can be made to account for the patient's specific needs while an inpatient. It may also be useful for discharge planning and for providing continuity of care on discharge.

163. The court was greatly assisted on this issue by the broad experience of Professor Trollor and his ability to place Kelvin's specific experience in a wider context. I accept Kelvin's experience was not an isolated one. Professor Trollor told the court that the current health care landscape in Australia is one of lack of preparedness for the needs of people with developmental or intellectual disabilities. I accept this lack of preparedness exists at all levels and is a major contributor to the mental and physical disadvantage experienced by people with disabilities compared to the general Australian population.

164. The draft recommendation was designed to trigger planning and assistance for those experiencing disability from the point of first admission. It strikes me that it was likely to have been clear from the point of admission that adjustments were necessary to manage Kelvin's wandering behaviour once he was placed on the unlocked ward. It is important to remember that Kelvin's death is likely to have been preventable if increased supervision had been provided consistently from admission.

165. The draft recommendation put forward by counsel assisting was not supported by NNSWLHD. NNSWLHD was concerned that staff would be overwhelmed if there was an automatic referral to the HDIM for all patients with either an intellectual disability or who might receive NDIS funding. It was submitted that the proposal may even have the potential for those with a complex disability to be "lost in the system" or "fall through the cracks".

166. The recommendation was also not supported by the NDIA, which submitted that automatic referral to the NDIA Health Liaison Officer is not always warranted. The Agency submitted that assessment and review by the NNSWLHD should take place prior to any referral to the NDIA. It was submitted that in most cases the NNSWLHD's Health Disability Inclusion Manager would be the appropriate contact point. I accept this is likely to be correct. I accept that given there are only five NDIS Health Liaison officers in NSW at present that automatic referral of every admission might be time consuming and ineffective

167. In response to concerns raised by the NNSWLHD and the NDIA, counsel assisting provided an amended recommendation drafted to take into account the potential for an overwhelming number of referrals and the possibility of duplication of work between the NDIA Health Liaison Officer and the Health Disability Inclusion Manager.

168. The amended recommendation was also opposed by NNSWLHD. It pointed out that the electronic medical record currently in use already has a field where staff can record a patient's NDIS status. It remained concerned that the amended recommendation would still present an unnecessary work burden on staff without providing a corresponding benefit. It submitted that an automatic referral to the Health Disability Inclusion Manager for all patients who receive NDIS funding would prove overwhelming and may be counter-productive. In its view the decision to involve the HDIM or an NDIA HLO should be left for staff to decide on a case by case basis. It was submitted that staff can use their clinical judgement to identify patients with complex needs who may require this kind of extra assistance. The NNSWLHD also pointed to evidence that Mr Todoroski, the LHD's Health Disability Inclusion Manager had provided multiple training sessions at Byron Central Hospital prior to and following Kelvin's death. Further, that a memorandum had been sent to all staff during the inquest reminding them of Mr Todoroski's ongoing role.

169. I have limited confidence in this approach. Kelvin was at Byron Central Hospital for over ten days. He was a patient who experienced increasing disability and who received NDIS funding. His admission centred on a need to increase his NDIS funding and his family were working desperately hard to increase his level of care and yet nobody appears to have ever used their judgement to involve the Health Disability Inclusion Manager who may have been able to assist in the escalation of family concerns. This is particularly striking as it appears Mr Todoroski, the HDIM was assisting another patient on the ward at the time. Staff knowledge about his position appears patchy. Even years later, Hospital staff appeared to have limited understanding of the role.

170. While it may seem superficially appropriate to "leave it to clinical judgement", I accept Professor Trollor's evidence that "the vast majority of doctors and nurses receive little or no training in the clinical care of people with intellectual disability in their undergraduate or continuing medical or nursing education at this point."[60] That being the case, implementing a system which asks them to explicitly consider these issues and contemplate referral may be useful. It is likely that further training is also called for.

171. Having considered all the material before me, I accept that the recommendation as drafted may be too prescriptive. However the issue is an important one and one which in my view has not been solved by other changes already made by the NNSWLHD. As Professor Trollor points out we still have a long way to go in training medical and nursing staff on issues of disability and inclusion. In my view it remains a useful process to ask admitting staff to consider whether a patient experiences a disability which may provide a barrier to best practice care. Trigger questions may assist busy staff in their consideration about what adjustments need to be made. Taking into account all the matters raised, I intend to ask the NNSWLHD to consider this issue again.

That consideration is given to the Revised Algase Wandering Scale (RAWS) – Long-Term Care Version for implementation and/or adaption for those patients who present with a history of wandering or who engage in wandering whilst admitted.

172. This recommendation arose out of evidence which suggested that there had not been adequate attention given to understanding the nature of Kelvin's wandering and the ongoing risks it involved.

173. NNSWLHD opposed the recommendation to consider the RAWS scale as a basis for providing staff with a tool to assist them in understanding and managing a patient's wandering behaviour. In short it was considered inappropriate in a hospital setting as it had been designed for an aged care setting.

[60] 4/11/21/21 T 54.4

174. The recommendation does not suggest that the scale need be adopted without change. Rather it is suggested as a starting point for developing a useful tool. In my view it is appropriate to consider the utility of such a tool and I intend to recommend it

That all staff engaged in casework, Team and Support Coordinator roles and managerial roles at United Disability (ACCnet21) complete mandatory training in consultation with an NDIA representative in

a. the requirements under NDIS act regarding the approval, review and increasing funding for a participant;

b. training regarding the terms of the "Determining Need - Identifying Suitable Housing Solutions guideline; and

c. training regarding the evidence required in completion of all forms submitted to the NDIA, including but not limited to "Plan Review Report"; Change of Circumstance Form; Review of a Reviewable Decision form; Support Coordination End of service Report and advice form.

175. This recommendation arose out of identified gaps in knowledge that emerged in staff tasked with assisting Kelvin and his family. I note that while United Disability (ACCnet21) was represented throughout the inquest and provided with the draft recommendation, it elected to make no comment.

176. The recommendation was supported by the NDIA which indicated a willingness to consult with ACCnet21 in relation to mandatory training on the specified matters. I intend to make the recommendation and advise United Disability of my decision.

Findings

177. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Kelvin James Forrest.

Date of death

He died on 28 July 2018.

Place of death

He died at Byron Bay Hospital, Ewingsdale Road, Byron Bay NSW.

Cause of death

He died of multiple injuries.

Manner of death

Kelvin accidently fell from the first floor at the Byron Central Hospital, in circumstances where the Hospital failed to adequately manage his wandering behaviour. Kelvin was an inpatient while waiting for increased funding pursuant to the NDIS.

Recommendations pursuant to section 82 *Coroners Act 2009*

178. For the reasons stated above, I make the following recommendations

To Northern NSW Local Health District

That NNSWLHD give consideration to implementing an admission process whereby explicit consideration is given and recorded as to whether the patient experiences a disability and/or is a NDIS participant. Further, that explicit consideration is given (and recorded) to identifying any barriers to care that may be associated with the disability so that the necessary service adjustments can be made. The process should explicitly record whether consideration has been given to a referral to the Health Disability Inclusion Manager in the first instance.

That NNSWLHD give consideration to the Revised Algase Wandering Scale (RAWS) – Long-Term Care Version for implementation and/or adaption for those patients who present with a history of wandering or who engage in wandering whilst admitted.

To United Disability and NDIA

That all staff engaged in casework, Team and Support Coordinator roles and managerial roles at United Disability (ACCnet21) complete mandatory training in consultation with an NDIA representative in

a. the requirements under NDIS act regarding the approval, review and increasing funding for a participant;

b. training regarding the terms of the "Determining Need - Identifying Suitable Housing Solutions guideline; and

c. training regarding the evidence required in completion of all forms submitted to the NDIA, including but not limited to "Plan Review Report"; Change of Circumstance Form; Review of a Reviewable Decision form; Support Coordination End of service Report and advice form.

Conclusion

179. Finally I offer my sincere thanks to counsel assisting, Ragni Mathur and her instructing solicitors Gareth Martin and Leah Burgoyne for their hard work and enormous commitment in the preparation and conduct of this inquest. I thank the experts who assisted the court and the officer in charge of the investigation.

180. Once again I offer my sincere condolences to Kelvin's family. I acknowledge that the pain of losing a loved one in these circumstances is profound. I greatly respect Kelvin's family's decision to participate in these difficult proceedings to highlight the need for change. Kelvin was a trailblazer in many ways and one hopes NNSWLHD continues to reflect on ways of improving service for patients, such as Kelvin, who experience disability.

181. In closing, I acknowledge Kelvin as a shining example to us all in his obvious capacity to find joy and meaning in life through love of family and engagement with his community. His example is not forgotten.

182. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
11 March 2022
NSW State Coroner's Court, Lidcombe