CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of Hazel Brockett**
Hearing Dates:	**2-6 September 2019, 28 November 2019 at Newcastle**
Date of Findings:	**3 March 2020**
Place of Findings:	**Newcastle Local Court**
Findings of:	**Magistrate Stone, Deputy State Coroner**
Catchwords:	**CORONIAL LAW – Manner of death – Residential Aged Care Facility – Resident to Resident Aggression in dementia unit – policies and procedures – identifying cause of behaviour and reporting incidents – actions taken to prevent escalation of behaviour – whether actions adequate**
File Number:	**2016/224411**
Representation:	**Mr P Aitken, Counsel Assisting, instructed by the Crown Solicitor's Office** **Mr D Evenden for the Brockett family** **Mr G Gemmell for Southern Cross Care Pty Ltd, Amelia Gray, Karen Gough, Amanda Mika and Helen Emmerson, instructed by Maddocks** **Ms B Epstein for Patrina Noud, instructed by Carroll & O'Dea** **Ms T Berberian for Dr Margaret Himmelhoch, instructed by Avant Law** **Mr R Coffey for Dr Martin George, instructed by Makinson d'Apice**

Mr T Hackett for John Filby, instructed by HWL Ebsworth

Ms M England for the Aged Care Quality and Safety Commission, instructed by Clayton Utz

Findings: **The time and date of death was 8:00am on 23 July 2016**

The place of death was John Hunter Hospital Newcastle

The cause of death was complications of femoral, radial and ulnar fractures, and an antecedent cause was Alzheimer's disease

The manner of death involved the infliction of severe injuries to Mrs Brockett in her room in an unwitnessed act performed by a fellow resident who was suffering from severe dementia

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Inquest into the death of Hazel Brockett

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

2. *I make a non-publication order under s. 74 (1) of the Act in relation to the name of* [redacted] *in this Inquest. I make a further non-publication order prohibiting the publishing of the real name of "Patient A" described in Exhibit 5 of the evidence and a similar order as to names of any residents of the Caves Beach Facility that are referred to in evidence in the Inquest.*

Introduction

3. Hazel Brockett died on 23 July 2016, aged 86 years. Her death as defined by s. 6 of the Act was an unusual death arising from severe injuries she received while a resident in a dementia care unit at an aged care facility and as such it was a "reportable death" to the Coroner. As will be outlined in this decision, I am satisfied her injuries were caused by another resident also suffering dementia. Those injuries were occasioned on 14 July 2016. She was transferred to the John Hunter Hospital and despite operative intervention in relation to fractures she sustained she was not able to overcome the trauma and died 9 days later.

The Inquest

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

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

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

Background

6. I have effectively adopted Counsel Assisting's opening remarks and the agreed facts dated 13 September 2019[1] to provide the following material.

[1] Exhibit 10.

7. At the time of Mrs Brockett's death she had been married to her husband Thomas for some 60 years. They raised two sons and she was described as a valuable member of the community shown by her voluntary assistance for many years with Meals on Wheels and local hospitals.

8. In or about 2011 Mrs Brockett was diagnosed with dementia, and up until 2015 she was able to be cared for at home. However, over time she became progressively worse and when she started wandering away from her own home the difficult decision was made to admit her to an aged care facility.

9. She was admitted to Southern Cross Care at Caves Beach ("the facility") in a secure dementia unit. Within the facility there were 11 residents with dementia and each resident had their own room and private bathroom facilities. This secure area was known and described at the Inquest as the Memory Support Unit ("the MSU").

10. The MSU is a specialised ward that provides dementia specific care which was said to include close supervision for residents, as well as specific care and lifestyle activities directed to reducing behaviours and associated risks caused by dementia. In that respect, the MSU had a Lifestyle Officer who had a particular role directed to lifestyle activities.

11. While the MSU is a locked or secure facility, residents are able to move freely between residents' rooms within the unit. There was no CCTV facility within the MSU. Staff members were responsible for the monitoring of the residents.

12. The Manager of the facility in 2016 was Ms Patrina Noud. She had been appointed Facility Manager in 2006. She was on extended leave for varying periods in January, April and July 2016 and during those periods Ms Amelia Gray was Acting Facility Manager. Ms Noud stated that it was common for residents of the MSU to wander in and out of other residents' rooms.[2]

13. As at July 2016 the staffing ratios for the MSU were as follows: morning shifts, 2 care staff; afternoon shift, 2 care staff; nightshift, one care staff; a Lifestyle Officer providing ongoing diversional therapy to residents, including a sundown program between 2:00pm and 7:00pm daily using personalised activities to assist in mitigating the risk of escalated behaviours. In addition, one registered nurse ("RN") was on duty each day from 8:00am to 4:00pm at the facility. That RN would also be on-call overnight until the next RN's shift commenced at 8:00am. In 2016, John Filby and Karen Gillies were the RNs at the facility. RN Filby worked Monday and Tuesday, and RN Gillies worked Wednesday, Thursday and Friday. In addition, from time to time the facility employed contract agency nurses.

[2] [31] of the statement of Patrina Noud dated 17 October 2018, Tab 15A, Exhibit 1.

14. As at July 2016, the handover process for care staff at the facility comprised of a verbal handover meeting at shift change run by Ms Noud, Ms Gray or the RN on duty. Secondly, a daily handover sheet was located in the RN's office or Ms Gray's office, where staff members would write relevant information regarding a resident to inform staff on the next shift. This sheet was also used to run the handover meeting. Thirdly, a communication book or daybook was located in an administrative office, in which Ms Noud and Ms Gray wrote instructions to staff members. When starting a shift, staff members were required to read the communication book and sign the page. The staff were also required to read progress notes made on the electronic system called "AutumnCare" for each resident since their last shift.

15. Resident care information was documented in the following ways. There was a resident Care Plan which documented the resident's health care needs – this was an electronic document in AutumnCare and it could be updated from time to time. The second way that resident care information was documented was to use the AutumnCare program to record progress notes on residents. The third way was to keep a pain chart for each resident and whenever a resident started on a new pain medication the staff would fill out a pain chart in AutumnCare for 5 to 7 days. It was also a policy that a pain chart would be commenced for any new pain reported, observed or suspected in a resident. Lastly, the handover process was apparently also set out on a displayed poster.

16. It was the facility's policy in 2016 that staff documented in AutumnCare any behaviours such as aggression, confusion and disorientation displayed by residents, and that they ought to speak with the Facility Manager and/or RN about any concerning behaviours, including in morning conferences. In addition, the facility had a process in place that, in every case, the RN on duty at the facility must, within 24 hours of physical aggression involving residents, review the behavioural care plan of the alleged perpetrator.

17. Resident in the MSU at the same time as Mrs Brockett was, [redacted]. He was 67 years old in July 2016. He was still physically able and mobile but was suffering from severe dementia. Mrs Brockett lived in room 103 and [redacted] was living in room 101. He had been a resident at the MSU since 15 December 2015. [redacted] did not recognise his family, had significant difficulties with everyday tasks, often refused food and assistance with everyday tasks, and was not always compliant with his medication. While he was still verbal he did not always communicate coherently and often appeared to talk to people who were not present. In late December 2015, Ms Gray completed a cognitive skills assessment for [redacted] and checked the box which is marked "cannot complete prescribed instrument due to severe cognitive impairment or unconsciousness". Clearly, [redacted] was not unconscious; so that the

conclusion is that the facility considered that he suffered from a severe cognitive impairment.

18. The general practitioner Dr Margaret Himmelhoch saw approximately half of the residents of the MSU at the relevant time.[3] She would generally attend on a Wednesday afternoon for her clinic. Dr Himmelhoch saw both [redacted] and Mrs Brockett when required.

19. In February 2016, a continence assessment completed by Ms Gray noted that [redacted] had a history of constipation and there were a number of drugs used to relieve this. [redacted] also suffered from joint pain from osteoarthritis. He was prescribed a slow-release Norspan transdermal patch which had to be checked by care staff when taking him out of bed, dressing and showering him. The medication chart would be initialled to show that it was in situ. Records from the facility indicate that [redacted]'s Norspan patch was unable to be located on 27 May and 3 June. It was not unusual that some residents had the habit of taking them off. The last Norspan patch applied was on 10 July, four days before the incident involving Mrs Brockett.

20. Records for [redacted] from the facility showed that from January 2016 to April 2016, instances of verbal and/or physical aggression numbered approximately 3 to 4 per month. The vast majority were verbal rather than physical. Generally the instances of aggression were usually directed towards care staff. In February 2016, there was only one documented instance of aggressive behaviour. The records indicate that [redacted] complained of soreness in his ribs on 13 April 2016, apparently from a fall out of bed that was not witnessed by staff. He was visited by Dr Himmelhoch later that day who prescribed clonazepam, a benzodiazepine used to treat seizures or panic disorder. The doctor was aware that [redacted] had an allergy to benzodiazepines but she charted the clonazepam and used it as a once only medication to manage agitation that [redacted] displayed in relation to being transferred to hospital in an ambulance.[4] He was transferred to Belmont Hospital for examination where he was diagnosed as suffering from 2 broken ribs.

21. [redacted] was subsequently prescribed Ordine, a morphine based syrup, and a higher dosage of his Norspan patch. After being seen at the hospital he was transferred back to the MSU. The facility's records show that [redacted]'s aggression appears to have increased following the rib injury, both in frequency and, at times, in the nature of the physical aggression. Not surprisingly, staff at the facility attributed his episodes of aggression and sometimes agitation to pain, presumably from the rib fractures.

22. When Dr Himmelhoch was on leave in May 2016 Dr Martin George, another GP at her practice, attended on her patients in the MSU. Dr George conducted an

[3] Transcript of proceedings, 4 September 2019, T73.15 - 73.22.

[4] Transcript of proceedings, 4 September 2019, T63.34 – 63.39.

examination of [redacted] on 12 May 2016. He noted that [redacted]'s reported increased aggression may have been related to the increased Norspan dose. He reduced the dosage to the original level prior to [redacted]'s attendance at Belmont Hospital. When [redacted] was seen again by Dr Himmelhoch on 25 May she noted in her records "mood has improved".

23. There was an escalation of [redacted]'s aggression and violent behaviour in the two months prior to the incident on 14 July 2016. In May 2016, there were 22 reported instances of verbal or physical aggression involving [redacted]. Again these were largely directed at or involved care staff. In June 2016, there were at least 29 documented instances of verbal and physical aggression or violence initiated by [redacted], some of which involved another resident. In one case another resident was found to be assaulting him. About 24 of these involved care staff and some of the instances pertaining to physical threats. There were ten occasions in June 2016 where [redacted] was found in the rooms of other MSU residents. On some of those occasions, [redacted] was found lying on the beds of other residents, including in Mrs Brockett's room, on 6 and 21 June. On an additional seven occasions in June he initiated physical assaults or threats on other residents. On four of these occasions 7, 9,10 and 25 June he grabbed the wrist or arm area of the other resident in a forceful way, although on one of those occasions it was said that he was trying to dance with the other resident, and it was seen to be unintended in that context.

24. In July 2016, there were further instances of [redacted] being physically violent or verbally aggressive towards staff and wandering in and out of other residents' rooms. The AutumnCare notes for the period prior to the incident reveal that staff often observed [redacted] to be "delusional." He was also refusing to take his medication at times, as documented on 14 and 17 June, and on 3, 6 through to 9, 11 and 12 July 2016.

25. On 3 June 2016, an RN provided permission to another staff member to administer risperidone to [redacted] for agitation. On 6 June, RN Filby reviewed [redacted] and noted that staff should check every day that [redacted]'s Norspan patch was in place. He believed that [redacted]'s behaviours may be related to pain and so suggested the GP "review analgesia". On 7 June, Ms Noud emailed Ms Gray and asked Ms Gray have Dr Himmelhoch review [redacted]'s medications for aggression.

26. On 8 June Dr Himmelhoch saw [redacted] and found no physical concerns. She prescribed an increased dose of risperidone to "reduce his antisocial and aggressive behaviours". She also increased doses of paracetamol. On 12, 14, 17 and 18 June [redacted] was administered 2ml of Ordine for the reasons documented, including pain and agitation and "aggression and agitation" (on 18 June 2016).

27. At about 9:00am on 20 June, [redacted] physically assaulted another male resident and a staff member. He was administered a further 2ml of Ordine. RN Filby noted that the GP was to review the medication. He also made a note that a referral to the National Dementia Behaviour Management Advisory Service ("DBMAS") (a geriatric referral service) or a geriatrician may be required.

28. As it transpires no referral was made. On the same afternoon of the assault Dr Himmelhoch was contacted and she adjusted [redacted]'s dosages of risperidone and clonazepam (the letter being prescribed as needed "for agitation").

29. On 22 June 2016, Dr Himmelhoch reviewed [redacted] and noted behaviour difficulties associated with his dementia. She prescribed Epilim and Ordine as needed for pain. The Autumncare notes entered by Ms Gray on 22 June note that a referral was to be made to Dr Bernard Walsh, a geriatrician. This referral was not made.

30. On 29 June, Dr Himmelhoch again reviewed [redacted] and noted his behaviours remained "variable". The doctor was then on leave and on 1 July Dr George received a telephone call from Ms Gray who requested a prescription for Endone for [redacted] to address "agitation".[5] There was a further incident of aggression towards staff later the same day and he was given Ordine and Clonazepam.

31. On 1 July 2016 Ms Gray completed or modified a physical behaviour assessment for [redacted] which noted behaviour of: grabbing onto people, striking others, pinching others, banging self or furniture, pushing, spitting, throwing things, destroying property, hurt self or others, eating or drinking inappropriate substances, inappropriate disrobing, inability to sit still and repetitious mannerisms, and stereotypic movement.

32. On 3 July [redacted] was administered Ordine after being verbally aggressive towards staff and throwing walkers around. [redacted] refused his medication at 8:00am and his medications at 12:00 noon were omitted. On 5 July he was again administered Ordine due to agitation. On 6 July Dr Himmelhoch reviewed him and noted he had been more settled since commencing Endone on 1 July. A new medication plan was commenced; Endone to cease from 8 July, the Norspan patch and Epilim were increased, and Ordine to continue as needed.

33. On 13 July Dr Himmelhoch reintroduced Endone. Instances of verbal aggression, spitting food and throwing things (on one occasion) were documented during the period between 8 and 12 July 2016.

[5] [40]-[44] of statement of Dr George, Tab 24D, Exhibit 1.

The Incident

34. On 14 July, Amanda Mika and Michael Abel were the two care staff rostered on to assist residents of the MSU during the morning shift, until 2:00pm. Michelle Cassells was rostered on during the afternoon shift which commenced at 2:30pm. Ms Gray was the Acting Facility Manager that day.

35. During the morning [redacted] was described as settled and allowed staff to massage his legs as he rested in bed. He then attended a concert in the facility and he was reportedly in excellent spirits and engaged positively with staff and other residents. At about 1:15pm he was observed sitting with other residents in the MSU telling stories and smiling and photographs were taken of him. A staff meeting was scheduled for 2:00pm at the Café within the facility and was conducted by Ms Gray. As a result both Ms Mika and Mr Abel continued to work past the usual 2:00pm finishing time so that the usual staffing ratios were met. The Lifestyle Officer was not present in the MSU at the time of the incident.

36. It was at about 2:05pm when Ms Mika heard screaming coming from Mrs Brockett's room. She immediately walked towards the room and when she entered she saw [redacted] standing next to Mrs Brockett who was lying on her bed. [redacted] was holding her arm and talking to her calmly. Her recollection was that he spoke words to the following effect:

> *"Don't scream darling, I am not trying to hurt you" and*
> *"I'm just trying to get the poison out"*

37. She then saw Mrs Brockett's leg was next to her head – that is her left leg was up near her right ear. She pressed the emergency call button in Mrs Brockett's room and walked up to [redacted] and told him to let go of Mrs Brockett. She walked him to the end of the bed and stood with him at the end of the bed until someone else came. As it transpired Mrs Brockett also had a broken arm.

38. Mrs Brockett was conveyed to the John Hunter Hospital where she underwent surgery on 15 July 2016 to repair the fractures sustained during the incident. Because of her age and the quality of her skeletal structure the procedure was lengthy and complicated. In the recovery unit she suffered from ongoing hypotension despite all efforts of medical management. Following consultation with her family she was kept comfortable and palliated until she subsequently passed away at 8:00am on 23 July 2016.

39. In the meantime [redacted] was taken to Belmont District Hospital. He was closely monitored over the ensuing days. He continued to complain of painful ribs but was also noted to have periods of agitation and some evidence of paranoia with

hallucinations. On 19 July he was transferred to the Mater Mental Health Unit for Older Persons ("MHUOP").

40. Upon his admission to the MHUOP his medications and prescriptions were reviewed and he underwent physical and mental health assessments. There was a cessation of his Norspan patch and other opioid analgesia. While he remained grossly confused, he was increasingly compliant with his medication, eating well, interacting appropriately with staff and not demonstrating any aggressive behaviour, which raises the question of whether the change in medication might have had something to do with the settling of [redacted]'s behavioural difficulties. The discharge summary stated "withdrawal of the high dose opioid analgesia and resolution of his bowels with aperients and Fleet Enemas, [redacted] became settled and seemed back to the reported baseline as per the family". On 12 August 2016, he was transferred to Ibis Lodge which is an intermediate psychogeriatric facility for people who have moderate to severe behavioural and psychological symptoms of dementia.

41. There were a number of witnesses who gave evidence at the inquest. Unless comment is made I otherwise find that each of the witnesses was creditable, genuine in the evidence they gave and attempted to assist the Inquest to the best of their ability.

Plain Clothes Senior Constable Jamie Taylor

42. Plain Clothes Senior Constable Jamie Taylor is with the Lake Macquarie Police District. He replaced Detective Senior Constable Nathan Webb who was the officer-in-charge of the coronial investigation. Through PCSC Taylor the brief of evidence was tended and marked as Exhibit 1. The brief was prepared in collaboration with DSC Webb and two experts were engaged and provided a number of reports. A statement of advice was received from the Director of Public Prosecutions which also formed part of the brief.

Amanda Mika

43. Amanda Mika worked as a care service employee at the facility in 2016 and is now an administrative receptionist there. As a care service employee (also known as an Assistant in Nursing, or 'AIN') her primary functions were personal care, assisting with showering, feeding and social care. That involved getting residents out of bed showered, attending with them to the toilet, assisting with clothing and sometimes some residents required two care service employees assisting. When that was happening, no one was overseeing what other residents were doing. This was so particularly in the morning when the Lifestyle Officer would only come on shift from 2:00pm.

44. If she witnessed an incident, for example, if a resident was aggressive to another resident or towards a staff member she understood her obligation was to report it to her RN, to document it in AutumnCare and to fill out an incident form.

45. In her evidence she confirmed the staffing numbers as set out in paragraph 13 of these findings. The MSU comprised 11 beds and she thought the remaining facility comprised of 49 or 50 beds. As would be expected, she gave evidence that care staffs' time was devoted to the personal care of each of the residents. She agreed in cross-examination from Mr Evenden that it was "impossible with only two of you there to properly supervise what was happening outside while you were doing the work in a particular room".[6]

46. Ms Mika stated that incident forms were handwritten and the residents' names would be placed on the form where there is an act of aggression against another resident or staff member. Her evidence was that each resident would have a form completed for the one incident.[7]

47. She made clear that if there wasn't an incident then it was unlikely to be reported so that if there were acts of agitation or delusional behaviour that was part and parcel of a resident's normal behaviour that would not be recorded.[8]

48. As to AutumnCare records, she recounted this was an electronic record where staff can make an entry under their name about a resident, and that entry remained in the database. An event (such as aggressive behaviour) would ordinarily be recorded by a staff member in AutumCare and staff can access this record at the desktop computer at the nurses' station. Ms Mika stated that it was not possible to access AutumnCare whilst in a resident's room. Acts of intrusive behaviour where a resident would wander into another resident's room and lie on their bed would be a matter that she would record in the AutumnCare notes, but not on an incident report form.[9]

49. In terms of instruction from senior people such as the Facility Manager or the RN, Ms Mika stated that instructions concerning residents were provided through a handover process, direct communication and the communication book. At the end of each shift, handover ordinarily occurred with an RN, care staff member and the Facility Manager (sometimes without a registered nurse being present). Generally, what had occurred during the day would be discussed. Ms Mika understood that the communication book was filled out by the Facility Manager and was meant to be read before each shift started. It contained instructions and advice that needed to be followed or to be alert

[6] Transcript of proceedings 2 September 2019 at T40.10 – 41.8, T62.14 – 62.17, T63.4 – 63.7 and T95.1 – 95.4.
[7] Transcript of proceedings 2 September 2019 at T43.
[8] Transcript of proceedings 2 September 2019 at T38.
[9] Transcript of proceedings 2 September 2019 at T39-40.

about (i.e. certain behaviours in residents).[10] For example one of the entries in the book contained the following:

> "*17/6/16 Staff please follow up with any aggression as possible pain with dementia residents. 9 times out of 10 pain is the cause. Call R.N. for instructions and advice".*[11]

Ms Mika acknowledged that she had initialled that entry.

50. As noted above, when witnessing an incident of aggression the obligation was to report to the registered nurse on duty, document the incident in AutumCare and complete an incident form. This form was then given to the facility manager. The procedure for a reportable assault was that it was a notification in writing and then given to the Facility Manager.

51. Ms Mika stated that physical and verbal aggression, or threats of aggression, would be reported immediately "definitely before you go home or at the end of your shift". Reports of agitation were put in the incident report if this was connected to an incident, however reports of agitation to nurses varied depending on the behaviour of the resident as "some residents were agitated a lot; some weren't". Any behaviour out of the ordinary for the resident was reported.[12]

52. Overall Ms Mika considered that [redacted]'s behaviour was escalating during the time she cared for him, including more frequent outbursts and more frequent physical occasions that involved not only the staff but residents. She could not recall whether or not they had become a topic of discussion collectively at any of the handovers. She was taken to paragraph [48] of her statement where she stated: "it seemed that when he took Ordine he also calmed down if he was in agitated state."[13] She confirmed that was taken to mean if [redacted] was showing signs of agitation or aggression the underlying cause was pain and Ordine was a way of dealing with that by addressing the pain. If signs of aggression were detected, the RN would be contacted to administer Ordine. She did not consider that the signs of aggression could be viewed as something else – her answer was "from my level, I don't know. We took directions from management and registered nurses".[14]

53. She observed [redacted] as having conversations with himself. She had a recollection this was discussed by staff at handover and a vague recollection about [redacted] going to the Mater Hospital for a mental health assessment. Ms Mika was not actively

[10] Transcript of proceedings, 2 September 2019 at T43.49 – 45.32.
[11] Annexure JR-15 of the statement of Julie Rossi, Tab 15B, Exhibit 1.
[12] Transcript of proceedings, 2 September 2019 at T37 - 38.
[13] Statement of Amanda Mika dated 8 January 2019, Tab 12A, Exhibit 1.
[14] Transcript of proceedings 2 September 2019 at T47.15 – 47.16.

taking part in those discussions and on occasion observed discussions, however she did not believe she had a role to play, and she did not discuss residents with doctors. If she had any concerns she would take them up with the RN. Much of the information received about [redacted] and his pain, was through management.[15]

54. Ms Mika gave evidence that [redacted]'s periods of aggression would come on suddenly and he would calm down suddenly. Staff would try various 'behaviour interventions'. Staff had access to the "Physical verbal wandering plans", which listed behaviour interventions for staff to use with residents. Examples included 'sitting with residents' and 'reading to residents'. Ms Mika said these interventions generally worked, and if they did not work the first time staff would leave and come back later to try again. If [redacted] was becoming aggressive with other residents he would be moved away first to give him space and normally he would often calm down.[16]

55. In summary, she saw her role as responding to daily events and trying to manage them, to record events as they needed to be recorded so those higher up the chain could build a picture of what was going on and consider what more could be done. Further, if any direction was to come it would be from someone more senior and she would endeavour to put responses into place.[17]

56. Counsel Assisting asked a number of questions of the witness in relation to the possibility of improving safety, particularly for vulnerable residents such as those that are bedridden in their rooms. Ms Mika considered that an increase in staff care numbers would improve monitoring of other residents and improve safety.[18]

57. Evidence was given of another resident known as Mr A, a previous resident who was considered very aggressive who was scheduled and taken to the Mater Hospital under the *Mental Health Act 2007* and then returned to the facility. Upon return, an extra staff member was appointed immediately to supervise him at all times.[19]

58. Again in cross-examination it was suggested to Ms Mika that as Mrs Brockett had become quite immobile in the last three or four weeks before the incident in July 2016 and was effectively bedridden, that she could have been managed safely in another part of the facility rather than staying in the MSU. Ms Mika agreed with this proposition. She also agreed that she had seen that course taken with other residents.[20]

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[15] Transcript of proceedings 2 September 2019 at T49 - 51.
[16] Transcript of proceedings 2 September 2019 at T74-76.
[17] Transcript of proceedings 2 September 2019, T51.12 – 51.26.
[18] Transcript of proceedings 2 September 2019, T59.
[19] [15] of the statement of Patrina Noud dated 30 August 2019, Tab 15AB, Exhibit 1.
[20] Transcript of proceedings 2 September 2019, T65.33 – 65.49.

59. Ms Mika received yearly online dementia training in her early years with the facility - she started with the facility in about 2013. She stated that agitation would have been covered in this training, as well as knowing the cues to recognise pain such as facial expressions and a change in behaviour.[21]

60. Ms Mika said the safety measures at the facility included lockable entry doors to MSU accessible with passkeys. She noted that residents are not able to lock the door from within their rooms, nor are the doors self –closing. There is a CCTV camera located at the front doors but not in residents' rooms. The recording of the CCTV film is in the nurses' station.[22]

61. She agreed that the approach she adopted for [redacted]'s care and, indeed all residents in the MSU was a "person-centred care approach." Ms Mika said "every person has different needs and certain things aren't going to work for everybody" therefore "different interventions will work differently for each individual resident".[23]

62. Ms Mika stated that after Mrs Brockett's death, staff received training with Altura about dementia. She also agreed that "somebody from head office came to talk about dementia" and she agreed that that was also helpful.[24]

Karen Gough

63. In 2016, Karen Gough was working as a Lifestyle Officer and care member at the facility. She had dual roles depending on what assistance was needed at the time. She was also trained as an AIN.

64. Ms Gough has a Lifestyle Certificate 4 and a Certificate 3 in Aged Care. She also has training in dementia, specifically a three-day in-house course in 2016. This course looked at "what signs to look for and how to help someone with dementia to live their life and be the best they can".[25] Ms Gough received training on assessing signs of delusion or psychosis and when to pass information on about issues that may warrant further investigation.[26]

65. As noted above, in 2016 at a handover meeting the people present were generally the care staff from the two shifts, (ie. one finishing and one starting) as well as the Facility Manager or Deputy, or an RN depending upon availability. As a care staff member and Lifestyle Officer, Ms Gough was not involved in any periodic reviews of

[21] Transcript of proceedings 2 September 2019, T56.01 – 56.09; T66.
[22] Transcript of proceedings 2 September 2019, T57 – T59.
[23] Transcript of proceedings 2 September 2019 at T76.48 – 77.18.
[24] Transcript of proceedings 2 September 2019, T76.
[25] Transcript of proceedings 2 September 2019, T83.16 – 84.02.
[26] Transcript of proceedings 2 September 2019, T85.

residents as this was not in her scope of practice. She became involved once she became Coordinator of Lifestyle, a position she was appointed to on a full-time basis in May 2018.[27]

66. Rather than have meetings it was Ms Gough's usual practice to review resident's files every three months. This review would focus upon how to change a resident's day-to-day management in relation to lifestyle; so factors such as changes in needs and choices would be considered, as well as any problems that emerged. Ms Gough provided strategies or ways to alleviate or assist with a problem as part of a resident's Care Plan. It was not within Ms Gough's scope to put forward intervention strategies to management.[28]

67. Ms Gough said any concerns she had about a resident would have been documented, by speaking to management and an RN, and Dr Himmelhoch would often 'call her in' to the Doctor's room to discuss a resident's health. Ms Gough cannot recall if she spoke to any staff members about concerns of [redacted] that warranted further investigation of his behaviour.[29]

68. Ms Gough stated that [redacted] presented as delusional in his behaviour, as "he spoke to people that weren't there and tried to include them". Ms Gough cannot recall if she spoke to clinicians about [redacted]'s behaviour, she did speak to the RNs about [redacted] and the delusions. The delusions did not concern Ms Gough at the time as they 'were quite happy delusions.' She described them as "like he was having conversations laughing, smiling, telling me about his story about who (sic) Paddy and Murphy were".[30]

69. Ms Gough indicted that residents can be moved out of the MSU once their danger and risk has reduced. This responsibility lies with the combined opinion of management, the RN and the doctors, not herself.[31]

70. In both her statement to police and her oral evidence, Ms Gough confirmed that after [redacted] fell out of bed and broke his ribs in April, his behaviour became more aggressive and he became resistive to care. This change in behaviour to agitation and aggression was discussed at handovers and placed in the progress notes. The consensus of the discussions was [redacted]'s aggression and agitation was due to his pain from the fall. This view was formed from the notes that Ms Noud put in the

[27] Transcript of proceedings 2 September 2019, T82.16; Statement of Karen Gough dated 24 September 2018, Tab 14B, Exhibit 1.
[28] Transcript of proceedings 2 September 2019, T82-83.
[29] Transcript of proceedings 2 September 2019, T84.
[30] Transcript of proceedings 2 September 2019, T84 – 85.4.
[31] Transcript of proceedings 2 September 2019, T92.27 – 92.43.

communication book.[32] Ms Gough was not involved in any discussions about alternatives, such as getting a specialist to assess [redacted] as that was a management decision.[33]

71. Ms Gough, from her observations of [redacted] said that his aggression would be reduced once he'd been given his pain medication; this also pointed to her belief that he was being aggressive because he was in pain.[34]

72. Ms Gough made reference in her statement of an incident where [redacted] held her wrist saying "I could break your wrist". She did not see this as an aggressive incident, more of a statement by [redacted] She did not make a record of this. However, Ms Gough said if this incident were to happen today she would chart it and record it as an instance of aggression.[35]

73. An issue in the MSU is that residents can wander into other residents' rooms. Ms Gough said this was a common occurrence. The policy of dealing with this was re-direction of the resident in an attempt to return them to their room. Ms Gough indicated that this may have occurred due to residents not always being supervised, as well as residents resisting redirection.[36]

74. Ms Gough did not endorse a suggestion from Counsel Assisting to an arrangement of locking doors from the outside, but not from the inside, where only staff members with passes could access residents' rooms. In her opinion "some people would not have the cognitive ability to open the door for themselves". So being in a room with a door already closed could be detrimental to their mental health.[37]

75. She accepted that once a resident became bedbound and no longer capable of mobilising then there was an opportunity to be removed from the MSU and moved to another part of the facility. It was of course dependent on availability of beds in the other part of the facility. She agreed that there were other examples of this having happened within the facility. She accepted that there were advantages in moving a resident once they were in this vulnerable state of being immobile and bedbound. She said it happens because they are not able to wander and do not have any behaviourial issues so there is no possibility of them hurting someone else. She also agreed that that the general part of the facility was likely to be a safer place rather than being in

[32] Transcript of proceedings 2 September 2019, T86.
[33] Transcript of proceedings 2 September 2019, T87.27 – 87.44.
[34] Transcript of proceedings 2 September 2019, T93.30 – 93.44.
[35] Transcript of proceedings 2 September 2019, T97.37 – 98.3, T104.3 – 104.7.
[36] Transcript of proceedings 2 September 2019, T95 – 96.
[37] Transcript of proceedings 2 September 2019, T89.35 – 89.47.

the MSU. Her understanding was that it was a decision that had to be made by management and the RN and the resident's doctor.[38]

76. Ms Gough was asked for suggestions as to any improvements that could be made. Her suggestion was implementing a safety area. She envisaged this would be a large cordoned off area for residents that appears as a 'homely' lounge room, and has a viewing space for staff. In times of extreme aggression, residents could be placed in the room until further assistance, such as a mental health care team arrives. Ms Gough said this space would allow residents to have peace and allow them to calm down as "a lot of residents in Memory Support don't have a boundary restriction. They don't understand it".[39]

77. Ms Gough stated that CCTV could be useful if it wasn't in residents private rooms, "but only if someone monitored it", or it could be replayed.[40]

78. In cross-examination from Mr Evenden she explained that each resident in the MSU had a bed alarm on the bed, so when they sit up from their bed, or stand up, it activates a buzzer sound on a staff pager to let them know that the resident is up and moving.[41]

John Filby

79. John Filby is a registered nurse. Mr Filby worked in the aged care industry from 2005 until 2016, and for the past few years has worked in a general medical practice at a medical centre.[42]

80. Mr Filby worked in the MSU at the facility for about two years. He worked two days a week and Ms Karen Gillies and, at times of vacancies Ms Corine Breen, an agency nurse, filled the other days of the week. At the relevant time, there was only one RN working five days a week in the whole facility during the morning shift.[43]

81. He explained that each resident would have an individualised care plan which is formulated by undertaking certain assessments under each care domain. The care plan was reviewed by an RN every three months.[44] For example, for residents who exhibited behaviours of aggression, a care plan would firstly involve identifying the aggressive behaviours and then working out strategies for staff to deal with this.[45]

[38] Transcript of proceedings 2 September 2019, T91 – 92.
[39] Transcript of proceedings 2 September 2019, T92.
[40] Transcript of proceedings 2 September 2019, T96.13 – 96.31.
[41] Transcript of proceedings 2 September 2019, T96.5 – 96.11.
[42] Transcript of proceedings 3 September 2019, T7.5 – 7.6, T8.24 – 8.32.
[43] Transcript of proceedings 3 September 2019, T8.35 – 8.50.
[44] Transcript of proceedings 3 September 2019, T9.33 – 9.37.
[45] Transcript of proceedings 3 September 2019, T9.39 – 10.5.

82. However the care plan didn't formulate or review the behaviours and formulate an alternative approach if things were escalating. A review could be done as it were ad hoc, arising from incident of concern. Within the Care Manual there was a section on "managing behaviours of concern" which identified various triggers for an assessment and then the response would include a period of observation over seven days and development of a resident care plan. The Manual refers to the need to introduce case conferencing with a view to consulting with outside consultants. He said that each resident would have at least one annual case conference and others as needed. It was a decision for management, so that if they found it necessary for any behaviour of concern or any other change in condition, (for example if a resident was going to be palliated, or whether they needed to be moved to another room) there would be a case conference with the family.[46]

83. Mr Filby had no recollection of whether or not a case conference had been held in relation to [redacted] He stated that if one were held the conference should have been recorded on paper, however he indicated that it was possible that a conference could have been held without any records being kept. His recollection was that he had a number of talks with the family about things but it would not have been a formal case conference.[47]

84. If the behaviour of a resident was escalating the RN and the Facility Manager would identify the issue and put in place mechanisms such as behaviour charting to assess what was triggering the behaviours. Behaviour charting involved care staff making an observation (for example: observing a resident wandering) and recording this behaviour as well as the time it occurred and who witnessed it. The various behaviours of a resident are given a code that is specific to the behaviour in question (for example: W1 means interfering while wondering, while P1 refers to physical threats, V1 – 3 would be some type of verbal abuse or aggression and graded as to severity).[48]

85. If there is a pattern in a resident's behaviours of concern, a mini case conference would occur where the resident would be reviewed by the RN and the managers, and the GP would be notified of these concerns when the GP consult occurred.[49] If behaviour was not a concern, the policy surrounding case conferences was to have one within six to twelve weeks of a resident's admission and then annually after that.[50]

86. Mr Filby stated that when medication for pain was to be given to a resident, the medication would be charted by the GP and so too would the reasoning for the

[46] Transcript of proceedings 3 September 2019, T10 – 11.
[47] Transcript of proceedings 3 September 2019, T11.38 – 12.13.
[48] Transcript of proceedings 3 September 2019, T14 – 16.
[49] Transcript of proceedings 3 September 2019, T17.
[50] Transcript of proceedings 3 September 2019, T58.18 – 58.21.

medication, under the column headed "for indications". So if the doctor had written Ordine for agitation, then they could have it. This was because the RNs did not always administer medication. If they were not on duty, care staff could administer a resident their medication if they had permission from a RN, which they would often obtain via a telephone call.[51]

87. The incident on the 20 June 2016 where [redacted] walked towards another resident and pushed him over in his chair onto the ground and then punched another staff member in the jaw with a closed fist, resulted in his care plan being altered to include a monitoring of his whereabouts. However, for the incident on the 25 June, where [redacted] grabbed a resident by the wrist and did not release him despite the attempts of other residents, there was no change made to prevent or manage his future physical behaviours.[52]

88. Referring to his written statement concerning the incident on 20 June (at paragraph [40])[53], Mr Filby made an entry of a suggestion that [redacted] be reviewed by a GP, have his medication reviewed and be referred to a psychogeriatrician or DBMAS. Mr Filby stated that a GP would have to be involved in the DBMAS or specialist referral.[54] DBMAS referrals involve a visiting team or person entering the facility on a pre-arranged day to carry out assessments, examine a resident's file and devise a strategy to put in place.[55]

89. In cross examination, counsel for Dr Himmelhoch took Mr Filby through various entries in AutumnCare on 20 June which started with his entry at 11:42am relating to the suggestion that the "GP was to review on next visit and medication review needed" and consideration of a referral to a psychogeriatrician and or DBMAS.[56] Following that, there was an entry created by Patrina Noud having a discussion with [redacted]'s wife about that issue. There was also an entry that the GP was notified by Ms Noud at about 1:08pm about increased behaviours and a physical episode, and as a result there was an increase in dosage of [redacted]'s risperidone and Clonazepam. Further, the staff were instructed to commence a behaviour assessment. There was a further entry by Ms Noud at 4:42pm that the doctor would attend on the usual Wednesday and a new medication order would be in place by that stage.[57] There was a further entry by Ms Gray after Dr Himmelhoch had examined [redacted] and that there was consideration of a referral to be written to Dr Walsh. The first entry on 23 June notes "Behaviour assessments to commence again to monitor behaviours and

[51] Transcript of proceedings 3 September 2019, T20.
[52] Transcript of proceedings 3 September 2019, T55 – 56.
[53] Statement of John Filby dated 1 April 2019, Tab 15C, Exhibit 1.
[54] Transcript of proceedings 3 September 2019, T22.8 – 22.16.
[55] Transcript of proceedings 3 September 2019, T31.49 – 32.17.
[56] Transcript of proceedings 3 September 2019, T42.29 – 42.36.
[57] Pages 25-26, Tab 33, Exhibit 1.

new medication".[58] On that basis, RN Filby was asked whether he considered that what essentially he had in mind in terms of his original entry on 20 June had been considered and implemented. His answer was "yes".[59]

90. Mr Filby made DBMAS referrals once or twice a year and was responsible for collating all the relevant information to prepare for the referral. It was Southern Cross Care's policy that the referral is signed off by the GP. However, he understood that a Doctor's approval is not required to take a resident to hospital in an emergency.[60]

91. Strategies were put in place in the Care Plan in an attempt to manage [redacted]'s physical behaviour, this included 'interact one on one with the resident, take the resident for a walk', and 'read to the resident'. Mr Filby stated that in the short term these one-on-one interactions were available but "if you needed to do more than a few minutes it probably wasn't possible".[61]

92. The visiting GPs did not have their own login to AutumCare, however Mr Filby gave evidence that the nurses would always login to the system and have the AutumCare notes available to the GP. Additionally, the GP would have access to the communication book and the doctor's book. The doctor's book is a folder containing all the doctor's names, and notes to the doctor by staff about a particular resident and what the doctor needed to address on their visit.[62] The doctor's book was always made available to the doctor. The communication book was also available if the doctor wanted to review it. "Incident reports" may also be discussed with the doctor but they were not necessarily in front of the doctor during their visit.[63]

93. Speaking in general terms about his experience in the aged care industry, Mr Filby stated that not every GP would read the nursing or care notes prior to a consultation with patients.[64] It was common that nurses or care staff would provide a summary of what issues have occurred since a resident was last seen by a GP and would send this information to the GP via fax, email, telephone or a note.[65]

94. He accepted that it was a high workload when you are looking after some 50 residents and there was only one RN. He also accepted that where there were different RNs rostered on, continuity was more difficult. He also agreed that it wasn't possible to deliver one-on-one care to 11 residents in the MSU.[66]

[58] Page 22, Tab 33, Exhibit 1.
[59] Transcript of proceedings 3 September 2019 at T42.16 – 44.11.
[60] Transcript of proceedings 3 September 2019, T32 – 33.
[61] Transcript of proceedings 3 September 2019 at T54.49 – 55.11.
[62] Transcript of proceedings 3 September 2019 at T45.6 – 45.9.
[63] Transcript of proceedings 3 September 2019 at T46.49 – 47.2.
[64] Transcript of proceedings 3 September 2019 at T47, T48.1 – 48.8.
[65] Transcript of proceedings 3 September 2019 at T47.44 – 47.50.
[66] Transcript of proceedings 3 September 2019 at T50 – 51.

95. Mr Filby suggested that improving forms of communication between parties, such as the family, doctors and allied health professionals should be implemented, perhaps by an increase in case conferencing. He also endorsed an increase in education and clarity of policies surrounding different workers' responsibilities.[67]

96. Mr Filby suggested changes could be made to policies to clarify when to refer residents to DBMAS and/or a geriatrician, and also when a GP needs to be involved in referrals. Also, Mr Filby found Counsel Assisting's suggestion of all staff who are involved in the care of residents in the MSU having dementia specific training suited to their level of expertise to be a good suggestion. Mr Filby agreed with Counsel Assisting's statement that:

> *"One of the things that practically occurs…is that it may be that the registered nurse is being consulted by phone to make some clinical decisions about management of a resident… Without necessarily directly witnessing what is the matter of concern or indeed going and seeing the resident to make the assessment… So there's a certain amount of responsibility sitting on the shoulders of the care members."*[68]

97. In relation to safety recommendations, Mr Filby believes that CCTV would be of limited use, that it may be effective in the shared common areas if it was monitored, but not in a resident's room as this was a breach of privacy.[69] He acknowledges that he has not been working in aged care for two years so offered a 'general comment' that pressure mats in the doorway of a resident's room would be a trip hazard or might confuse a resident with poor vision if they mistake it to be a hole.[70] He also accepted that family members of a resident in a dementia specific unit consider their family member is receiving better care because of higher staff ratios and better specific dementia training, so family are sometimes resistant to moving family members. He said it can be done, but would have to involve discussions with the family, senior management and bed availability.[71] He was also against the idea of a resident's door being locked from the outside but not locked from the inside. He considered that disorientation would be a factor, that perhaps the resident would forget how to open a door, or if that they are in the dark they may not even know where the door is and might try to climb out the window.[72]

98. In responding to Associate Professor Macfarlane's report where he stated there were issues with the assessment tools which were utilised and that there was no proper

[67] Transcript of proceedings 3 September 2019 at T 34.11 – 34.33.
[68] Transcript of proceedings 3 September 2019 at T36.1 – 36.14.
[69] Transcript of proceedings 3 September 2019 at T36.33 – 36.44.
[70] Transcript of proceedings 3 September 2019 at T38.26 – 38.47.
[71] Transcript of proceedings 3 September 2019 at T40.
[72] Transcript of proceedings 3 September 2019 at T39.6 – 39.20.

assessment being made of [redacted] so that his situation could be properly understood, Mr Filby responded "We can only use the tools made available or the suggestions made by others, including management, head office, the GP, whoever says he should try this, do this".[73]

99. He was also asked to comment on Associate Professor Macfarlane's opinion that, after having reviewed [redacted]'s behaviours and the notes, that the behaviours were so extreme that they justified a transfer to an inpatient setting before the incident with Mrs Brockett took place. His answer was "insight's wonderful so probably yes, I would suggest it a bit more strongly, but two days a week, three other days, I don't know what would happen" (he was referring, I assume, to the number of days he worked which was two days a week and the fact that not working for the rest of the week would make it difficult to know when a referral should take place).[74]

Patrina Noud

100. Ms Noud was the Facility Manager for the entire Southern Cross Care facility at Caves Beach from about 2006 until about August 2017. She is by qualification an enrolled nurse and she also has a management certificate in clinical care training, dementia training and first aid certificates. While she was uncertain as to who provided the dementia course her evidence was that she had been to an intensive course that lasted several days rather than an online course that might have only gone for an hour or two. Her estimate was that she would visit the MSU at least once a day. She would attend handover meetings on average with the changeover shift, from morning to afternoon shift, possibly three or four times a week. She would try also to have a "catch up" meeting with the registered nurses and/or Amelia Gray – "most days".[75]

101. Ms Noud was asked to confirm that she considered [redacted]'s aggression was a by-product or a result of pain and that that pain came from his fractured ribs. Despite reviewing the reports of Associate Professor Macfarlane and Professor Ibrahim in which it was suggested that there may have been other possible factors influencing [redacted]'s aggression other than simply pain which she accepted, she still considered that at the time it was due to his fractured ribs.[76] It was clear that although there were other factors that could provide an explanation for aggression this witness did not consider them.

[73] Transcript of proceedings 3 September 2019 at T60.50 – 61.16.
[74] Transcript of proceedings 3 September 2019 at T60.38 – 60.48.
[75] Transcript of proceedings 4 September 2019 at T2 – 3.36.
[76] Transcript of proceedings 3 September 2019 at T67 – 68.

102. She agreed that there would be benefit in providing dementia training for staff in positions like herself as a Facility Manager to understand the wider range of explanations that can cause different behaviours.[77]

103. Ms Noud was taken to the entry made by RN John Filby about the behavioural issues of [redacted] on 20 June 2016 and the suggestion by RN Filby that [redacted] be referred to a psychogeriatrician or DBMAS. She had no specific recollection but there are entries made by her in Autumncare indicating that she spoke to the family of [redacted] and also to Dr Himmelhoch. There is an increase in an antipsychotic medication called Risperidone and the introduction of clonazepam to be introduced on a PRN basis. There was also a direction made for staff to commence behaviour assessments.[78] She has no recollection of attempting to organise or there being a joint meeting between herself and the staff with Dr Himmelhoch to discuss what should happen.[79]

104. She thought that there were case conferences held in relation to [redacted] but there is no mention of them in AutumnCare, nor did she have any specific recollection of a meeting with family members and the GP. She agreed that in hindsight that would have been a sensible thing to have done. She could offer no explanation as to why a meeting was not held.[80]

105. Having recently reviewed the AutumnCare notes, Ms Noud agreed that [redacted]'s progression of incidents was increasing in frequency including physical aggression towards both residents and staff. She accepted that the MSU was caring for highly vulnerable people that included frailty and mental and emotional vulnerabilities with their dementia. Despite acknowledging the priority of the residents and their well-being and safety and the well-being and safety of staff she could not give an explanation as to why a formal case conference had not occurred.[81]

106. Overall Ms Noud's recollection of events was poor. She accepted that the kind of behaviours exhibited by [redacted] on an almost daily basis were not normal behaviours for residents in the facility, and in particular in the MSU, however she continued to answer that she had no recollection as to why some formal meeting was not held.[82] She accepted that as the Facility Manager she had a role to play in chasing things up however did not have any recollection as to whether she chased up a referral by Dr Himmelhoch that [redacted] be referred to Dr Walsh. She has no recollection of what her thinking was at the time as [redacted]'s troubling behaviours continued

[77] Transcript of proceedings 3 September 2019 at T68.26 – 68.33.
[78] Page 26, Tab 33, Exhibit 1.
[79] Transcript of proceedings 3 September 2019 at T71.48 –72.1.
[80] Transcript of proceedings 3 September 2019 at T 72.8 – 72.28.
[81] Transcript of proceedings 3 September 2019 at T72-73.
[82] Transcript of proceedings 3 September 2019 at T73, T74.18 – 74.41.

through June and into July. She has no recollection of speaking to Dr Himmelhoch about [redacted] on any other occasion other than 20 June.[83]

107. Ms Noud was asked how long it took a resident to be seen by DBMAS – again she couldn't recall but thought it was about two weeks.[84] She couldn't recall whether any details of verbal and physical charts were ever sent to Dr Himmelhoch. She couldn't recall if those sorts of things were provided to a GP by way of background for someone who's exhibiting troubling behaviours – she said it could be arranged and then when asked whether it had been done for anyone Ms Noud's answer was "I don't recall".[85]

108. The evidence indicates that it wasn't routine to provide a visting GP with AutumnCare notes or the behaviour charts. Ms Noud said that they could view them, however the question is how the doctors would know about them unless it was communicated to them. She accepted that it would be an improvement for the general practitioners to have access to AutumnCare.[86]

109. Ms Noud was asked whether there were any fresh guidelines or further instructions to staff as to how communication should occur between staff members and GPs after the incident between [redacted] and Mrs Brockett and her answer was again "I don't recall".[87]

110. She accepted that behaviour charting was a strategy that could have continued other than for the two week period it had been implemented for [redacted]. She accepted that would have been a strategy to assist in what was happening and that it could have been valuable information. She had accepted that it was necessary to consider and utilise case conferences, and that in doing so, it would have more likely than not have led to consideration of referral to specialist services. She appeared to agree that because Dr Himmelhoch was not accurately informed of the severity of the behavioural issues, her clinical response was impacted.[88]

111. She was asked whether she had considered increased staffing in the MSU to assist in [redacted]'s behaviours and again her answer was "at the time I don't recall". She accepted that if she needed extra staff it could have been accessed with the approval of the area manager and the submission of a business plan (in a non-emergency situation).[89]

[83] Transcript of proceedings 3 September 2019 at T75.32 – 75.37.
[84] Transcript of proceedings 3 September 2019 at T76.30.
[85] Transcript of proceedings 3 September 2019 at T76.49 – 77.08; Transcript of proceedings 4 September 2019 at T35.44 – 36.9.
[86] Transcript of proceedings 3 September 2019 at T77.
[87] Transcript of proceedings 3 September 2019 at T79.03 – 70.06.
[88] Transcript of proceedings 3 September 2019 at T80.
[89] Transcript of proceedings 3 September 2019 at T81.34 – 81.48.

112. Again her view was that the locking of resident doors from the outside was an issue in relation to possible disorientation for the resident and that pressure mats alerting staff to movement within the room could cause a trip hazard unless level with the floor covering.[90] Overall Ms Noud considered that staffing levels could be improved in all areas of aged care.[91] In her opinion she considered that on all shifts there should be a RN present.[92] She also considered it would be an advantage if it was easier to access mental health units – that is, in-patient facilities for voluntary or scheduling purposes.[93] She was also of the view that the use of CCTV being available to monitor common areas would be an improvement.[94]

113. It was her opinion that up until about 14 July 2016 there were no acute (urgent) matters which were concerning the staff that required some consideration to escalate [redacted]'s care by contacting DBMAS or an emergency admission to hospital. She did not consider that [redacted] was out of control.[95]

114. Ms Noud was asked a number of questions by counsel for Dr Himmelhoch, Ms Berberian, concerning notification of matters to the GP and in particular to Dr Himmelhoch. Ms Noud had a poor recollection of what information was sent to the doctor.[96]

115. She agreed that most of the time the usual practice was that the doctor would be assisted by whoever was there from the facility, in terms of drawing their attention to any specific issues and specific matters rather than looking up the AutumnCare records.[97] She acknowledged that further information in relation to a particular resident could be made available for a visiting GP. She also acknowledged that Dr Himmelhoch insisted on working with Ms Gray because she thought very highly of her and her competency.[98]

116. She was asked by counsel for the Brockett family, Mr Evenden, whether more could have been done to manage Mr [redacted]'s behaviour and her answer was that she had considered that she should have at least held a case conference.[99]

117. In her answers to questions from Mr Evenden in relation to a referral to DBMAS she indicated that she relied on Dr Himmelhoch's opinion in relation to [redacted]'s

[90] Transcript of proceedings 3 September 2019 at T82.33 – 82.49.
[91] Transcript of proceedings 3 September 2019 at T84.1.
[92] Transcript of proceedings 4 September 2019 at T52.12 – 52.16.
[93] Transcript of proceedings 3 September 2019 at T84.
[94] Transcript of proceedings 3 September 2019 at T83.
[95] Transcript of proceedings 4 September 2019 at T7.1 – 7.14.
[96] Transcript of proceedings 4 September 2019 at T9 – 14, T42.46 – 43.10.
[97] Transcript of proceedings 4 September 2019 at T13.43 – 13.47.
[98] Transcript of proceedings 4 September 2019 at T13 – 14.
[99] Transcript of proceedings 4 September 2019 at T19.42 – 20.26.

behaviours and what was the best and appropriate management for him. She considered that medical input was required for a referral to DBMAS.[100]

118. She agreed with the proposition put by counsel for Southern Cross Care ("SCC"), Mr Gemmell, that in hindsight, in circumstances where she was aware of increasing physical and verbal aggression from [redacted] and given that she had a good rapport with the family and with doctors and registered nurses, she could have spoken to each of these people to try and better manage [redacted]'s behaviour.[101]

119. When Ms Noud made her first statement,[102] she stated at paragraph [36] that she had a conversation with Ms Gray on her return to work shortly after the incident involving [redacted] and Ms Brocket. Her recollection is that Ms Gray said to her that some staff had not given [redacted] his medications because he was aggressive when attempting to administer them and that this was not recorded in the relevant documentation. It was suggested to Ms Noud that this conversation did not occur. She said that that was a conversation that she could recall when she returned to work. It was put to her that if that was said then it would have come as a big surprise to her and of concern. She agreed. She was asked what steps she took to ensure that it did not occur again if it was a matter of concern. Her answer was "I can't recall". When pressed on her recollection of the conversation again, her answer was "I recall that conversation to a degree at the time when I made this statement".[103] For the reasons that I have stated at the conclusion of the summary of her evidence, on balance I am not prepared to accept a conversation occurred in the terms recounted by Ms Noud. If it did occur it was not with any emphasis on the staff issues with medication as put by Ms Noud in her statement. In her supplementary statement she was taken to paragraph [22] where it referred to her indicating that she had no recall of any member of staff telling her that they thought [redacted] needed increased or different medical treatment or removal to a different facility or hospital.[104] She agreed that it was not the role of staff to make clinical decisions of that nature however from her perspective she thought that an RN should be able to provide an opinion.[105]

120. In answer to questions again from Mr Gemmell, Ms Noud could not recall whether or not pain records, pain charts or behaviour charts appeared on AutumnCare as at July 2016. She thought they were but couldn't really recall.[106]

[100] Transcript of proceedings 4 September 2019 at T27.13 – 27.17.
[101] Transcript of proceedings 4 September 2019 at T32.9 – 33.41.
[102] Statement of Patrina Noud dated 17 October 2018, Tab15A, Exhibit 1.
[103] Transcript of proceedings 4 September 2019 at T34.30 – 35.20.
[104] Supplementary Statement of Patrina Noud dated 30 August 2019, Tab 15AB, Exhibit 1.
[105] Transcript of proceedings 4 September 2019 at T35, T47.26 – 47.31.
[106] Transcript of proceedings 4 September 2019 at T35.44 – 36.9.

121. It was suggested to her that prior to the incident at the facility that she was required to hold a monthly service review committee meeting with senior staff. She accepted that was the case. Further, in respect of the meeting that occurred the month after the incident on 14 July 2016, no reference to the incident appeared in the minutes, so there was no recording of it. She accepted that the Regional Manager would normally attend the service review meetings and would also receive a copy of the minutes. She also accepted that monthly meetings took place between the Regional Manager and herself to discuss care issues. She was also taken to the compulsory reporting log and her attention was drawn to the issue that the log was not complete in respect of this incident.[107]

122. She agreed that SCC had systems in place designed to ensure that behaviours such as [redacted]'s were identified and appropriately managed.[108]

123. She was challenged in relation to agreeing with a suggestion by Mr Evenden that it was not uncommon to move a resident from the MSU to another part of the facility when they became bedridden. She was asked to recall in the 12 months prior to the incident how many times that had occurred and she could not recall a figure. She was asked if in fact no one had been moved in the 12 month period and she couldn't be sure of that either.[109]

124. She believed that a monthly report that went to the Regional Manager of SCC would have identified the number of behaviour concerns in relation to the residents at the facility without specifically naming the residents. That report would then go on to head office.[110]

125. Overall Ms Noud had a very poor recollection of events and in some cases the procedures that were in place at the time. She appeared to be quite vague and if her Counsel had indicated to the Inquest that Ms Noud had been suffering from some health issue that was impacting on her recollection, I would better understand. I do not find she was not creditable. Rather she appeared not to be able to answer most (not all) critical questions with any sense of certainty or knowledge. She appeared to lack insight into [redacted]'s escalating behaviours.[111] The overall impression is one where appropriate and timely management skills that might be expected in a facility of this nature were not displayed. Where her evidence differs with another I would not prefer the evidence of Ms Noud, unless specifically commented on in these findings. Counsel Assisting in his submissions said there were "glaring inconsistencies" in

[107] Transcript of proceedings 4 September 2019 at T38 – 39.
[108] Transcript of proceedings 4 September 2019 at T39.49 – 40.3.
[109] Transcript of proceedings 4 September 2019 at T40.13 – 40.45.
[110] Transcript of proceedings 4 September 2019 at T38.42 – 38.45, T54.13 – 54.25.
[111] Transcript of proceedings 3 September 2019, T71 – 75.

some answers given.[112] Having read the submissions from her Counsel it may be there was some misunderstanding about her knowledge of the escalating behaviours of [redacted] Ms Noud's Counsel submitted she wasn't made fully aware because of under reporting (downplaying) or no reporting. Overall there was a failure to communicate between care workers and senior staff including her. She had overall responsibility.

Dr Margaret Himmelhoch

126. Dr Margaret Himmelhoch is a general practitioner. Dr Himmelhoch prepared three statements for the Inquest.[113]

127. [redacted]'s previous Doctor from Lakeside Surgery, Dr Paul Gobbo, sent via fax a summary of his care to Dr Himmelhoch on 7 December 2015 detailing [redacted]'s prescription medication. The fax stated [redacted] was on a Norspan patch where 10 micrograms per hour were released once a week, for his large joint (hips, knees and shoulders) osteoarthritis pain. Panadol Osteo was also prescribed for arthritic pain.[114]

128. Dr Himmelhoch took over [redacted]'s care on approximately the 16 December 2015. Dr Himmelhoch continued to prescribe [redacted] 10 micrograms of Norspan, but ceased to administer Panadol Osteo. The Norspan patch continued due to [redacted]'s long term issue with osteoarthritis that required management.

129. In April 2016, after [redacted]'s rib injury and his treatment in Hospital, [redacted]'s dose of Norspan was increased to 20 micrograms per hour. This is classified as a 'middle dose' and Dr Himmelhoch stated that the Hospital increased the dose to treat both the osteoarthritis pain and the rib fracture pain.[115]

130. Dr Himmelhoch worked closely with Ms Amelia Gray, who was the deputy care manager, during her Wednesday afternoon clinics. Ms Gray would inform Dr Himmelhoch of any issues with each resident and what actions needed to be done. Dr Himmelhoch states that she was not aware of the increasing frequency of [redacted]'s aggressive behaviours. She said that she would have recorded this if she had been told of it. Dr Himmelhoch stated that since recently reading the AutumCare records, the picture that was presented to her in 2016 regarding [redacted]'s behaviours was vastly different from the picture that the AutumCare records presented. In 2016 Dr Himmelhoch was under the impression that "[redacted] *was getting the symptoms of his dementia, behavioural symptoms which are common amongst people in the*

[112] Supplementary submissions of Counsel Assisting dated 5 December 2019 at [7].
[113] Tab 23, Tab 24A and 24AA of Exhibit 1.
[114] Pages 28-30, Tab 34, Exhibit 1.
[115] Transcript of proceedings 4 September 2019 at T63 – 64.

Memory Support Unit. I was not aware of him becoming more – I'm going to use the word dangerous to other people".[116]

131. The symptoms that she was told about were that he was "a little bit aggressive at times, bit more verbally – and he's difficult, he doesn't like being cared for much, he doesn't like having showers …". [117]

132. Her recollection is that she was asked by the facility to provide an Ordine prescription on about 22 June 2016 and she would have provided the prescription to enable [redacted] to be given the medication if he was in pain. It is possible that [redacted] was given Ordine on top of his Norspan at the discretion of a nurse in the facility.[118]

133. Counsel Assisting put to her the proposition that the PRN provision of Ordine was being given without her surgery being updated. She agreed with that proposition. She also accepted that it would have been helpful to know when it had been administered.[119]

134. After Dr Himmelhoch had a discussion with [redacted]'s wife on or about 8 June she received approval to try medication to help reduce his antisocial and aggressive behaviours. She was therefore using Norspan to treat pain and attempting to treat the aggression with the use of Risperidone, an antipsychotic. After the 20 June incident where he pushed a resident over in a chair and punched a staff member, she also introduced clonazepam PRN for agitation. It became clear to her through the evidence given at Inquest that the facility was treating Mr [redacted]'s aggression at times with Ordine, which is a pain reliever. It was her opinion that there was a lack of communication as she was not aware of the ongoing Ordine use. She also accepted that having read the AutumnCare notes, there were a lot of concerning behaviours and that it painted a very different picture from the one that she understood when she prescribed Risperidone in terms of frequency.[120]

135. She accepted from looking at the AutumnCare notes that on 22 June, after discussion with Ms Gray, it was agreed that a referral would be written for [redacted] to see Dr Walsh, a specialist geriatrician. She accepted that no referral was undertaken and she presumes that it was overlooked. The doctor also indicated that if she was considering referral to a geriatrician she would ordinarily seek DBMAS involvement as a first step. This was not initiated either.[121]

[116] Transcript of proceedings 4 September 2019 at T66.23 – 66.45.
[117] Transcript of proceedings 4 September 2019 at T66.47 – 66.50.
[118] Transcript of proceedings 4 September 2019 at T67 – 68.
[119] Transcript of proceedings 4 September 2019 at T69.37 – 69.45.
[120] Transcript of proceedings 4 September 2019 at T70.42 – 71.22.
[121] Transcript of proceedings 4 September 2019 at T72.

136. The doctor did not accept that even the behaviour that she was aware of was flagging something more serious that needed further attention. She answered that was not necessarily the case because "I see a lot of people like this and nothing usually comes of it".[122]

137. She was asked what she thought was the best way forward in terms of communication between the facility and general practitioners. She thought that a verbal summary was still a very good thing. She stated that she sometimes looks at the AutumnCare notes although they are very time-consuming to review. She accepted that you are therefore relying on a summary that is as good as the person's memory of what they have read, been told or seen. She said she would now ask more probing questions and that the behaviour charts would be part of the solution to achieving more effective communication with the GP, particularly if actual physical aggression was charted.[123]

138. The doctor was taken to the "Silver Book" and in particular to page 29 of the book where there was a guide where there may be delirium dementia and depression present.[124] The book indicated that aggressive irritable presentation is associated with delirium rather than with either dementia or depression. She accepted that but also indicated that aggression can also be part of the behavioural and psychological symptoms of dementia. Ultimately it was accepted that simply an assumption that "9 times out of 10 aggression is the by-product or a product of pain" was not the correct assumption to make. She further acknowledged that there was a lot more learning for the facility to have undertaken in terms of trying to identify what was going on at the time with [redacted] She was also taken to page 30 of the Silver Book under the heading "Management of behavioural and psychological symptoms of dementia" which indicated that increasing interventions were needed as symptoms became more serious, and that where physical aggression occurs it suggested management in a psychogeriatric or neurobehavioral unit. She agreed that the MSU in which [redacted] resided was not such a unit.[125]

139. She was asked by Counsel Assisting whether, when looking back on [redacted]'s behavioural difficulties and being armed with the information she had at Inquest, she would have considered more alternative explanations for his behaviours and undertake further investigation. She answered that it would have been useful but also remarked that you had to bear in mind that Risperidone can take 4 to 6 weeks to be completely effective and at that stage he had only been taking that medication for two weeks.[126]

[122] Transcript of proceedings 4 September 2019 at T73.6 – 73.12.
[123] Transcript of proceedings 4 September 2019 at T74 – 75.
[124] Exhibit 2.
[125] Transcript of proceedings 4 September 2019 at T78 – 79.
[126] Transcript of proceedings 4 September 2019 at T83.26 – 83.34.

140. To the question as to whether there was an issue about staffing her answer was a fair one:

> "*I think in the ideal world we would all like more staff but the other comment I can make which is I think a recent institution is that the staff were asked who would like to be there and so they have a regular staff there rather than anybody who was rostered into the three areas of the home. Having staff that like being there makes a big difference because they know their residents well and they're happy to be there. Staff that know their residents does make an enormous difference*".[127]

141. She did accept that the MSU should have more staff than the general area of the facility and in her view two staff during the day shifts was "frightening".[128]

142. She accepted one way to improve safety and supervision would be through education of the carers so that they had a better understanding of the types of behaviours that arise, their causes and the appropriate interventions that can be adopted for the particular resident.[129]

143. In answering questions put by Mr Evenden she accepted that after [redacted] had been moved from the facility and placed into the MHUOP there was a significant resolution of his aggression within three or four weeks, and that was as a result of the removal of the Norspan patch and the Ordine medication. On reflection she considered that the medication that he was on may have contributed to his behaviour within the facility however she also commented that there was an increase in his Risperidone medication upon admission to the MHUOP and that that may have also made a difference.[130]

144. Dr Himmelhoch did not think it was her sole responsibility to initiate the referral to Dr Walsh, the geriatrician. She accepted that she had forgotten but expected that the facility would have followed it up or initiated the referral themselves.[131]

145. From a question from Mr Gemmell, her evidence was that she was not aware of the severity of the behaviours that had been described in the AutumnCare notes. Her evidence was that she did not recall from her discussions with Ms Gray the severity of the aggressive behaviours.[132]

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[127] Transcript of proceedings 4 September 2019 at T84.1 – 84.12.
[128] Transcript of proceedings 4 September 2019 at T85.11 – 85.21.
[129] Transcript of proceedings 4 September 2019 at T85.23 – 85.45.
[130] Transcript of proceedings 4 September 2019 at T89.39 – 90.11.
[131] Transcript of proceedings 4 September 2019 at T90.13 – 90.26.
[132] Transcript of proceedings 4 September 2019 at T104 – 105.

146. Dr Himmelhoch stated that when she attended the facility she would see on average 20 to 25 patients and it would be over a period of 4+ hours, sometimes even 6 or 7 hours. She said that she would stay for as long as she was needed and once finished she would go home. If she hadn't finished making notes she would finish them later.[133]

Amelia Gray

147. Ms Gray was the Deputy Facility Manager at the facility.[134] Her practice was to read the notes on AutumnCare on a daily basis in relation to each of the residents.[135] Her role effectively was the supervision of all residents at the facility not just in the MSU. She attended doctor's rounds, she attended to resident's wounds, maintained the audit schedule and other associated work of an administrative nature. In attending to doctor's rounds she would assist Dr Himmelhoch and sometimes other doctors on a Tuesday. If she was not available to attend a doctor's round then normally RN Filby would fill in.[136]

148. Presently she no longer attends the doctor's rounds and an RN now attends. At the time of the incident she would read the AutumnCare notes for every resident every day, and guessed that was probably in excess of 40 residents at the time. It was suggested to her that it would have been a difficult task to try and track particular issues with particular residents in any detail and her answer was that she would write down any particular issues in a doctor's book day by day. Further, that if there was a matter that needed escalating to the doctor on any one day she would fax or call the relevant GP. She also expected Ms Noud to be escalating anything if she saw some pattern or issue emerging consistently with a resident. She could not recall having any meetings with Ms Noud about [redacted] although she did say "we would have discussed him".[137]

149. At the time of the incident the facility did not have monthly or weekly meetings on a regular basis. They do now have a clinical handover at least four times a week where Ms Gray and the RN and the team leader are present. The purpose of that handover is to go through the incident forms to see if there's been any falls, any admissions to hospital or any appointments, if anyone has passed away, or any complaints or staffing issues. At present she says it is the role of the RN. to detect any emerging problems with a particular resident. She oversees these meetings with the RN on the Monday, Wednesday, Thursday and Friday. There is an RN who attends the facility

[133] Transcript of proceedings 4 September 2019 at T106.34 – 106.44.
[134] Transcript of proceedings 5 September 2019 at T7.5 – 7.9.
[135] Transcript of proceedings 5 September 2019 at T10.36 – 10.38.
[136] Transcript of proceedings 5 September 2019 at T11.
[137] Transcript of proceedings 5 September 2019 at T11.13 – 13.28.

on Monday, Tuesday and Wednesday and another RN on Thursday and Friday, so they share the responsibilities during the week.[138]

150. She was taken through some of the other procedures involved with the documenting of resident care. She indicated that there was a wandering chart which was implemented for each resident and maintained throughout everyone's admission, even if they never wandered. The same principle applied to the physical behaviour and verbal behaviour chart. Care staff are expected to not only record on the charts but also to write it in the AutumnCare records as well. They are then reviewed by the RN on a weekly basis.[139]

151. Ms Gray was taken to a conversation that she had with one of the attending police officers at the time of the incident, Detective Senior Constable Nathan Webb, in which she told the detective that they had noticed in the past 3 to 4 weeks that [redacted]'s aggression was escalating and that staff thought it may be related to his pain. She accepted that that was more likely than not what she said at the time. She was then asked a series of questions by Counsel Assisting as to whether or not there was some frequency of aggressive behaviours earlier than that and her statement to the officer suggested that they hadn't been recognised by her earlier. She didn't agree. She said that she was aware of escalating behaviours but she wasn't sure that she could talk about other residents because of a confidentiality issue. It was pointed out to her that she wouldn't have to name the resident and that it would not have been a confidentiality issue and her answer was "yeah. I'm, I'm not sure why I haven't mentioned residents, but I did know about it".[140]

152. She gave evidence that she became concerned about [redacted] when she witnessed the broken curtain rod in his room (which occurred on 22 June). Her usual practice was prior to the doctor visiting she would read the progress notes for the relevant residents. She would then tell the GP what was happening with the resident. She did not prepare notes or any form of summary. She indicated she would have the doctor sheet with the name of the resident and she would write a very brief reason for the consultation on what has been happening – probably one line of information.[141] She would start reading notes from about 10:00am on the day the doctor was visiting and the doctor would arrive at about 1:00pm. She would be reading notes for some 20 residents or so and only the notes for the last 24 hours, not for the whole of the week. Her evidence was she reads the notes every day so she didn't need to go back earlier than the last 24 hours.[142] She was therefore relying on her memory for the earlier days. In cross examination from Ms Berberian she acknowledged that she could be

[138] Transcript of proceedings 5 September 2019 at T14.
[139] Transcript of proceedings 5 September 2019 at T15-16.
[140] Transcript of proceedings 5 September 2019 at T17.46 – 19.38.
[141] Transcript of proceedings 5 September 2019 at T20.
[142] Transcript of proceedings 5 September 2019 at T22.

reading anywhere up to, potentially, notes for 50 residents and that they were likely to be more entries in the AutumnCare notes for MSU residents because of their behavioural issues.[143] Further incident forms were not placed on AutumnCare and so there was only reference to the actual incident in the AutumnCare notes. She said that for any incident prior to the last 24 hours she would start completing the doctor's consult form the day after the doctor completed her clinic ready for the following week. She was asked then if a resident wasn't on the list for the following Wednesday clinic then she would have to rely on her memory for any incidents which had occurred earlier than the last seven days. Her answer was that if there were any incidents the doctor would have known within the week because that was what the policy was in 2016.[144] She was taken to the material produced by Dr Himmelhoch's practice and the only incidents that were notified were a missed Norspan medication of 13 June and a fall incident on 3 July 2016. She was surprised and expected there to have been more notifications of incidents – particularly physical incidents.[145]

153. From her point of view if there was any resident on resident aggression the doctor was to know ASAP. This was to happen by telephone or fax. She said it wasn't her job to do so, it was the facility manager's job.[146] There was no log kept at the facility to indicate a phone call had been made to the doctor reporting other than it should have been notified on the compulsory reporting form. She was taken through incident reports,[147] where there was provision for reporting of an incident and she accepted that there is provision in the forms for the doctor to be notified yet it wasn't necessarily always happening. For issues of aggression on staff by a resident there was a staff incident form, but that wasn't a matter that was notified to the doctor either. She accepted that if a doctor is going to form a picture of an escalating issue or the extent of a problem it effectively fell onto her shoulders to be the conduit of information.[148]

154. She agreed with Counsel Assisting that because forms were not always being completed in a way that could accurately track whether or not the doctor had been notified and in addition some information wasn't being relayed to the doctor at all (resident to staff aggression) then only part of the picture was being conveyed to the doctor. She said that that has now changed and there is a new procedure where all incident forms are on AutumnCare so that all incidents get notified to the doctor.[149]

[143] Transcript of proceedings 5 September 2019 at T37.
[144] Transcript of proceedings 5 September 2019 at T38 – 39.
[145] Transcript of proceedings 5 September 2019 at T39.
[146] Transcript of proceedings 5 September 2019 at T21.9 – 21.28.
[147] Tab 15, Exhibit 1.
[148] Transcript of proceedings 5 September 2019 at T24.
[149] Transcript of proceedings 5 September 2019 at T24.1 – 24.20.

155. In summary, it was her view that [redacted]'s behaviours escalated after he broke his ribs and the reasoning in the facility at that time was that the pain from his ribs was causing increased aggression, even though there had been behaviours of concern by [redacted] before the injury. She could not recall discussing that particular issue with Dr Himmelhoch.[150]

156. The following two questions from Counsel Assisting and their answers are illustrative of the communication problem that was occurring.

> *"Q. Would you accept though, that there appears to have been a communication failure in the sense of the care staff, and perhaps the nurses even, appreciating the differences, the nuances, between why the different drugs were being used and what they were being used to treat, looking back?*
> *A. Yes.*
> *Q. Do you accept that that may then feed into a lack of proper understanding by management on the one hand of what's going on, in the sense that they're thinking, "oh well, the doctor's treating it, but we're not really understanding what precisely the doctor is treating and how", and then a communication problem with the doctor in terms of them targeting the feed of information back?*
> *A. Yes."*[151]

157. She also agreed with Counsel Assisting that if the escalation of behaviours had been identified when it should have been a case conference ought to have been conducted with doctor, nurse, facility manager, and perhaps a care team member to discuss what was occurring and develop a proper understanding.[152]

158. Ms Gray accepted that when Dr Himmelhoch overlooked writing the referral to Dr Walsh that she also overlooked chasing that up. She indicated that now the RNs take control of all the referrals and other outside interventions. All referrals are kept in the front of the residents' folder until the resident attends their appointment. Ms Gray explained that AutumnCare has a system of alerts where staff can highlight an entry and an alert will stay up on the screen until it has been read and ticked prior to opening the resident's file. She said there is now a policy in place as to what should be entered as an alert and what shouldn't.[153]

159. It was accepted from her work in the facility over a number of years that it is not possible for the care staff to always know who is in whose room at any given time.[154]

[150] Transcript of proceedings 5 September 2019 at T25.38 – 25.45.
[151] Transcript of proceedings 5 September 2019 at T26.12 – 26.24.
[152] Transcript of proceedings 5 September 2019 at T26.38 – 26.42.
[153] Transcript of proceedings 5 September 2019 at T29.
[154] Transcript of proceedings 5 September 2019 at T30.8 – 30.14.

160. Moving forward, and with a view to improving the communication process between the GP and the RNs she proposed flagging particular AutumnCare notes so that when the RN saw the GP, those particular flags could be checked off with the GP.[155]

161. Ms Gray was taken to a number of suggestions in relation to supervision. The first was in relation to locking doors of the resident from the outside of their bedrooms (not from the inside). She indicated that some of the residents do not like their doors closed. She thought the use of some form of sensor in an open door which would activate if anyone crossed the threshold of the door was also impractical, as it would more likely than not be triggered by people walking in and out, be it staff or other family members. In addition, she noted that some residents get lost and may have to be redirected.[156]

162. Ms Gray thought that the number of care staff workers that operate on each shift was sufficient. She explained that not all residents get out of bed at 6 o'clock in the morning. They are left until they wake up themselves. In addition there is a lifestyle officer that comes to the facility in the morning at 8 o'clock who commences cleaning up the common areas and putting out activities for the day. Even with a resident who requires two care staff to assist, for example with showering, she believed another care staff member could come in and help within the MSU unit.[157]

163. Again when taken through the care plan for [redacted] while she acknowledged that those sorts of interactions in the care plan is similar with other residents' plans and it was "pretty busy", she still thought two care staff was sufficient for 11 residents. In a situation where there is a resident with escalating aggression she agreed that dealing with those with that type of behaviour you would need to spend a lot of time with that particular person both in terms of watching them, perhaps calming them and then diverting them. She agreed that a temporary staff member in those situations might be appropriate. She was then asked how often does the MSU draw on staff from the rest of the facility to help out in those types of situations and she couldn't answer that question because she was not on the floor. She said she's in her office and not sure what the staff do. She was asked whether she was therefore best placed to see what's really going on in regard to a daily routine of care staff if she is not in there. She agreed that she wasn't in there all day.[158] In my opinion from that answer I don't consider that she is best placed to offer an opinion on staffing levels.

164. As a result of what had happened she thought an improvement of care in the MSU would arise from improved education for everyone. She said "at the moment we have selected staff to work in MSU and not rotate them around, keep the same staff in there

[155] Transcript of proceedings 5 September 2019 at T69 – 70.
[156] Transcript of proceedings 5 September 2019 at T32.45 – 33.28.
[157] Transcript of proceedings 5 September 2019 at T33 – 34.1.
[158] Transcript of proceedings 5 September 2019 at T35.

so it's – the residents get used to the same staff in there, the staff know what's going on with a resident's day-to-day. So I feel education for them (sic) staff more than online training, education for them (sic) staff that are working in the MSU unit, yeah to deal with behaviours".[159] Again through Counsel Assisting she was taken to a series of quick reference cards that in particular deal with antipsychotics. She was asked if she saw a benefit in having those available strategically for care staff to consult. She agreed with that suggestion.[160]

165. When cross-examined by Ms Berberian she agreed that she was the conduit between what was going on with the residents and the doctors who were attending the home to assess the residents. She accepted that it would have been a difficult task for doctors in the time that they had available to read through all the AutumnCare records for each patient that they were seeing.[161] She said that she had the facility's records open for each patient at the time that she was with the doctor. She accepted that she was being relied upon to draw any issues from the facility's AutumnCare notes to the doctor's attention.[162] She accepted that Dr Himmelhoch preferred her over the RNs because RN Filby was only there on Mondays and Tuesdays, not available on Wednesdays, and during the period June to July 2016 there were agency nurses during the latter part of the week and they weren't always the same people. Ms Gray was there from Monday to Friday and was regarded as competent by the Doctor.[163]

166. She recounted that the doctor's usual practice would be to see the patients and then the doctor would then type up notes and give a copy of her notes to Ms Gray (or leave them on her desk in her absence). Ms Gray would then distribute the notes to the appropriate RN for them to read on the next shift. They were expected to sign the notes and then place the notes in the resident's folder.[164]

167. She agreed with the suggestion by Ms Berberian that before 14 July 2016 [redacted] wasn't considered to be out-of-control in terms of his behaviour. He wasn't considered to be a resident with a real problem that needed to be specifically managed.[165] She also accepted that if she had any serious issues with the way in which [redacted] was behaving or in the medication he was taking she would have flagged that with Dr Himmelhoch. She agreed with the suggestion that there was obviously some communication issue between the facility and the doctor and that it included more likely than not that the doctor wasn't receiving faxes about incidents. She accepted the proposition that she assumed that the doctor would have been

[159] Transcript of proceedings 5 September 2019 at T35.47 – 36.2.
[160] Transcript of proceedings 5 September 2019 at T36.25 – 36.29.
[161] Transcript of proceedings 5 September 2019 at T40.
[162] Transcript of proceedings 5 September 2019 at T40.
[163] Transcript of proceedings 5 September 2019 at T41.
[164] Transcript of proceedings 5 September 2019 at T42 – 43.
[165] Transcript of proceedings 5 September 2019 at T45.11 – 45.20.

receiving information during the week about the incidents from one week to the next.[166]

168. In response to questions from Mr Evenden she accepted that it was the case that transfers took place within the facility from the MSU to other wards and that in the five weeks between when Mrs Brockett became immobile and the incident with [redacted] that there was ample time during that five weeks for the facility to take action and move her or at least discuss it with the family.[167] She didn't agree with the idea that there should be a secure space which would allow the facility to manage an aggressive resident by placing them in an area not accessible to other residents. In her view she said it felt like locking someone away. In her opinion if they required segregation from other residents then they should be moved to another facility. In her opinion it would be a better choice for a temporary staff member to provide one-on-one care for the more aggressive resident.[168]

169. Her evidence was that since 2016 they have had an RN seven days a week from 8:00am until 4:30pm and then commencing in about mid-September 2019 another RN starting at 2:00pm or 3:00pm and going through until about 11:00pm. The Facility Manager is also an RN and is on duty from 8:00am until 4:00pm.[169]

170. She was taken to the Care Manual attached to Ms Emmerson's statement and the fact that within the document it makes reference to a case consultation with the SCC dementia care consultant. She has no recollection of there being such a consultant.[170] At page 62 of the document, which refers to incidents and accidents, there is a policy set out that for notifications of assaults by a resident on a staff member or resident then "if assessed as necessary notify the residents doctor immediately". She agreed that the document did not provide any clarification as to what that meant or how to assess whether it's important to notify the resident's doctor or not. She accepted that it would be useful to have that written into the policy document. The suggestion of having CCTV cameras in the common areas was also explored and in her opinion it would require a staff member to be constantly watching the TV screen and care staff spend no more than about 20% of their time at the nurses' desk in any event.[171]

171. While she accepted that she had the responsibility to convey to Dr Himmelhoch during June 2016 all of the relevant matters from the AutumnCare notes and reportable assaults that had been occurring with [redacted] her answer was "I would

[166] Transcript of proceedings 5 September 2019 at T46 – 47.1
[167] Transcript of proceedings 5 September 2019 at T50.
[168] Transcript of proceedings 5 September 2019 at T51.42 – 51.43..
[169] Transcript of proceedings 5 September 2019 at T54 – 55. See Exhibit 3 at [105].
[170] Transcript of proceedings 5 September 2019 at T57.32 – 57.43.
[171] Transcript of proceedings 5 September 2019 at T58 – 59.

have told Dr Himmelhoch my concerns".[172] In my opinion, "would have" is not compelling evidence that she did convey all relevant concerns and in view of her evidence that she was assuming incidents were being reported to the doctor by staff during the week I am not persuaded that all relevant concerns were conveyed.

172. From questions by Mr Gemmell she thought she attended about four handovers a week on average and that she has a recollection of discussing [redacted]'s behaviour at those handovers. When she had consultations with Dr Himmelhoch it was her usual practice to inform the doctor regarding those issues concerning behaviour which she had noted in the AutumnCare notes and at the handovers. Her evidence was that the doctor would have available her notes on computer and she could also bring up on the same screen the AutumnCare notes and if one was opened you had to minimise the other to get the other one opened.[173] She does not recall the doctor asking her to access any particular AutumnCare notes. It's the case now that the Doctor would have access and can login to AutumnCare notes. She was taken to a sheet which became Exhibit 6 which had three columns on it which was used by Ms Gray to remind her of particular concerns for a number of residents to be seen that day by the Doctor. She said she would use the one sheet of paper for about 10 residents and there would be paperwork for other residents.[174]

173. There has been a change to AutumnCare since the incident in that a staff member can put a note in the progress notes as a "red flag" so that you can highlight a care alert or handover in red. If a staff member goes to the notes and they open the notes to that flag then they would have to tick the flag note to say they have read it before the resident file is then able to be opened.[175] She said there are other changes that have come in in relation to the notes in relation to behaviour assessments. She did not agree with Dr Himmelhoch's statement that she saw 20 to 25 patients per consultation. She said it was between 10 and 12 residents.[176] She denied saying to Ms Noud that some staff had not given [redacted] his medications because he was aggressive when attempting to administer his medications and that this was not recorded on some occasions in the relevant documentation.[177] There was some discussion between Ms Gray and me at the time about whether she denied the conversation or didn't remember it. Ultimately she said "I can't remember whether that was talked about or not".[178]

[172] Transcript of proceedings 5 September 2019 at T60.43.
[173] Transcript of proceedings 5 September 2019 at T67.1 – 67.18.
[174] Transcript of proceedings 5 September 2019 at T68 – 69.
[175] Transcript of proceedings 5 September 2019 at T69.34 – 69.44.
[176] Transcript of proceedings 5 September 2019 at T70.24 – 10.26.
[177] Transcript of proceedings 5 September 2019 at T70.38 – 48.
[178] Transcript of proceedings 5 September 2019 at T71.28.

174. Mr Aitken, Counsel Assisting, clarified with Ms Gray that while she had concerns in late June about the fact that [redacted] might hurt other residents or staff she agreed she couldn't recollect conveying that concern to Dr Himmelhoch.[179] She was reminded that when she provided her statement to police dated 15 July she recalled one push of a staff member (by [redacted] to which her response was that she wasn't thinking clearly on that day. She was asked whether she could recall when other incidents involving [redacted] first started and her response was April or May. She was then taken to other incidents that occurred on 6 January and 13 March but she couldn't recall those incidents. It was suggested to her that when she was speaking to police that she wasn't aware of all the incidents at the time that had occurred and her reply was "I feel I just was not thinking about the other incidents at that time".[180] Even with further questions from Mr Aitken I was not able to ascertain why Ms Gray did not disclose other incidents to the police at the time she made a statement.

Professor Joseph Elias Ibrahim

175. The Professor was engaged as an expert and provided two reports, dated 11 August 2019 and 18 August 2019.[181]. He is the clinical director of Ballarat Health Services which is responsible for rehabilitation, palliative care and geriatric medicine and the head of the Health Law and Ageing Research Unit at the Department of Forensic Medicine, Monash University. He has been working in the public health system in Victoria as a consultant specialist in geriatric medicine since 1996.[182]

176. He confirmed a number of matters from his reports in general terms about the causes of resident to resident aggression which can be explained by a combination of predisposing individual risk factors, proximal triggers and environmental factors. Risk factors may include the nature of the dementia and proximal triggers are things that might occur during the course of their care that might act as fuses as it were, and environmental factors might be the design of the building or the flow-through traffic, what the person is able to see, the amount of stimulation they have in contact with the outside environment.[183]

177. He considered that when accepting someone new to a facility who may be in their early stages of admission and they are demonstrating some aggression, then there is a greater need for vigilance because they are new to the environment and they need time to settle into a routine and with staff and feel comfortable with it.[184]

[179] Transcript of proceedings 5 September 2019 at T72.30 – 72.38.
[180] Transcript of proceedings 5 September 2019 at T75.7 – 75.10.
[181] Tabs 24E and 24EE of Exhibit 1.
[182] Transcript of proceedings 5 September 2019 at T80.
[183] Transcript of proceedings 5 September 2019 at T81.
[184] Transcript of proceedings 5 September 2019 at T82.12 – 82.26.

178. He agreed with Associate Professor Macfarlane that appropriate interventions would include a comprehensive multidisciplinary assessment to identify contributing factors to the responsive behaviours, so that you get an understanding of what the behaviours are, why they may be occurring, how they're influencing others and to get different insights about what may be useful approaches to do that. Each professional discipline would therefore be involved in what is a complex situation to try and approach the problem and gain the best outcome. He recited "A nurse may be able to provide a non-pharmacological or behavioural management plan; a psychologist or psychiatrist may be able to provide insight into the underlying mental illness and consultation with family because they are in the best position to explain whether the behaviours had been previously exhibited, whether there's been a change in pattern, whether there's a particular facial look or a raised eyebrow or a habitual tick or something that tells the family this is an early signal the person is distressed." He accepted that the type of services available may depend on the location of the facility, for example in a major city compared to a regional town.[185]

179. He considered that a referral to DBMAS for [redacted] would have been appropriate and should have been made sooner. He did not consider that a GP assessment was a precondition to calling out DBMAS. So in circumstances where someone is showing escalating behaviours in a facility he would have expected the nursing staff or the facility manager to initiate the referral perhaps along with the GP – there is no rule or pathway for it – "it's about having the common sense to say we are struggling, where can we get help, who's going to do the task?"[186]

180. In this matter he considered that the threshold for calling DBMAS was when you are not gaining the results that you're seeking with the response to a person with dementia, and that could have been any time from April 2016 and onwards.[187] He acknowledged that the threshold for each carer is different, and for each practitioner is different, based on their experience, tolerance and understanding of aggression. He was surprised that when the staff member was punched in the jaw that there wasn't an immediate escalation given the issues related to both the resident and the staff member, namely the Occupational Health & Safety issues related to being assaulted at work.[188] He also acknowledged the resistance in the public health system in accepting referrals from aged care facilities where they needed help. He said this resistance then creates an environment where staff and facilities are reluctant to refer because they get no help.[189]

[185] Transcript of proceedings 5 September 2019 at T82 – 83.
[186] Transcript of proceedings 5 September 2019 at T83–84.
[187] Transcript of proceedings 5 September 2019 at T84 – 85.
[188] Transcript of proceedings 5 September 2019 at T84 – 85.
[189] Transcript of proceedings 5 September 2019 at T85.40 – 85.47.

181. He was asked questions by Counsel Assisting in relation to whether or not he would encourage the provision of what he termed "summaries of concern" that could be within the care notes of a particular resident, that could then be presented to the doctor. His answer illuminated in my opinion the difficulties in that. He said that his preference;

> "*is always to get a first-hand account and to understand the dynamic within the service because the ability to cope "with particular types of behaviour depends on your staffing profile, and what the cohort of residents that you currently look after require, and what's written on paper, so in health we don't always write – you all know we don't always write things down, and sometimes some of the subtleties around anxiety or fear of staff willingness to look after someone, is not going to be communicated in the medical record. I, I don't know you know how likely is that anyone would have written that three staff members refused to provide for* [redacted] *based on his behaviour.*
>
> *That's not likely to make it into the record, but it may come up in a conversation about the staff are very nervous, which gives you another sense of it, or the staff have it all under control, what was written was by a first-year nurse who lacks experience in the field and so saw it in a far more dramatic fashion. The interpretation is critical and to get the interpretation you need to understand the person who's giving you that information".*[190]

182. He agreed that it was not an ideal situation that the person that was dealing with Dr Himmelhoch - that is, Ms Gray - was sitting in an administrative role, was not working on the floor and she was not a nurse. These were areas where she may not have been best able to communicate those concerns to the doctor.[191]

183. His evidence was that people (carers) are taught that pain is a significant contributing factor to behaviour and that if you treat the pain that will fix the problem. So for example, in providing Ordine to treat the pain, it may also have a sedating effect after it is administered. The consequence was that the resident then presents as being calm, which makes the care staff feel that their suspicion, that it was pain that was present, was confirmed. He said **there needs to be a structured approach to the issue because you need information from the day and night staff as well as from the family, as well as from the doctors to be able to sort through and try and work out the causes of for the behaviour.[192] The information then needs to be disseminated via a meeting so that you can maintain engagement and reassure the staff that the situation is in hand. He said you need a sense of calm in the whole service because if there is persistent anxiety on any part of the staff that**

[190] Transcript of proceedings 5 September 2019 at T86.46 – 87.13.
[191] Transcript of proceedings 5 September 2019 at T87.15 – 87.22.
[192] Transcript of proceedings 5 September 2019 at T89.

will come through to the resident and likely precipitate more aggressive behaviour (emphasis added).[193]

184. He was asked if there was anything from the evidence that he'd witnessed at the inquest that he considered deserved comment, in terms of ways that matters could be improved. His answer included:

> *"My read of the files and what I've heard is there's nothing there that stood out to me that was out of the ordinary compared to other peers or what other groups would have been doing around the country, and this is a tragic set of circumstances that required – it, it required one person to twig that they weren't managing to take the next step, and it could have been anyone involved in the care. My frustration is that the question – and what were the families told about going into the facility, what were their expectations? Did they know the type of person being housed, did they know that there would be a risk, and why there wasn't prompter action when it was clear that Hazel Brockett no longer needed a specialised dementia service."*[194]

As Mrs Brockett was no longer capable of getting out of bed and self-mobilising the facility should have started to think about whether there was a bed available and talking to the family and perhaps moving her out of the Memory Support Unit. That unit is a specialised service that provides care with those with special needs. If Mrs Brockett no longer needed the special needs it makes no sense to leave her in that unit.[195]

185. In relation to [redacted] care he made the following point:

> "[*there were a number of*] *professional groups involved; each one would have had a reason to ask for help based on what was occurring within their scope of practice. That didn't occur…presumably because there was a lack of drawing together the sequence of information, knowing the number of events that have occurred, taking the temperature of the staff and the family and the other residents to be able to say you know this situation is no longer within our scope of practice and needs to be escalated and something needs to change."*[196]

186. As to why [redacted]'s behaviour became easier to manage once he was sent to Belmont Hospital and then onto the MHOUP, Professor Ibrahim noted there was a cessation of the opioid-based medication. He said it was difficult to provide any certainty as to why that happened. He accepted it was feasible that [redacted] was

[193] Transcript of proceedings 5 September 2019 at T88.26 – 88.34.
[194] Transcript of proceedings 5 September 2019 at T91.3 – 91.12.
[195] Transcript of proceedings 5 September 2019 at T91.14 – 91.39.
[196] Transcript of proceedings 5 September 2019 at T91.48 – 92.6.

having a delirium, and that the delirium may have been induced by the medication, but it could also have been the change of environment, staff or the approach to him that altered those behaviours, or indeed a combination of all of these things.[197]

187. He didn't agree with the idea of secluding [redacted] in some form of secure room. In his opinion it would have been preferable if he had one-on-one care and, if needed, that extra staff member could help him go outside if he enjoyed doing so.[198]

188. The challenges in providing care to residents affected with dementia was highlighted by this answer:

> "*… I think any service that is providing care for people with dementia because you know that there's going to be interpersonal conflict arising from people who have lost their social skills. The, the question about what is reasonable remains I think largely untested because at the moment what is reasonable is split between arguments around human rights and no restrictive practices through to public safety and safety of others, and depending on who you talk to, and what the situation is, you will get a different answer. I don't have a hard and fast answer about what would constitute dangerous…* "[199]

189. He considered it would be helpful to have a policy outlining what the options are, a policy that triggers a review to say we are in a potentially dangerous place, to provide some assurance to staff that the organisation will support them and that there are types of supports that can be made available and accessed.[200]

190. He agreed and recommended training programs for staff. He said that Dementia Training Australia has a number of different programs that assist training staff for responsive behaviours, that delivered cognitive aids to assist staff including "flashcards to talk people through what you can do". He recommended ongoing training because if you're running a specialised service then all staff need to have an understanding and be familiar with how to manage persons with dementia along with the support and backing of management.[201]

191. He commented that reporting incidents is not rewarded in the aged care industry. He said "it's usually framed negatively and either the blame falls on the care worker at hand and it generates paperwork and generates potential for concerns about how the regulator sees it, so we don't have the same reporting culture that we do in most of

[197] Transcript of proceedings 5 September 2019 at T92 – 93.
[198] Transcript of proceedings 5 September 2019 at T93.
[199] Transcript of proceedings 5 September 2019 at T94.10 – 94.18.
[200] Transcript of proceedings 5 September 2019 at T94.
[201] Transcript of proceedings 5 September 2019 at T94 – 95.

our public hospitals where people are encouraged and rewarded to report with the focus being on improving safety of care".[202]

192. He considered that case conferences should have guidelines as to the type of matters that might trigger the need for formal case conferencing. In regards to a memory support unit in his opinion he would be looking to have a conference at a minimum three months as the starting point and then extending that based on whether the behaviours are settled or not.[203]

193. Professor Ibrahim had read Ms Emmerson's statement and he found a number of positive areas that had changed within the facility. He noted the emphasis on training, the additional nursing support; there appeared to be a greater sense of teamwork or collegiality and structure about what they were doing. He thought that helpful. He didn't yet have the sense that the executive was fully engaged and supportive of what the people on the floor need to do and he would have liked to have seen something where "we're all in this together", from the Board of Management down through to the personal care workers, about providing the best care that can be achieved.[204] He accepted that there had been governance changes and he saw that as positive and the changes in care documentation and training that had occurred since July 2016 had changed and again he thought that positive.[205] He also stressed again because of the difficulties in successfully managing behaviour that there is a need to have a formalised case conference with family involvement – "with five or six people around discussing an issue you're more likely to come to something that is reasonable, than you are by yourself".[206]

Helen Emmerson

194. Ms Emmerson is the Chief Executive Officer of Southern Cross Care New South Wales and ACT. She commenced with the organisation in September 2013 and in the last 12 months had been appointed CEO. She has had over 20 years' experience in the aged care sector. There are currently 32 aged care facilities within the organisation and about 85% of them have a specific MSU or dementia specific units.[207]

195. She accepted that some of the important issues with residents with dementia are intrusive wandering, resident to resident aggression and managing other difficult

[202] Transcript of proceedings 5 September 2019 at T95.49 – 96.16.
[203] Transcript of proceedings 5 September 2019 at T97.45 – 98.24.
[204] Transcript of proceedings 5 September 2019 at T103.
[205] Transcript of proceedings 5 September 2019 at T104.
[206] Transcript of proceedings 5 September 2019 at T105.
[207] Transcript of proceedings 6 September 2019 at T3.

behaviours, incontinence and the residents' mental health – factors such as depression and anxiety.[208]

196. Her evidence was that they keep records of physical aggression which are collated into monthly statistics which are discussed at facility level, at regional level and then also within their quality and clinical governance committee which has overarching supervision. The monthly statistics are assembled by the facility managers and the material inputted into a shared drive. The incident report form should not only pick up resident on resident aggression but also resident to staff aggression (verbal or physical).[209] She said there is a regional quality team member who is a registered nurse that oversees a number of facilities within her region or portfolio. From there you can go to a senior quality and clinical governance manager. She said the facility manager could also report issues to the regional manager as an opportunity to escalate a problem. She said the regional quality coordinator is a position that has being created in the Caves Beach area since 2016.[210]

197. They do not have a reward system for reporting incidents but they do encourage a very open and transparent reporting system. She said there is an open door policy so that all managers are available to staff coming in and talking to them about issues. There is not only a handover each day but there are monthly staff meetings. Minutes are taken of the staff meetings and they are available in the staff rooms, usually put up on a noticeboard for staff who haven't been to a meeting to have a read. She said there are also feedback mechanisms at each site that anyone can use.[211]

198. The improvements that have taken place since the incident with [redacted] include a continued focus on dementia training for staff and focusing on making sure that the staff are aware of information on what to do in situations. She indicated that there is a flip chart for staff to review different situations and which provides quick reference guides to assist staff. As was recognised in her statement, in her opinion "coordination" was lacking when the incident occurred in 2016.[212] The facility manager has overall responsibility for the care and service delivery to residents and as such they have to make sure that where there is increasing frequency or severity of behaviours occurring they have to be followed up. If there is an issue it has to be documented, the situation has to be assessed so as to attempt to put in place a preventative measure to stop it happening again. In her opinion coordinated communication as a shared responsibility between the facility staff, GP and any specialist services being involved, was missing.[213] She accepts that a case conference

[208] Transcript of proceedings 6 September 2019 at T5.
[209] Transcript of proceedings 6 September 2019 at T6 – 7.
[210] Transcript of proceedings 6 September 2019 at T8.
[211] Transcript of proceedings 6 September 2019 at T8 – 9.
[212] Transcript of proceedings 6 September 2019 at T9 – 10.
[213] Transcript of proceedings 6 September 2019 at T11.7 – 11.9.

or family conference or some regular meeting with relevant people including the family should have taken place concerning [redacted].[214]

199. One of the improvements is that registered nurses now sit in with the doctors at their clinic rather than Ms Gray. She also thought it would be better if the GP wasn't seeing as many patients in any one clinic. It is still expected that incidents of resident to resident aggression would be reported to the doctor by a report at the time either by phone call or fax and there is a requirement to note that on the compulsory reporting checklist. It was acknowledged that this wasn't being filled in, however there are now audits conducted that cover the appropriate completion of the compulsory reporting form.[215]

200. She acknowledged through questions from Counsel Assisting the training of staff, particularly in relation to behaviours exhibited by dementia residents, was important and she indicated that staff receive intensive training including online learning as well.[216] She accepted that learning should also include being tested in a practical way about having as it were 'rehearsals' about the way in which to manage behaviour issues in residents.[217]

201. She was taken to page 74 of the Care Manual which referred to "case conferencing" and she accepted (i) the suggestion made by Counsel Assisting that in a case conference dealing with emerging frequency of aggressive behaviour it should include a general practitioner and (ii) that there should be a guideline for the staff which would provide some information as to the issues that the staff might be dealing with in a particular resident where there is a need to organise a case conference.[218] She accepted also that there should be regular case conferencing and that they shouldn't be at a fixed time, but rather held when needed.[219]

202. Evidence was provided that Southern Cross Care was investing $2 million-$3 million over the next two years in upgrading their nurse call systems on each of the sites. With these systems comes better monitoring. In her view those improvements will be better able to monitor resident's movements. In her opinion CCTV was not appropriate as it is the residents' home – so privacy was the main priority. Again physical restraint was not an option in her opinion as they are human beings and it is their home.[220]

[214] Transcript of proceedings 6 September 2019 at T11.11 – 11.19.
[215] Transcript of proceedings 6 September 2019 at T19.27 – 20.47.
[216] Transcript of proceedings 6 September 2019 at T22.39 – 22.43.
[217] Transcript of proceedings 6 September 2019 at T22 – 23.
[218] Transcript of proceedings 6 September 2019 at T24.
[219] Transcript of proceedings 6 September 2019 at T24 – 25.
[220] Transcript of proceedings 6 September 2019 at T30.

Associate Professor Stephen Robert Macfarlane

203. Associate Professor Macfarlane is a geriatric psychiatrist currently employed as head of clinical services for Dementia Support Australia.[221]

204. He indicated that between 2007 and about November 2016 there were eight different states and territory DBMASs in operation. Since November 2016 there is now a single national provider. The current benchmark requirements for involvement of DBMAS are to complete a triaged referral within 24 hours. Once the referral has been triaged it needs to receive a response from the service within five business days, or a total of seven days for the severe behaviour response team. Once a referral has been triaged as requiring that level of response DBMAS is required to be on the ground at the facility within 48 hours.[222] The usual situation is that there is a single referral line or telephone number and the clinician who takes the call will go through a series of questions with the referrer that enables them to determine whether it requires a severe behaviour response team (SBRT) or DBMAS level of response. It is essential that the person making the referral be able to give a history about the particular resident's behaviour. The referral can be made by anybody, including family, GP, and aged care facility. The organisation receives around 10,000 referrals nationally annually which has been increasing year by year since the service started. Of the 10,000 referrals probably about 8,500 are actually converted into cases that are accepted. The remainder don't meet their criteria for various reasons. For some, the person doesn't have dementia or there are other services already involved and they wouldn't value add anything. In regard to SBRT cases there were about 880 cases in the last 12 months.[223]

205. From his understanding of various studies and statistics he suggested the prevalence of disturbed behaviours in people who have dementia is at about 95% of people having some sort of issue during the course of their illness. About 80% of the referrals to DBMAS involve aggression and agitation and about 95% for those that are referred to the SBRT. He indicated they use a tool called the neuropsychiatric inventory to try and track the nature and extent of behaviours that they see. The leading behaviours would be agitation, aggression, psychosis, night-time behaviour and inappropriate motor behaviour (for example wandering), and verbal behaviour such as calling out. He said it's rare that they get a referral where there is only one type of behaviour present, particularly in the severe behaviour cases where there's probably 6 different behavioural domains and probably 4 to 5 domains for a typical case.[224]

[221] Transcript of proceedings 28 November 2019 at T3.6 – 3.7.
[222] Transcript of proceedings 28 November 2019 at T5.
[223] Transcript of proceedings 28 November 2019 at T5 – 6.
[224] Transcript of proceedings 28 November 2019 at T7.

206. He told the Inquest that Hammond Care is planning to open a specialist dementia care program based at Cardiff that would be open in the early part of 2020 which will be targeting people who exhibit behaviours at the extreme range – just below involuntary secure psychiatric facility involvement. The intention of the new unit is that it will have an emphasis on being of a transitional nature so that when residents no longer require the intensive level of support that that facility would provide they would be given the option of being housed in a bed within a residential aged care facility. (The highest level of extreme behaviour (classified as Tier 7) would require a secure psychiatric facility.)[225]

207. From his reading of [redacted]'s records he considered that what appeared to be induced delirium was an underlying issue but may not have been the only underlying issue. He said "it's pretty unusual in my experience for there to be one single cause of delirium. Most of them are multifactorial".[226] He also accepted Professor Ibrahim's opinion that it was possible that [redacted]'s delirium settled down when transferred to the Mater as a result of a change of environment and the way in which staff interacted with him.[227]

208. Again from his review of all of the notes and in particular Dr Himmelhoch's notes he thought the treatment appeared to be reasonable based on the information that she, as the doctor, then had. Ultimately he considered it was a communication problem: "if you get bad information you going to make bad decisions".[228] As a matter of best practice he agreed that a registered nurse should be in consultation with the doctor when they come to attend their clinic. He also said that it doesn't really require a registered nurse to convey the nature and severity of the behaviours to the doctor in that they were pretty obvious from the progress notes and could have been conveyed by a person with minimal training.[229]

209. From his report he commented on the physical verbal wandering assessments and he thought that the documents which consisted largely of a series of tick boxes describing various behaviours and interventions were more of a way of describing behaviours that might be related to ACFI funding rather than a clinical useful tool to inform management. For example the interventions that were listed were not tailored to the individual's particular needs. He said the interventions listed are commonly used and simply list a range of generic interventions that might be appropriate for some forms of behaviour disturbance, but are not tailored to any of the interventions that were ticked as suggestions for the management of [redacted]'s behaviour. In his opinion they couldn't reasonably have been expected to have an effect on the

[225] Transcript of proceedings 28 November 2019 at T8 – 9.
[226] Transcript of proceedings 28 November 2019 at T9.
[227] Transcript of proceedings 28 November 2019 at T9 – 10.
[228] Transcript of proceedings 28 November 2019 at T11.5 – 11.6
[229] Transcript of proceedings 28 November 2019 at T11.

extensive and frequent aggressive behaviours that [redacted] was displaying, for example throwing his walker around and assaulting other residents. He said there is no guidance within the document that he could see to guide staff on which of the interventions would be appropriate for which type of behaviour, in which circumstance. In his opinion you need to identify interventions specific to that individual that might assist and you need to identify which of those interventions is suitable for the type of behaviour that is being shown and you need to ensure that the staff have the capability to implement those interventions and understand what they mean and contextualise them appropriately.[230] Ultimately it requires specific dementia training and time.

210. In [redacted]'s matter while the fall and rib fracture resulted in pain, it is rare that there is only one contributing factor. He said "an approach that focused purely on pain management resulted in the increased prescription of analgesics and over time that resulted in a worsening of behaviours rather than in a remediation of them. Also thinking about the duration of time following the rib fracture where pain could reasonably be expected, you know, we're probably talking about six weeks, by which time the rib fractures would largely have healed and the pain shouldn't have required opiates".[231]

211. From his evidence he indicated that there was little in terms of the material that he was provided with that spoke to the environment and the resident mix and the staff approach to the resident and the degree of training that they had. He could only speculate on that but from the material that he was presented with the obvious causes for the aggression to consider would have been pain, opiate induced delirium and constipation. Constipation was raised but he said there was conflicting evidence about its possible contribution as the notes at the Mater record bowel movements conflicting with this diagnosis.[232]

212. In his evidence he said that at the point when a person comes into a facility there should be particular attention focused on gathering the positives and the negatives about that person's functioning before dementia. The care plan can then be tailored to that in the event that disturbing behaviours emerge. He added the proviso that it didn't hold true for behaviours that arise in the context of a delirium complicating a dementia. You have to recognise that you are dealing with delirium and then attempt to treat the underlying cause of the delirium, which is often multifactorial.[233] Psychotropic medications can be useful in managing the behavioural and psychiatric manifestations that accompany a delirium but they don't treat the underlying cause –

[230] Transcript of proceedings 28 November 2019 at T12.
[231] Transcript of proceedings 28 November 2019 at T13.34 – 13.40.
[232] Transcript of proceedings 28 November 2019 at T14.
[233] Transcript of proceedings 28 November 2019 at T14.

rather they provide relief from symptoms. He recommended a tailored care plan with 5 to 10 positives and negatives for that resident listed on it.[234]

213. He was asked his opinion in relation to the use of an opiate derivative such as Ordine and he indicated it was unclear whether it has a calming benefit because of the analgesic effect or because it's sedating. It is therefore difficult to understand whether it proves that pain was the cause of the behaviour. It just demonstrates that you've achieved a degree of sedation.[235]

214. He accepted that in terms of guidance as to who is best placed to offer advice as to what interventions might be useful or particular, it was poorly covered in the training and education programs of residential aged care staff generally. He added it was very poorly covered in the nursing training curriculum and the medical curriculum. Trainee doctors get taught very little about problematic behaviour in dementia, so they often looking to the well-meaning GP for a solution to the problem; you're asking "somebody who doesn't know much about it in the first place. Really, all most doctors [sic] are taught about managing problem behaviours is that non-pharmacological intervention should be taught – should be tried first line and if that fails psychotropic medication. But they're not actually taught what these non-pharmacological interventions are and they are therefore not well-placed to make suggestions about what they might be".[236]

215. In his opinion where there is the emergence of escalating and increasing aggressive behaviour, more likely than not you are going to need outside intervention to help manage the problem. This includes people such as Consultant geriatricians, old-age psychiatrists and geriatric medicine outreach services, aged psychiatry outreach services, and DBMAS.[237]

216. In his opinion charting behaviour patterns should have been implemented at the point at which behaviour changed, to give an initial sense of the pattern of what was then in future occurring. He added that "there's no point keeping the chart if you not going to do anything about the results".[238]

217. He agreed with the proposition that the incident of the 20 June 2016 where a staff member was punched and a resident pushed off a chair would be a time that he thought "that to me would seem the logical point to convene a case conference".[239] (provided similar behaviours were occurring with regularity) as there was a level of

[234] Transcript of proceedings 28 November 2019 at T15.1 – 15.2.
[235] Transcript of proceedings 28 November 2019 at T14.14 – 14.24.
[236] Transcript of proceedings 28 November 2019 at T15.13 – 15.20.
[237] Transcript of proceedings 28 November 2019 at T15.
[238] Transcript of proceedings 28 November 2019 at T17.39 – 17.45
[239] Transcript of proceedings 28 November 2019 at T18.

severity such that people were getting hurt or at risk of getting hurt, and the management processes that had been put in place thus far had failed to adequately address the problem. He also agreed that the referral to Dr Walsh would have also been advantageous to help manage a complex set of behaviours. He said that if a particular provider cannot attend within a timely manner then other referral options have to be considered.[240]

218. In regard to other options such as extra staff, he said having more staff is not an answer as even with a reasonable amount of dementia training it may not equip front-line staff to be able to manage behaviours of [redacted]'s severity.[241] In his opinion "when things first reared their head perhaps in about April extra staffing may not have been necessary but a range of other tailored strategies and investigations for cause of delirium would have been appropriate". He said "certainly by the time July was reached I don't think anything that could have been put in place could have removed the need for an inpatient admission for [redacted]".[242] Again, in his opinion, by July 2016 [redacted] was exhibiting Tier 7 behaviours and he needed inpatient care.[243]

219. He agreed that it was of benefit if staff were willing to work in just the one place, so that they become familiar with the resident mix and the issues. Staff would be better able to understand the person and what is causing their behaviours in view of their known likes and dislikes.[244] He criticised the care plan for [redacted] which was referred to in his report: "whilst the tick box fields…all related to non-pharmacological interventions the progress notes failed to record where these interventions were used if indeed they were".[245] He acknowledged that: "even if I consider the interventions to have been inappropriate there was no evidence from the progress notes that they had been implemented".[246] He agreed that some form of conference or ward round with the GP and staff with working knowledge of the residents should occur every three months or so.[247] He accepted that within an organisation there has to be engagement of management in recognition of and the understanding of a problem. He said that starts from a registered nurse (who should be a care manager) who can gain the support of a regional manager so that there is better coordination of a response.[248]

220. He agreed in principle that the progression of dementia can be accompanied by behavioural symptoms such as aggression and that this may result in the use of

[240] Transcript of proceedings 28 November 2019 at T19.
[241] Transcript of proceedings 28 November 2019 at T20.5 – 20.8.
[242] Transcript of proceedings 28 November 2019 at T22.9 – 22.11.
[243] Transcript of proceedings 28 November 2019 at T23.
[244] Transcript of proceedings 28 November 2019 at T23.32 – 23.35.
[245] Transcript of proceedings 28 November 2019 at T20.27 – 20.31.
[246] Transcript of proceedings 28 November 2019 at T20.31 – 20.33.
[247] Transcript of proceedings 28 November 2019 at T21.
[248] Transcript of proceedings 28 November 2019 at T24.37 – 24.50.

medication aimed at managing aggressive behaviour rather than managing pain. He agreed that pharmacological management of pain is often overrated and that they should try non-pharmacological methods such as massage, heat packs, mobilisation and physiotherapy.[249] He agreed with the proposition that some form of summary of the incidents of verbal and physical aggression that the facility are dealing with in a resident like [redacted] needs to be available to be given to the GP at visits.[250] He also agreed with the proposition that where you have the types of behaviours that were happening with [redacted] and their frequency, particularly from June onwards, then some form of notification to the GP of those behaviours should happen.[251] He didn't think sight charts in the way that they were completed were of great value in managing risk. He said they keep tabs on where a person is, but they don't necessarily describe what the person is doing, and where there are two staff for a 11 bed unit it would be difficult to complete a sight chart on a person every 15 minutes. He said there should be a clear policy guideline to support when to identify when the GP ought to be informed about acts of resident to resident and resident to staff aggression (there needs to be a determination about what constitutes an assault and the level of severity because these incidents are very common) and there should be ongoing training of care staff, including registered nurses, as to how to respond to aggressive behaviours using interventions appropriately and trying to identify underlying reasons why aggression may be displayed.[252]

221. Through questions from Mr Evenden he thought it appropriate that there should be a policy developed to know when steps need to be taken to escalate the situation and to arrange some sort of external placement in cases such as [redacted]'s. It would have to be developed locally with local resources in mind.[253]

222. He again confirmed that while pain is a contributing factor it is not the only factor. Poor environmental design, boredom, loneliness, medication side-effects, lack of sleep, too much sleep, overstimulation, under stimulation are all or can be contributing factors.[254] He didn't believe that the use of CCTV in common areas would reduce the incidence of aggression. He thought it might help in the monitoring of incidents but it doesn't help in the reduction of incidents. He accepted that it might be useful as a part to play in the assessment process for DBMAS.[255]

[249] Transcript of proceedings 28 November 2019 at T27.16 – 27.27.
[250] Transcript of proceedings 28 November 2019 at T28.17 – 28.25.
[251] Transcript of proceedings 28 November 2019 at T28.27 – 28.31.
[252] Transcript of proceedings 28 November 2019 at T28 – 29.
[253] Transcript of proceedings 28 November 2019 at T32.
[254] Transcript of proceedings 28 November 2019 at T33.1 – 33.9.
[255] Transcript of proceedings 28 November 2019 at T33 – 34.

223. While he accepted that the SCC staff had attended dementia training courses in 2015 and 2016 and thought that positive, he also added that attendance in itself is no demonstration that learning has occurred:

> *"It really depends how the training is evaluated and also putting even a three day intensive course into the perspective of the depth of knowledge that really is required to manage people with very complex behaviours, a three day course is relatively a drop in the ocean but certainly all attempts to educate people should be applauded."*[256]

He indicated that the course is targeted towards the basics which affect the greatest number of people and they are aimed towards up skilling front-line staff from a very low base to a slightly higher base but he wouldn't expect the course to enable staff to manage tier seven behaviours in a residential aged care setting.[257]

Resolution of Issues

224. There was an agreement between the parties of interest that the Inquest would concentrate upon the following issues discussed below.

Determination of Statutory Findings

225. The following findings are not in dispute and are in accordance with the autopsy report prepared by Dr Leah Clifton and dated 9 January 2017.[258] Hazel Brockett died on 23 July 2016 at John Hunter Hospital, Lookout Road, New Lambton Heights, NSW 2305. The direct cause of death was complications of femoral, radial and ulnar fractures. A significant condition contributing to the death, but not related to the cause of it, was Alzheimer's Disease.

226. I find, based on the circumstantial evidence, that the fractures occasioned to Mrs Brockett were inflicted by a fellow resident of the MSU, Mr [redacted] who was suffering from advanced dementia, and was not in a position to fully appreciate either the nature or consequences of his actions. In view of the advice received from the Office of the Director of Public Prosecutions that they did not intend to prosecute [redacted] due to insufficient evidence, I am satisfied that the test in s. 78(1)(b) of the Act is not established. Accordingly the provisions of s. 78(2) of the Act do not apply.

[256] Transcript of proceedings 28 November 2019 at T36.
[257] Transcript of proceedings 28 November 2019 at T36.43 – 36.47.
[258] Tab 8, Exhibit 1.

Other Issues

Whether there was adequate supervision of residents in the MSU as at 14 July 2016, given the significant care needs of those residents and the behaviours exhibited by [redacted] in the period prior to Mrs Brockett's death.

227. Overall, the evidence establishes that the facility did not do enough to manage [redacted]'s behaviours. Ms Emmerson's frank admission in her statement accepts that.[259] Forms were not always completed in a way that could accurately describe the behaviours (e.g. acts of verbal aggression that were treated by some staff as being normal, or agitation, or delusional behaviour) that were being exhibited by [redacted]. And for reasons that will be elaborated on further in these findings, there was a communication breakdown between the facility and [redacted]'s treating GP, Dr Himmelhoch.

228. In relation to the incident of 20 June 2016, I find that incident should have triggered a coordinated communication between the facility staff, GP, [redacted]'s family, and specialist services. Because [redacted] was still physically active he was capable of entering the room of others (as he did on numerous occasions), and he was an enduring risk to the safety of others so long as his aggression persisted. Associate Professor Macfarlane opined that by June 2016, [redacted]'s behaviours were more likely than not at Tier 7 level (i.e. extreme) on the seven-tiered model developed by Brodaty, Draper and Low, that the facility were not able to manage [redacted], and that they should have sought external assistance of some kind.[260]

229. In my opinion, the evidence establishes that [redacted]'s behaviours were not properly identified. As Professor Ibrahim commented, what occurred in this facility with [redacted] could occur anywhere and that this was a tragic set of circumstances that required one person to recognise that the facility was not adequately managing him and to take the next step.[261] There was an escalating level of violence and aggression displayed by [redacted] yet it was not recognised in a way that provided for the level of aggression and its frequency to be communicated in an effective way to the GP and senior staff. My clear understanding of Ms Mika's and Ms Gough's evidence is that their obligation extended to recording an incident in the notes, yet they had no involvement with more senior staff as to identifying the problems and trying to ascertain any underlying issue. On Ms Mika's evidence, not all incident reports named the aggressor, with the result that such reports were not able to be used to chart and review a resident's behaviour consistently. She also stated that delusional behaviour would not tend to be reported if it was regularly observed, nor would

[259] Statement of Helen Lascelles-Hadwen 30 August 2019 at [81], Exhibit 3.
[260] Transcript of proceedings 28 November 2019 at T8 – 9, T23, T32, T36.
[261] Transcript of proceedings 5 September 2019 at T90.43 – T91.8.

behaviour such as wandering, unless it became intrusive.[262] Essentially there was no ongoing collaboration between those working at the coalface of care and those in the administration of the facility.

230. In his submissions on behalf of SCC, Ms Emmerson, Ms Gray, Ms Mika and Ms Gough, Mr Gemmell attempted to draw a distinction in terms that even if behavioural interventions suggested in [redacted]'s Care Plan did not always work, that did not mean they were ineffective.[263] While I accept that some suggested interventions were practical and appropriate, ultimately the bottom line is that [redacted]'s behaviours were escalating and those behaviours were not being identified. More importantly the cause of the behaviours was not being analysed so that appropriate action could be taken.

231. The vexed issue of staffing levels was raised in evidence. Dr Himmelhoch was of the opinion that staffing levels were "frightening".[264] She did not work in the facility on a day-to-day basis. It is possible that the doctor only attended the MSU once a week for her clinic on a Wednesday although the evidence was not clear whether she came on other days. None of the actual care staff and RNs who worked in the facility that gave evidence expressed a similar concern to Dr Himmelhoch. That is important to acknowledge. There was no specific comment or criticism made by the experts. There were issues overall with accurate reporting of forms, the conveying of incidents to the GP, the following up of referrals and arranging for appropriate case conferencing (being informal or formal) that are suggestive of pressures related to time and the amount of work for which care staff and senior staff such as RN's were responsible. However I am not in a position to make a specific finding that there were insufficient staff numbers in the MSU.

232. I am satisfied on balance that at times staffing levels must have been stretched; otherwise the issues that I have described would not likely have taken place. Ms Mika accepted that on occasion the two care staff could be assisting with the one resident so that on those occasions supervision of other residents in a practical sense was not happening.[265] She also stated that at times an extra staff member could have helped, particularly with monitoring.[266] That appears to be logical and realistic, particularly if the cohorts of residents (or some of them) are becoming increasingly problematic. While paragraph [17] of the submissions filed on behalf of Southern Cross Care may well be accurate: that the Caves Beach facility is "well above the industry

[262] Transcript of proceedings 28 November 2019 at T39 – 40, T43.
[263] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [13] – [14].
[264] Transcript of proceedings 4 September 2019 at T85.18.
[265] Transcript of proceedings 2 September 2019 at T63.4 – 63.7.
[266] Transcript of proceedings 2 September 2019 at T79.

benchmark",[267] [redacted]'s behaviour issues were still occurring and may well have been identified if there were more staff and better collaboration.

233. On the evidence, [redacted]'s behaviours were increasing with frequency and measures needed to be taken to address it. With the available staff at the facility at the time I find there was a risk to the safety of others due to his escalating behaviours. Ultimately it depends on the quality and experience of staff and the number of residents within the MSU, and the degree of varying challenging behaviours displayed by each resident. On any given day the facility may well require more staff than on another day. That factor does not appear to be recognised. Perhaps some rostering of casual on-call care staff needs to be utilised. The incidents of aggression, both verbal and physical, that are identified in paragraphs [20]-[24] and [27] of this decision, clearly indicate that the management of [redacted]'s behaviour was not being appropriately identified as being serious enough to warrant (at the very least) outside assistance of some form, be it a geriatrician or DBMAS or both, certainly by 20 June 2016. Associate Professor Macfarlane commented on staffing levels in the context that better educated staff working in dementia would improve outcomes, however qualified that by saying "I wouldn't expect in any way that even a reasonable amount of dementia training would equip front line staff to be able to manage behaviours of this severity." Unfortunately Ms Noud as Facility Manager did not consider it was her responsibility to refer a resident for outside assistance without approval from a GP - even if she knew there were incidents regularly occurring.[268]

234. I do not intend to make any further adverse comment about any individual staff member and their actions or inactions in this matter, other than as commented. The problems highlighted in this inquest are more general systematic and management issues.

The extent to which care staff responsible for the care of MSU residents are required to undertake tasks unrelated to resident care, and the effect this might have on resident safety.

235. This has already partially been addressed in the preceding issue. Ms Noud said that care staff primarily had to attend to personal care of residents, monitor them, manage their behaviours and attend to feeding. Sweeping and cleaning was attended to by cleaners.

236. There is no clear evidence or any specific criticism that indicates that care staff were involved in other tasks that diverted them from resident care. As has previously been commented upon, with two care staff looking after 11 residents (accepting that

[267] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [17].
[268] Transcript of proceedings 28 November 2019 at T20.3 – 20.8.

individual residents wake up at different times and that they MSU may not be at full capacity) the issue of supervision, particularly with a resident with challenging behaviours, puts the safety of other residents at risk. It is accepted that measures taken by the facility in relation to [redacted] were not sufficient, and that more coordinated consideration of [redacted]'s care needs should have been facilitated by it.[269] I also accept Counsel Assisting's submission that:

> "*failures were not assisted by having different registered nurses at different times involved in [redacted]'s daily care, an apparent lack of any meaningful collective discussion and the lack of case conferencing, and no system in place for picking up the complete picture of the behaviours as they progressively occurred. Behaviours were responded to and apparently considered 'dealt with' on an ad hoc basis, largely through the use of pain relief measures. The response might be described as 'outcome' focused rather than one focused on risk. That is, if no serious outcome resulted from a particular instance of behaviour, then the risk was not appreciated as being significant".*[270]

Whether there were adequate and timely procedures in place to review concerns and risks relating to resident behaviour and general well-being, and then to implement appropriate care and management plans to address those concerns and risks, including:

(a) Whether DBMAS referral or other specialist assessment should have been arranged for [redacted] in the months prior to Mrs Brockett's death, in light of the escalation of his behaviour.

237. SCC accepts that DBMAS referral or other specialist assessment should have been arranged for [redacted] no later than after the incident on 20 June 2016. This was also a submission made by Counsel Assisting.[271] In the supplementary report of Professor Ibrahim of 18 August 2019, he notes "a specialist referral to DBMAS would have been appropriate (as at 20 June) and ideally should have been made sooner".[272] In addition, the intended referral to Dr Walsh the geriatrician should have been followed up and acted on. Mr Gemmell submitted that a referral to DBMAS was a responsibility shared with the treating GP and while the doctor considered the facility should have initiated the referral as a medical practitioner she also had a responsibility.[273] It is acknowledged that there was a breakdown in communication with the doctor and I accept and find that she was not given all the necessary

[269] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [23].
[270] Supplementary submissions of Counsel Assisting, dated 5 December 2019 at [19].
[271] Submissions of Counsel Assisting, dated 4 November 2019 at [48].
[272] [17] of Addendum to Statement of Professor Ibrahim, dated 18 August 2019, Tab 24EE, Exhibit 1.
[273] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [25].

information by the facility to ensure she had a complete understanding of the escalation of [redacted]'s behaviours.

238. Ultimately I find and accept the following submission made by Counsel Assisting:

> *"Why these measures did not occur appears to have its genesis in a failure by anyone in a position of responsibility at the home to identify there was an emerging escalation of the frequency of [redacted]'s incidents of aggression and the risk that he posed given the physical ability he had in the resident profile in the MSU at the relevant time".*[274]

Ultimately, overall responsibility in the facility at the time was with Ms Noud. Ms Noud was aware of the incident on 20 June as there was an entry by her at 12:15pm in the Autumncare notes that she had a discussion with [redacted]'s wife concerning a referral to a psychogeriatrician or DBMAS.[275] This suggests she was contemplating outside assistance (likely from a discussion with RN Filby) yet then took no further action. In my opinion, it is highly unlikely she would have spoken to [redacted] about a referral in relation to just one incident. Then there is an entry in Autumncare by Ms Gray after Dr Himmelhoch examined [redacted], indicating an intention of a referral being made to Dr Walsh. As we know, no referral was written, nor was it followed up. It is not in dispute that Dr Himmelhoch intended to write one and forgot and that Ms Gray knew a referral was to be written and also forgot. That it was not followed up is the responsibility of the facility that has the care of the resident. The very problem identified by Ms Noud's Counsel in her submissions that she was not aware of the significant incidents or issues because they were not reported or were downplayed by staff[276] is a significant factor that played a major part in the overall problem, as was the problem of not taking proactive steps in recognising and managing an escalating behavioural problem with [redacted]. It was the style of management that was in place at the time that contributed to the tragic incident that ultimately unfolded.

239. I am aware that there is a conflict between Dr Himmelhoch's evidence that she was seeing upwards of over 20 residents each clinic visit and Ms Gray's evidence that the doctor saw about 10 to 12 residents. While there is no credit issue with either witness, on balance I prefer the evidence of Dr Himmelhoch, as she was the person seeing the residents. My suspicion is that the word "seeing" might be interpreted fairly loosely. Some residents may have only needed a repeat prescription yet that would have been recorded, more likely than not, as a consultation. There might also be other reasons why a patient's file was being reviewed (eg. for a medication review) and that might also be recorded as a consultation. That may account for the difference, however it is

[274] Submissions of Counsel Assisting, dated 4 November 2019 at [48].
[275] Transcript of proceedings 3 September 2019 at T42 – 44.
[276] Submissions on behalf of Patrina Noud at [13].

speculation. If that is the case (and I accept there was no cross-examination on this point) the actual discussion about particular residents and their care might be closer to the lower figure as described by Ms Gray.

240. I accept the submission by Mr Gemmell on behalf of SCC and find that there was a failure to fully appreciate, collate and communicate the extent of [redacted]'s issues to the GP at the relevant times after April 2016.[277] Counsel assisting also acknowledged at paragraph [41] of his submissions[278] that the onus was on the facility to properly brief the GP on the issues relating to a particular resident, particularly where concerning behaviours were repeatedly occurring. I accept that submission.

(b) Whether the practices and policies of the MSU in relation to resident movement within the MSU are appropriate.

241. The issue of wandering by a resident and the possibility of restricting movement of that resident was not given significant consideration during the hearing of the inquest, as it was identified that restricting movement was not an appropriate response. In short, the reasons for that, as articulated by Ms Emmerson, involved the possibility of a resident being confused as to how to open a door, or, if it were locked, social isolation, particularly in relation to residents who like having contact with other residents. She also noted that as residents become physically frail they are therefore at high risk of falls and at high risk of choking. Lastly, if a resident became stuck in their room because they couldn't open the door, this would be a form of restraint.

(c) Whether case conferencing should have occurred in relation to [redacted]'s behaviours during the first half of 2016.

242. From the evidence, I find that a formal case conference should have been held as soon as practicable after 20 June 2016 involving [redacted]n's family, the facility (including an RN and the Facility Manager) and the GP. That was the evidence of Ms Noud, and Ms Gray also accepted that a formal case conference should have been held in relation to [redacted] once the escalation of his behaviours had been identified. SCC is of view that one should have been held prior to or upon the prescription of Risperidone (which first occurred on 12 May 2016 and then again by Dr Himmelhoch on 8 June). Dr Himmelhoch agreed with this view.[279]

[277] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [31(d)].
[278] Submissions of Counsel Assisting dated 4 November 2019.
[279] Transcript of proceedings 4 September 2019 at T104.46 – 105.5.

Whether the care provided to Mrs Brockett and other residents of the MSU by the care staff was of an appropriate standard.

243. There was no evidence to suggest that the medical and therapeutic care of Mrs Brockett was other than adequate. The only issue that arose was whether, in the last weeks of her life when she was bedridden, she should have been considered for transfer into the general accommodation at the facility – i.e. a transfer out of the MSU. There are competing issues and concerns; there are advantages and disadvantages. The views of the family of Mrs Brockett are not known from the evidence - perhaps by inference from questions asked by Mr Evenden, the family of Mrs Brockett may have liked the opportunity at the time to have considered it. From the evidence, it was not uncommon for residents who became immobile to be moved out of the MSU into other accommodation within the facility. Obviously the first issue is whether or not there is a bed available. A second concern is that the wishes of the family of the resident are taken into account. Being in a room that you are familiar with, and interacting with staff that you are familiar with could override other matters. In addition, particular health issues such as the risk of dysphagia would have to be considered.

244. A bedbound resident moved out of the MSU is less vulnerable in a situation where there are wandering residents with dementia in the MSU. As Mrs Brockett had been bedbound for some five weeks, in my opinion some consultation and consideration of a move out of the MSU should have been considered in that time. Professor Ibrahim thought Mrs Brockett no longer needed to be a resident in the MSU and that she would have been better off in the general area of the facility, notwithstanding the various advantages of the MSU. The responsibility to consider a transfer rested with management in the first place, obviously in consultation with the family of the resident. It was not considered, let alone discussed with the family of Mrs Brockett. Professor Ibrahim stressed the need for family to be informed in relation to possible moves:

> "… *With the new standards where the family needs to be informed, the family need to understand what they're signing up for. And I don't know whether Hazel Brockett's family knew the, the cohort of patients that were going to be looked after, what the facility might become in the future, and what their rights around moving or not moving, depending as it happens.*"[280]

[280] Transcript of proceedings 5 September 2019 at T123.17 – 123.22.

Whether the care provided to [redacted] by care staff of SCC Caves Beach and attending GPs was of an appropriate standard.

245. In short, the answer to this question is no, in relation to the care by SCC staff. There were a number of factors that relate to this answer: –

I. The Facility Manager Ms Noud thought that [redacted]'s aggression was related to pain, principally from his fractured rib injury. She did not consider that pain on the one hand, and delirium (from some underlying issue) on the other hand, were two competing possible explanations for his aggression. She did not give any thought to whether the sedating effects of the pain medication may have caused [redacted]'s difficult behaviours to subside. She accepted that it was possible that her note to staff (to the effect that 9 times out of 10 pain was the cause of aggression) (see paragraph [49] of these findings) had the potential to divert care staff from thinking about other reasons as to why a resident was displaying aggression. Ms Noud accepted during cross-examination that she could have coordinated better care for [redacted].[281]

II. It is accepted by SCC that there was a breakdown in coordinated communication between the facility and [redacted]'s GP. Relying on Ms Gray, who at the time was in administration, was not ideal and that has been accepted by SCC.

III. The practice of having Ms Gray make a one page summary of any concerns by relying on her memory of having read the Autumncare notes for upwards of 20 residents each morning (but for the day prior, which she reviewed on the morning of the doctor's clinic) was not, in my opinion, good practice. She also assumed that particular incidents of misbehaviour by [redacted] were being conveyed to the doctor during the week. That was an incorrect assumption.

IV. It is also accepted by SCC that there was a communication breakdown that matters were not coordinated at a senior level within the facility. Ms Noud was not aware at the relevant time that a benzodiazepine or opioid administered to dementing residents could potentially contribute to delirium. Ms Gray thought that instances of resident-to-resident aggression would be communicated to the relevant GP by way of phone or fax by the Facility Manager Ms Noud, however resident-to-staff aggression would not be so notified. There is no record of any faxes about resident-to-resident aggression involving [redacted] being sent to Dr Himmelhoch, and from the notes recorded in AutumnCare and on the incident forms, not every incident involving [redacted] appears to have resulted in phone calls being made to Dr Himmelhoch by Ms Noud.

[281] Transcript of proceedings 4 September 2019 at T33.

V. Ms Gray, who was the main conduit to Dr Himmelhoch, was not aware that Risperidone was being prescribed to [redacted] for aggression perceived to be a result of underlying dementia, rather than for pain. The doctor stated that the Risperidone was being used to treat aggression as part of the behavioural and psychological symptoms of dementia. When she was taken to the fact that Ordine was administered on 2 and 3 July for aggression, Dr Himmelhoch said it was concerning that there was a lack of communication, and that she was not aware of the ongoing Ordine use.[282] It is also noted that RN Gillies recorded on 4 July 2016 that she had been telephoned five times over the weekend to authorise Ordine PRN.[283] In my opinion, Ms Gray was not aware of the reasoning as to the causes of aggression and the medication being used to treat it. As indicated by Counsel Assisting, opportunities for effective observation of [redacted]'s behaviours, their interpretation of them and adequate communication back to the GP were all compromised or impaired. As was noted by Mr Gemmell in his submissions, there may also be some confusion with the doctor who prescribed Ordine for "severe pain and agitation" on 13 April 2016[284] and that description did not change until 1 July, from which data indicated it could be administered "for pain". There is no indication in the doctor's notes or the Autumncare notes as to why this change was made, or whether it was communicated in person to any staff member. This may have had a part to play in the overall assumption by staff that [redacted]'s aggression was most likely to be a result of pain. Overall there was insufficient communication between the facility and Dr Himmelhoch as to the purpose of various medications being used to treat [redacted] and likely resulted in inappropriate use of Ordine to treat aggression rather than pain *per se*. This was made more problematic by an assumption of staff (reinforced by Ms Noud's note in the communication book) that aggression was most likely to be a result of pain. Consequently, little attention was given to the escalation of [redacted] aggressive behaviours because attention was focused on a perceived issue of ongoing pain from the rib injury. A failure to detect this escalation meant there was a failure to consider case conferencing, combined with the failure to properly communicate to his GP over a period of time the escalating behavioural issues of [redacted]. I agree with Mr Gemmell's submission that staff would be assisted in their administration and reporting of medication if a prescribing GP provides instructions as to when, and for what indications, PRN medication should be administered.[285]

VI. There was a failure to document incidents of aggression (physical and verbal) in a way that brought the incidents to management's effective notice (Ms Noud and or

[282] Transcript of proceedings 4 September 2019 at T71.9 – 71.12.
[283] Page 9 of Tab 33, Exhibit 1.
[284] See Medication Chart at Admission 1, Tab 35.
[285] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [41(a)].

Ms Gray) and in turn to the GP. There was no communication to the doctor during the day when an incident occurred, nor any communication to the doctor when Ordine was being administered.

VII. There was a failure to communicate to staff the various uses of medication, what they were for and when they should be used, either from the GP who prescribed it or from senior staff. There was a lack of knowledge by senior staff of the possible effects of the medication or the combination of them.

VIII. The nursing management plan did not comply with the policies in place at the facility at the relevant time, in that there was no formal case conference convened to discuss [redacted]'s care either within a three month period, or as required. Associate Professor Macfarlane was critical of the behaviour interventions on the Physical/Verbal/Wandering Behaviour Assessment. He gave evidence that the interventions suggested in the plan consisted "largely of a series of tick boxes describing various behaviours and interventions, are more a way of describing behaviours that might be related to ACFI funding, rather than a clinically useful tool to inform management".[286] Mr Gemmell takes issue with this assertion. What Mr Gemmell described in paragraph [84] of his submissions[287] does not, in my opinion address what the Associate Professor was generally describing. Associate Professor Macfarlane was talking about suggested interventions for behaviour. He described one such intervention – having [redacted] watch TV - as being wildly impractical and inappropriate in the context of [redacted]'s extreme behaviours. In his submissions on behalf of the Brockett family, Mr Evenden commented that in relation to the care plan certain suggested actions or interventions were ineffective or inadequate "in terms of their capacity to control or modify his physical behaviours and lessen the risk he posed to other residents".[288] For example, in paragraph [31] of his submissions he stated:

> *"Modifications made by RN Filby on 20 June 2016, after* [redacted] *pushed over a resident, involved adding 'monitor whereabouts' to the measures proposed to implement the plan. How this modification might have been implemented (given staffing ratios), or might meaningfully have prevented a further assault is unclear".*

He further submitted "that many of the suggested actions on page 23 of the care plan involved one-on-one contact between the resident and staff. Due to staffing levels, it was not possible to implement these suggested actions. One-on-one care

[286] Expert Statement of Associate Professor Macfarlane dated 29 September 2017, p. 4, Tab 24, Exhibit 1.
[287] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [84].
[288] Submissions on behalf of the Brockett family, dated 17 December 2019 at [29]-[36].

of residents in the MSU was not feasible".[289] Based on the evidence of Ms Mika and RN Filby, I agree with that submission. Further the physical behaviour care plan, even as modified, was insufficient to properly address the behaviour being exhibited by [redacted] While RN Filby was of the view that care staff would understand the language used in the plans,[290] the interventions that were recorded (eg. massage) as set out by Mr Gemmell in his supplementary submissions[291] do not, to my mind, indicate that interventions were put in place that effectively dealt with [redacted]'s escalating behaviour. There did not appear to be analysis of what was happening and why, nor any formal evaluation of interventions in place to establish if they were effective.

IX. I accept Dr Himmelhoch's evidence that she was not fully aware of the frequency and nature of [redacted]'s aggressive behaviours and that they were increasing. She was not made aware that [redacted] posed a risk to other people's safety. Ms Gray accepts she did not convey that concern to the doctor. Dr Himmelhoch's care was reviewed by Professor Ibrahim as being reasonable on the basis of the information that she had been given. I accept the Professor's opinion.

Generally

246. It is accepted that most of the failures identified in the Inquest have come about as a result of looking back at what has occurred and that hindsight therefore plays a role. In my view that is a considered factor that weighs against being overly critical of individuals and lessens the need for negative opinions or comment that should be expressed about those failures. I am aiming to be forward-looking. I am very conscious that, in general terms, all of the staff that gave evidence (including Ms Noud) were people who were trying to do their best in what has been termed as a very challenging environment.

247. In my opinion both experts made it clear that a significant number of people in aged care facilities have a diagnosis of dementia and of those, most exhibit various behavioural issues from time to time. It is critically important to have all clinical staff educated in dealing with dementia behaviours.

248. There are a number of recommendations that follow this decision. While there has been some discussion about the recommendations and their form and content, ultimately I have made the ones that appear below.

[289] Ibid at [34].
[290] Transcript of proceedings 3 September 2019 at T55.13 – 55.21, T55.36 – 55.40.
[291] Supplementary submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 20 December 2019 at [4].

249. I am reassured by the evidence given by Ms Emmerson that changes have been made not only to the Caves Beach facility, but more generally for all of the facilities owned by Southern Cross Care. It appears to be a proactive organisation and hopefully from this Inquest there will be continuing efforts to improve communication between care staff, management and treating clinicians, and care for all residents. Ms Emmerson's statement sets out changes which have been made at the facility and also changes at an organisational level.[292] There are also changes to the induction process for staff and changes to care documentation.[293] In his submissions for SCC, Mr Gemmell has already acknowledged that some of the recommendations have already commenced being implemented (Recommendation 2 and Recommendation 5). He also acknowledges on behalf of SCC that the other proposed recommendations will be adopted and implemented, with proposed qualifications to 4, 7, 8, 9 and 10. In regard to Recommendation 4, his client argues that the use of such chart should not be "continual" and should be targeted for a set period to help provide a clear picture which can be acted on. He submits there is a risk that staff would become normalised to recording the behaviours. I do not understand that logic. The purpose of a behaviour chart as set out in Recommendation 4 is to provide those who are assessing a resident in respect of behavioural issues an opportunity to look at the whole of the picture, rather than a specific period. A resident's behaviour may be escalating for all sorts of reasons. There may be a gradual decline or escalation that would be better seen by the complete picture afforded by a summary of the whole of the period from admission to the time of review. Surely a clearer pattern of behaviour would emerge from that kind of summary than from a shorter period. On that basis I do not intend to accept the suggestion made by SCC.

250. In relation to Recommendation 7, the proposal is that SCC provides guidance in its Care Manual for staff on the process of providing individually tailored behavioural interventions for a resident. SCC argues that it accepts the recommendation, but would rather the guidance to staff be by way of a Quick Reference Guide rather than in the Care Manual, as that best fits the way in which staff are required to document their care for each resident. If management of SCC are of the opinion that is a better way for the staff to document a resident's behaviour plan then I will accept it. The recommendation will therefore be as set out in paragraph [3] of Counsel Assisting's reply submissions,[294] with the proviso that the Care Manual makes reference to the Quick Reference Guide so that new staff are alerted to its availability.

251. In relation to proposed Recommendation 8, the qualification that is sought by SCC is to subparagraph (c), which makes reference to recording in AutumnCare notes the "surrounding context and any possible triggers that preceded the aggressive behaviour". SCC submits that such information is not always best captured in the

[292] Statement of Helen Lascelles-Hadwen 30 August 2019 at [37] – [49], Exhibit 3.
[293] Statement of Helen Lascelles-Hadwen 30 August 2019 at [51] – [55], Exhibit 3.
[294] Reply Submissions of Counsel Assisting, dated 19 December 2019.

"AutumnCare notes". In their submission it would be best captured in the resident's Care Plan. For the same reason I gave for Recommendation 7, I accept the proposed amendment as set out in paragraph [4] of Counsel Assisting's reply submissions.

252. As to Recommendation 9, the proposed recommendation as it presently stands requires the SCC Care Manual to be revised in the section "Managing Behaviours of Concern" to include more guidance as to when external review by a clinician other than a General Practitioner may be required. As I understand it, SCC accepts the recommendation but would prefer "this guidance in the form of a procedure, which will be supplemented by a policy, rather than by an update to the Care Manual".[295] I am unaware of the significance between guidance being provided in the Care Manual as distinct to a "form of procedure" and supplemented "by a policy". Again, if there is going to be some form of procedure and policy then in my opinion there should be reference to it in the Care Manual. However, if the SCC would like to add a "policy" and a form of procedure in addition that is an advantage. I therefore propose to make the recommendation as formulated by Counsel Assisting at [5] in his reply submissions.

253. Recommendation 10 was that SCC give consideration to installing CCTV in common areas of the MSU at the Caves Beach facility so that footage of "unwitnessed incidents may be subsequently reviewed". As correctly submitted by Mr Gemmell for SCC, there is no evidence that CCTV was effective in reducing incidents, but that is not what the recommendation is aimed at. The recommendation it is not directed at an attempt to prevent incidents. It is designed to **review unwitnessed incidents** (my emphasis). It was that utility that Associate Professor Macfarlane expressed in his evidence. The scenario could be that a resident is found on the floor with a serious injury and no staff member witnessed how the resident came to be there. In such a situation, CCTV can be reviewed to see how the resident came to be on the floor – be it by a push or shove from another resident, or that they overbalanced accidentally. Whilst there are issues of privacy, in my opinion resident safety is paramount and it may provide some evidence to determine possible triggers of behaviour. And as Associate Professor Macfarlane noted, it may also assist with a referral to DBMAS.[296] The recommendation in its present form will remain.

254. In relation to proposals put forward by Counsel on behalf of the Brockett family,[297] I was not persuaded from any of the evidence that I heard at Inquest that lockable doors on residents' rooms were an advantage. I understand the context in which the suggestion is made, however for the reasons that have been expressed by staff members and Ms Emmerson (including that a dementing resident might not

[295] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [69].
[296] Transcript of proceedings 28 November 2019 at T33.47 – 34.37.
[297] Submissions on behalf of the Brockett family, dated 17 December 2019 at [77].

understand that although the door had been closed they were able to open it from the inside, or that some residents didn't like their door being closed), I decline to adopt this proposal. It is best looked at in the same light as suggested by Professor Ibrahim who thought that it was a temporary solution and really wasn't coming to grips with the problem needing to be addressed more assertively. Overall, the consensus appeared to be (when considering issues of residents' rights and expectations) that a closed/locked door would create as many (if not more) problems as it might solve.

255. The related proposal of a separate area of seclusion for a problematic resident[298] was rejected by a number of witnesses. At best, seclusion should be for no more than a couple of hours and, as noted by Professor Ibrahim, if they needed more than that then perhaps they should be considered for assessment under the *Mental Health Act 2007* (and admitted somewhere else as an involuntary patient). I do not accept the proposal.

256. The proposal to amend the Care Manual to mandate that all resident-to-resident physical assaults be reported in all instances to the doctor[299] is in stronger terms than the present proposed recommendation, which is for SCC to give consideration to formulating a clear policy guideline for when, and in what form, there should be notification to the GP of acts of resident-to-resident aggression and resident-to-staff aggression. On balance I am not persuaded that it should be mandated at this stage because it is unclear what acts of aggression would appropriately trigger a notification. It may also be the case that the requirement to notify the relevant GP of all physical assaults creates an obligation on care staff to report any unwanted physical contact engaged in by a resident, even if benign.

257. As to the third proposed recommendation made on behalf of the Brockett family, in relation to amendments to the incident form,[300] I note that Professor Ibrahim supported any mechanism by which care and clinical staff could be provided with further guidance and prompts to consider GP review and external assistance. In his reply submissions, Counsel Assisting supported the amendment of the Incident Form proposed by the Brockett family. I agree with the submission by Mr Evenden to amend the form in the way suggested. In my opinion, the proposed changes may be of practical assistance to staff and management for the reasons set out at paragraphs [92] and [93] of his submissions. In light of the above, I make the recommendation as proposed by Mr Evenden at paragraph [91] of his submissions and it is included at Recommendation 11 below, with the following qualification. Mr Gemmell submitted that SCC is not able to "unilaterally amend" the Incident Form because it is an AutumnCare document.[301] If the basis for this submission is that SCC has no

[298] Submissions on behalf of the Brockett family, dated 17 December 2019 at [77].
[299] Submissions on behalf of the Brockett family, dated 17 December 2019 at [85].
[300] Submissions on behalf of the Brockett family, dated 17 December 2019 at [91]-[96].
[301] Supplementary submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 20 December 2019 at [12].

proprietary rights to amend the Form then I would accept the procedure outlined in Mr Gemmell's principal submissions at paragraph [29(e)][302] in lieu of Recommendation 11.

258. The Brockett family also proposed a recommendation in relation to the development of policy concerning the circumstances in which a resident in the MSU might be moved to the general area of the facility.[303] As noted in in the reply submissions of Counsel Assisting at [8], Associate Professor Macfarlane gave evidence to the effect that such a transfer did not offer a solution as a response to the issue of risk posed by another resident. On this basis, and in light of the factual context of this matter, I do not propose to make the recommendation. However this ought not preclude or discourage the facility from considering the transfer of residents from the MSU to the general cohort at the facility should it be appropriate.

259. The fifth recommendation proposed by the Brockett family was that SCC consider developing policy to stipulate the threshold at which a resident's aggression, and the threat posed by them, is at a level where immediate steps must be taken to arrange alternative placement.[304] Counsel Assisting notes that such a threshold may be difficult to predict, and if set "too low or too high, it may pose further problems". [305] It is also noted that evidence was given at Inquest as to the existence of clinical tools that assist staff to determine whether the steps described above are warranted (eg. the tiered approach by Brodaty, Draper and Low). I note the counter-proposal of Counsel Assisting in relation to an enhancement of draft Recommendation 9 and I intend to make the suggested alteration.

260. The final recommendation proposed by the Brockett family was in relation to temporary increases to staffing levels. Counsel Assisting notes that the measures proposed therein suggest that other steps, such as the consideration of external review and alternative placement would also be required if faced with aggressive behaviour by a resident. He stated that in those circumstances, the proposed policy would not meaningfully add to what is already proposed in Recommendation 9.[306] I accept that submission and do not propose to make the final recommendation proposed by the Brockett family.

261. Ultimately, Mr Evenden concluded in his submissions that the circumstances of Mrs Brockett's death are matters that fall within the scope of the Aged Care Royal Commission. The Court is being asked to forward its findings to the Royal

[302] Submissions on behalf of Southern Cross Care (SCC), Helen Lascelles-Hadwen (Emmerson), Amelia Gray, Amanda Mika and Karen Gough, dated 17 December 2019 at [29(e)].
[303] Submissions on behalf of the Brockett family, dated 17 December 2019 at [97].
[304] Submissions on behalf of the Brockett family, dated 17 December 2019 at [101].
[305] [9] of Reply Submissions of Counsel Assisting, dated 19 December 2019.
[306] [10] of Reply Submissions of Counsel Assisting, dated 19 December 2019.

Commission.[307] There is no power or jurisdiction to do so. Evidence taken at a Royal Commission is guided by its terms of reference and overall it has powers concerning the admissibility of evidence taken, and the way in which that evidence is treated and/or accepted. Likewise, the holding of an Inquest is guided by the *Coroners Act 2009*. The power to make recommendations provides coroners with the opportunity to identify any systematic failures in the health, law enforcement or other services to prevent similar deaths occurring in the future. As Coroner I am obliged at the conclusion of an Inquest to record in writing findings as set out in s. 81of the Act and to make recommendations under s. 82 of the Act. Subsection (4) of s. 82 sets out that the Coroner is to ensure that a copy of a record that includes recommendations made is provided, as soon as is reasonably practicable to: "(a) the State Coroner, and (b) any person or body to which a recommendation included in the record is directed, and (c) the Minister, and (e) any other Minister (if any) that administers legislation or who is responsible for the person or body, to which a recommendation in the record relates". Importantly, this subsection does not give power to a Coroner to provide a copy to anyone other than those nominated. The recommendations are not directed to the Royal Commission to be implemented.

262. From reading all of the evidence and in particular the suggestions of improvement provided by the witnesses, including the expert witnesses, I have set out below a summary of those matters that appeared to me to be useful in the better care and management of residents with dementia in specialist units like the MSU:

A. The use of the same staff (or continuity of staff) within the unit so that they have familiarity with the residents.
B. The introduction of red flags in AutumnCare to highlight various matters that need following up – such as referrals to doctors, the review of medication, the need for a meeting with family and the treating GP - is a particularly useful tool.
C. Training - ongoing education for care staff, registered nurses and senior managers in relation to identification of behaviours, the management of them, appropriate intervention (I note flip charts to provide quick reference guides for care staff have already been implemented) and some basic knowledge of the reasons why certain medications are used and perhaps the side-effects. It is important that for any training provided that there is then an evaluation of the training.
D. Coordination of information - This has to happen not only between registered nurses, managers and the relevant GP, but also between care staff. Appropriate documentary evidence of physical and verbal aggression should be kept for incidents directed both at staff and other residents. Staff should be discouraged as to the concept of accepting inappropriate physical and verbal aggression as being "normal". It is noted that reporting should still be taking place, and in particular that reporting of incidents be passed on to the GP. I further note that audits now take place to ensure compliance in relation to this aspect of resident care.

[307] Submissions on behalf of the Brockett family, dated 17 December 2019 at [112].

E. Case conferences - They should be held more frequently and involve RNs, the treating GP, the family and the Facility Manager - particularly where there is an increasing frequency of problematic behaviours. Guidelines should be provided to care staff and to RNs to indicate when case conferences may be required. Consideration should be given to obtaining the views of care staff where appropriate.

F. GP clinic - The R.N. to attend as well as care staff if appropriate. Those with intimate knowledge of the care of the particular resident are better placed to convey what is occurring, when it is occurring and why it is occurring.

G. Improvement with charts - Charts should be designed to assist in the practical management of residents. If charts used for outside auditing purposes are not necessarily ideal then the possibility of two sets of charts may have to be considered. They should be tailored to a specific resident and their needs. Guidance to staff as to the appropriate interventions for each resident needs to be given. There should be no broad brush approach where various generalised interventions are proposed for all residents. This ethos is reflected in the Aged Care Quality Standards that have been in force from 1 July 2019, which focus on "emphasise the need for evidence-informed and person-centred approaches to the provision of care and services".[308]

H. On the admission of a resident, effort should be made to work out "the positives (likes) and negatives (dislikes)" of the resident in a comprehensive multidisciplinary assessment to identify possible triggers or contributing factors to any responsive behaviours of the resident.

I. Senior staff and management need to be proactive about seeking outside assistance if they are of the view that it is required. If there is a realisation that the facility is not effectively managing a particular resident then external assistance ought to be sought. Efforts should be made at all times to consider such assistance and not to be "fobbed off" – particularly by public mental health units.

J. Once a resident is immobile and bedridden, consideration of a move out of the MSU and into the general area of the facility should be undertaken. The pros and cons should be discussed not only between management, but also with the family.

263. A great number of the witnesses at Inquest gave evidence about the importance of enhancing the education about dementia provided to staff in the aged care sector. Professor Ibrahim was of the view that all staff in aged care facilities, not just those in direct clinical and care roles, required training about responsive behaviours. It was recognised that any training that enhanced staff understanding of the range of responsive behaviours of residents with dementia, and the possible basis for those behaviours, would be positive. Both experts identified the importance of developing a sound understanding of the pre-morbid preferences and personality of residents

[308] [34] of the statement of Ann Wunsch, Tab 37, Exhibit 1.

suffering from dementia, to provide the best chance of identifying possible triggers and appropriate responses to behavioural difficulties.

Conclusion

264. At the conclusion of the inquest on 28 November 2019, Mr Thomas Brockett came forward and addressed all those present. I have to say that he spoke most genuinely and eloquently about his life and relationship with his loving wife Hazel. I don't think I have ever seen in my years on the bench such an emotional effect that Mr Brockett had on all that had the honour to hear him. He spoke with humility and gratitude about Hazel's warmth, loyalty, her smile and other personal traits. He described the pride that she had of their children and they themselves getting married and having children. He said:

> *"she was a good grandmother, a good mother and a lovely wife. After Hazel got her children off her hands with school she supported Hunter Health for 26 years… also the Belmont Hospital for 30 years. During school days with the boys she was on tuckshops and whatever else she could be in."*[309]

265. This has been quite a lengthy and complex hearing. I very much thank Mr Peter Aitken, Counsel Assisting and his instructing solicitor from the Crown Solicitor's Office , Ms Jennifer Hoy, who both provided significant help with the preparation of a background or agreed facts, issues paper, lengthy practical submissions and draft recommendations. Ms Hoy also assisted in editing the draft of this decision which I recognise would have taken up significant time. I also appreciate and thank the Officer In Charge Senior Constable Jamie Taylor (and his predecessor Detective Senior Constable Webb) for their efforts in obtaining statements and collating the brief of evidence. I extend my appreciation to the assistance provided by other Counsel and solicitors who represented persons of interest at the Inquest.

Formal Findings

266. I find Hazel Brockett died:

(i) On 23 July 2016

(ii) The time of death was 8:00am

(iii) The place of death was John Hunter Hospital, Lookout Rd, New Lambton Heights NSW 2305

(iv) The cause of death was complications of femoral, radial and ulnar fractures, and an antecedent cause was Alzheimer's disease

(v) The manner of death: Hazel Brockett died from injuries inflicted by another person also suffering from dementia

[309] Transcript of proceedings 28 November 2019 at T43.16 – 43.20.

267. I close this Inquest.

Recommendations

To Southern Cross Care NSW and ACT ("SCC"):

1. Recommend that SCC review its procedures for the clinical briefing of visiting general practitioners ("GP"), so that, in circumstances where a resident with dementia in a Memory Support Unit ("MSU") is currently exhibiting aggressive behaviour, the procedures provide that a chronological summary of incidents of verbal and physical aggression for that resident since the GP's last visit is printed out from the 'AutumnCare' database and provided to the GP. Consideration should be given to whether the need for such a summary to be provided in the circumstances described should be noted on the form currently used (see Inquest Exhibit 6), or otherwise included in the relevant SCC policy.

2. Recommend that SCC review the Care Manual section 'Managing Behaviours of Concern' to provide further guidance on the range of circumstances that would indicate when an unscheduled formal case conference should be held for an MSU resident (including for problematic aggressive behaviours) and to identify the minimum participants (namely family, facility staff and the treating GP).

3. Recommend that, if feasible, an alert be placed on 'AutumnCare' for outstanding GP referrals for MSU residents (including geriatrician, DBMAS and mental health referrals), to ensure that they are followed up and completed.

4. Recommend the use of behaviour charts (wandering and aggressive physical and verbal behaviours) on a continual basis for MSU residents exhibiting persisting aggressive behaviours; and amendment of the Physical Behaviour chart to include a separate code for acts of physical aggression.

5. Recommend that consideration be given to formulating a clear policy guideline for when, and in what form, there should be notification to the treating GP of acts of resident-to-resident aggression and resident-to-staff aggression carried out by a resident under the care of that GP.

6. Recommend that a detailed history ("History") be taken on admission for each resident of an MSU, identifying their likes/dislikes, pre-morbid personality, any environmental and social sensitivities, dietary preferences and general interests, and that the SCC Care Manual provide guidance on that process.

7. Recommend that the behavioural interventions listed on an MSU resident's Behaviour Plan be individually tailored (and modified as required) to the resident, having regard to both the nature and type of behaviours and the resident's history and that the SCC provide its staff guidance on that process via the Quick Reference Guide.

8. Recommend that there be ongoing training of care staff (including registered nurses and personal care workers) involved in MSU resident care as to:

(a) how to respond to residents displaying aggressive behaviours, including considering the underlying reasons why aggression may be displayed (including pain, mental health, delirium, and consequences of dementia);
(b) the use of behavioural interventions; and
(c) recording in the AutumnCare notes and, where necessary, a resident's Care Plan, the surrounding context and any possible triggers that preceded the aggressive behaviour.

9. Recommend that the SCC introduce a written procedure supplemented by a published policy, to provide guidance as to when external review by a clinician other than a general practitioner may be required and when external transfer may be required.

10. That consideration be given to installing CCTV in common areas of the MSU at Southern Cross Care Caves Beach, so that footage of unwitnessed incidents may be subsequently reviewed.

11. Recommend that SCC give consideration to amending its Incident Form – Resident[310] to include:
(a) In the section titled "Actions Taken By Staff" – guidance on when the doctor treating the apparent perpetrator of a resident-on-resident physical assault is to be notified;
(b) In the section titled "Referral" – further referral options, including referral to DBMAS, or referral for geriatric or psychogeriatric review; and
(c) An option to recommend a case conference in the section titled "Management Review."

Magistrate Robert Stone
Deputy State Coroner
3 March 2020
Newcastle Coroner's Court

[310] Annexure HE-10 to Exhibit 3.