New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of CA, Alice Bacon, Blanche Billinghurst, Margaret Brocklehurst, Edith Brownlee, Leone Corrigan, Ann Fahey, Ronald Farrell, David Gee, Olive Grego, Maria James, Barry Jehan, Raymond Jennings, Fay Rendoth, Keith Smith, Victor Stone, Margaret Sullivan, Marko Vidakovic & Shirley Yates
Hearing dates:	25 to 29 July 2022; 1 to 5 August 2022; 8 to 12 August 2022
Date of Findings:	24 January 2025
Place of Findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, COVID-19 pandemic, residential aged care facility, preparedness for infectious disease outbreak, surge workforce, Personal Protective Equipment, infection control, staffing levels, staff training, Hospital in the Home, Virtual Aged Care Service, telehealth, cohorting, transfer to hospital, Advance Care Plan, patient consent
File numbers:	2020/189457; 2020/189507; 2020/189558; 2020/189648; 2020/189684; 2020/189722; 2020/131688; 2020/189798; 2020/191785; 2020/191855; 2020/191949; 2020;191963; 2020/192004; 2020/225696; 2020/192028; 2020/192057; 2020;192075; 2020/192901; 2020/192922

Representation:

Mr S Buchen SC, Ms R Mathur SC & Mr J Harris, Counsel Assisting, instructed by Ms K McKinlay, Ms C Moore, & Ms A Heritage (Department of Communities & Justice, Legal)

Ms G Furness SC & Ms J Davidson, for Commonwealth of Australia Department of Health & Aged Care, instructed by Clayton Utz

Mr M Fordham SC & Mr I Fraser for NSW Health, Nepean Blue Mountains Local Health District, Dr B Forssman, Dr J Branley & Dr M Kakkat, instructed by NSW Crown Solicitor's Office

Ms K Richardson SC & Ms A Rose for Anglicare Community Services trading as Anglicare Sydney, instructed by Minter Ellison

Ms E Clarke for the families of Alice Bacon, Leone Corrigan, Ann Fahey, Victor Stone & Margaret Sullivan

Mr M Palfrey for Aged Care Quality and Safety Commission

Findings pursuant to section 81(1) *Coroners Act 2009*

Raymond Jennings died on 18 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Jennings' death was COVID-19 lower respiratory tract infection, with ischaemic heart disease, frailty, and Parkinson's disease being significant conditions which contributed to death.

Mr Jennings died of natural causes following diagnosis of COVID-19 infection. Mr Jennings' symptoms were appropriately managed and he was provided with adequate oxygen support. No other steps in Mr Jennings' clinical management could have been instituted which would have materially altered the eventual outcome.

Ronald Farrell died on 19 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Farrell's death was COVID-19 lower respiratory tract infection and pneumonia, with chronic lung disease and emphysema being significant conditions which contributed to death.

Mr Farrell died of natural causes following diagnosis of COVID-19 infection. Whilst transfer to hospital would have allowed for the possibility of antibiotic therapy and monitoring of oxygen saturations, no effective treatment could have been instituted which would have materially altered the eventual outcome.

Edith Brownlee died on 21 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Brownlee's death was ischemic heart disease with COVID-19 infection being a significant condition which contributed to death.

Mrs Brownlee died of natural causes following diagnosis of COVID-19 infection. No other steps in Mrs Brownlee's clinical management could have been instituted which would have materially altered the eventual outcome.

Maria James died on 23 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs James' death was the combined effects of COVID-19 infection and metastatic bone cancer of unknown primary, with

chronic obstructive pulmonary disease and ischaemic heart disease being significant conditions which contributed to death.

Mrs James died of natural causes following diagnosis of COVID-19 infection. Mrs James received suboptimal pain management regarding her fractured left humerus, particularly in the period between 20 and 23 April 2020, which, regrettably, most likely adversely affected the quality of Mrs James' remaining life during the terminal phase. However, this did not contribute to the cause of Mrs James' death, and no other management steps could have been instituted which would have materially altered the eventual outcome.

Margaret Brocklehurst died on 24 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Brocklehurst's death was COVID-19 infection, with ischaemic heart disease, hypertension and type II diabetes mellitus being significant conditions which contributed to death.

Mrs Brocklehurst died of natural causes following diagnosis of COVID-19 infection. Mrs Brocklehurst's symptoms were appropriately managed, and no other management steps could have been instituted which would have materially altered the eventual outcome.

Keith Smith died on 25 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Smith's death was COVID-19 infection with hypertension, type II diabetes mellitus and dementia being significant conditions which contributed to death.

Mr Smith died of natural causes following diagnosis of COVID-19 infection. Mr Smith's symptoms were appropriately managed. Anticipatory end-of-life medications were ordered for Mr Smith on 17 April 2020 but they were not provided until 24 April 2020, although this delay did not contribute to death. No other management steps could have been instituted which would have materially altered the eventual outcome.

Leone Corrigan died on 27 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Corrigan's death was COVID-19 infection with hypertension, congestive cardiac failure and type II diabetes mellitus and dementia being significant conditions which contributed to death.

Mrs Corrigan died of natural causes following diagnosis of COVID-19 infection. Mrs Corrigan received suboptimal fluids management between the time of her COVID-19 diagnosis and death, and her end-of-life pathway was not determined until the day of her death on 27 April 2020. Transfer to hospital would have allowed for improved clinical management which may have made a material difference to the eventual outcome.

Barry Jehan died on 28 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Jehan's death was COVID-19 infection with hypertension, type II diabetes mellitus, and Alzheimer's and vascular dementia being significant conditions which contributed to death.

Mr Jehan died of natural causes following diagnosis of COVID-19 infection. Following Mr Jehan's diagnosis, and when he was on an end-of-life pathway, anticipatory medications were charted but not administered which adversely affected the quality of Mr Jehan's remaining life. In addition, if Mr Jehan had been permitted to leave Newmarch House as requested by his family when he was negative for COVID-19 it is less likely that he would have contracted COVID-19. Following his COVID-19 diagnosis, if Mr Jehan had been transferred to hospital in accordance with his Advance Care Plan it is not possible to reach a conclusion as to whether this would have made a material difference to the eventual outcome given the difference in opinions in the expert evidence.

Shirley Yates died on 27 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Yates' death was COVID-19 pneumonia.

Mrs Yates died of natural causes following diagnosis of COVID-19 infection. Following Mrs Yates' fall on 19 April 2020 and reports of pain in her left breast over the days following, it appears that transfer to hospital for further investigations was medically indicated at least

by the time of a review on 23 April 2020. Transfer did not occur until 25 April 2020 and management of Mrs Yates' care and comfort is likely to have been improved if hospital transfer had occurred earlier. However, the timing of transfer did not contribute to death, and no other steps in Mrs Yates' management could have been instituted which would have materially altered the eventual outcome.

CA died on 28 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of CA's death was COVID-19 pneumonia with Alzheimer's and vascular dementia being significant conditions which contributed to death.

CA died of natural causes following diagnosis of COVID-19 infection. Although records from 11 April 2020 indicate that CA was not tolerating fluids by mouth, no order for administration of subcutaneous fluids was subsequently made. However, the absence of such an order did not contribute to death, and no other steps in CA's management could have been instituted which would have materially altered the eventual outcome.

Blanche Billinghurst died on 28 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Billinghurst's death was COVID-19 infection with vascular dementia and osteoarthritis being significant conditions which contributed to death.

Mrs Billinghurst died of natural causes following diagnosis of COVID-19 infection. Following her diagnosis, the care provided to Mrs Billinghurst was suboptimal due to certain deficiencies in her fluids and oxygen management, a delay in administration of anticipatory medications, and cancellation of Mrs Billinghurst's transfer to hospital on 24 April 2020, which was contrary to the terms of her Advance Care Plan. If transfer to hospital had been effected, management of Mrs Billinghurst's fluids and oxygen therapy would have improved, although the institution of such management may not have materially altered the eventual outcome.

David Gee died on 28 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Gee's death was COVID-19 lower respiratory tract infection with vascular dementia, ischaemic heart disease, atrial fibrillation and type II diabetes mellitus being significant conditions which contributed to death.

Mr Gee died of natural causes following diagnosis of COVID-19 infection. Mr Gee was diagnosed on 18 April 2020, eight days after the index case at Newmarch House, following propagation of infection which indicates that his infection could possibly have been prevented. Following Mr Gee's COVID-19 diagnosis, he was provided with appropriate supportive care, and no other management steps could have been instituted which would have materially altered the eventual outcome.

Victor Stone died on 30 April 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Stone's death was COVID-19 lower respiratory tract infection with dementia and schizophrenia being significant conditions which contributed to death.

Mr Stone died of natural causes following diagnosis of COVID-19 infection. Whilst investigations may have been performed to investigate the possibility of intracranial pathology following falls suffered by Mr Stone around 22 April 2020, subsequent observations provided no clinical indication for transfer to hospital for these investigations to be performed. Although there is a paucity of documentation during this period of time, it appears that the supportive care provided to Mr Stone was appropriate, and no other management steps could have been instituted which would have materially altered the eventual outcome.

Ann Fahey died on 2 May 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Fahey's death was COVID-19 pneumonia.

Mrs Fahey died of natural causes following diagnosis of COVID-19 infection. Following Mrs Fahey's transfer to hospital after her fall on 30 April 2020, the comfort and end-of-life care provided to Mrs Fahey at Nepean Hospital was disproportionate to her presentation, and caused additional distress for her family, although this increased care did not materially affect the eventual outcome. However, given

the timing of Mrs Fahey's COVID-19 diagnosis when a propagated wave of infections was spreading within Newmarch House, her infection may have been prevented if a different model of care had been implemented and the terms of her Advance Care Plan regarding transfer to hospital had been adhered to. Following Mrs Fahey's COVID-19 diagnosis, no other management steps could have been instituted which would have materially altered the eventual outcome.

Marko Vidakovic died on 4 May 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mr Vidakovic's death was COVID-19 lower respiratory tract infection, with ischaemic heart disease, hypertension and chronic obstructive pulmonary disease and dementia being significant conditions which contributed to death.

Mr Vidakovic died of natural causes following diagnosis of COVID-19 infection. Mr Vidakovic's oxygen therapy was suboptimal, partly because he was not being monitored effectively, and it is unclear whether Mr Vidakovic had capacity to understand and make decisions regarding his care and treatment given his cognitive impairment and absence of assistance from an interpreter. However, neither of these last two matters had any bearing on the eventual outcome. The timing of Mr Vidakovic's diagnosis raises the possibility that his infection may have been avoided. No other management steps could have been instituted which would have materially altered the eventual outcome.

Olive Grego died on 5 May 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Grego's death was COVID-19 infection with Alzheimer's and vascular dementia and generalised vascular disease being significant conditions which contributed to death.

Mrs Grego died of natural causes following diagnosis of COVID-19 infection. Due to the paucity of documentation it is unclear whether Mrs Grego received adequate oxygen therapy, although it is unlikely that any other management steps could have been instituted which would have materially altered the eventual outcome. However, given the timing of Mrs Grego's COVID-19 diagnosis on 23 April 2020, her

infection may have been prevented if a different model of care had been implemented.

Fay Rendoth died on 8 May 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Rendoth's death was COVID-19 pneumonia with ischaemic heart disease, hypertension and chronic obstructive pulmonary disease being significant conditions which contributed to death.

Mrs Rendoth died of natural causes following diagnosis of COVID-19 infection. Due to the paucity of documentation, it is difficult to reliably assess the adequacy of Mrs Rendoth's management. Whilst transfer to hospital may have improved some aspects of Mrs Rendoth's management it probably would not have materially altered the eventual outcome although it is noted that Mrs Rendoth's family had requested that she be transferred to hospital if appropriate care could not be provided at Newmarch House due to staff shortages. Given the timing of Mrs Rendoth's COVID-19 diagnosis on 17 April 2020, her infection may have been prevented if a different model of care had been implemented.

Margaret Sullivan died on 11 May 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Sullivan's death was COVID-19 infection with Lewy Body dementia being a significant condition which contributed to death.

Mrs Sullivan died of natural causes following diagnosis of COVID-19 infection. Mrs Sullivan did not have significant symptoms of COVID-19 infection until about 27 April 2020 and she was provided with appropriate supportive care. Given the timing of Mrs Sullivan's COVID-19 diagnosis on 17 April 2020, her infection may have been prevented if a different model of care had been implemented. If Mrs Sullivan had been transferred to hospital, the level of care that she would have received, particularly in relation to fluids and nutrition, would have been greater. This may have materially altered the eventual outcome.

Alice Bacon died on 19 May 2020 at Newmarch House, Kingswood NSW 2747.

The cause of Mrs Bacon's death was COVID-19 infection with ischaemic heart disease, asthma and chronic obstructive pulmonary disease being significant conditions which contributed to death.

Mrs Bacon died of natural causes following diagnosis of COVID-19 infection. Active supportive care for Mrs Bacon became confused when the treating team could not clearly determine whether Mrs Bacon had recovered from COVID-19 and whether her late clinical deterioration represented COVID-19 infection or her underlying co-morbidities. This changing medical treatment had consequences for Mrs Bacon and her family. In particular, uncertainty about whether Mrs Bacon's presentation on 16 May 2020 represented terminal agitation or a rational response to the distress of being isolated suggests that a face-to-face consultation with a palliative care specialist would have been of assistance prior to administration of a morphine syringe driver. Given the timing of Mrs Bacon's COVID-19 diagnosis on 24 April 2020, her infection may have been prevented if a different model of care had been implemented. If Mrs Bacon had been transferred to hospital a fuller clinical assessment would have been of assistance, appropriate anticipatory medications could have been given at the correct time, and Mrs Bacon would have received a level of care that may have made a material difference to the eventual outcome.

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1. Introduction

1.1 On 11 March 2020, the World Health Organisation declared the global outbreak caused by the novel coronavirus SARS-CoV-2 to be pandemic. From its beginnings in December 2019 in Wuhan, China, the SARS-CoV-2 spread rapidly worldwide leading to a global health crisis. The pandemic resulted in millions of infections and deaths worldwide, and widespread social and economic disruptions and challenges. Governments across the world imposed measures such as restrictions on movement and travel, social distancing, mandating the use of masks, quarantine protocols and vaccination campaigns in efforts to contain the spread of infection.

1.2 Whilst few people would not have felt the impact of the COVID-19 pandemic in some way, those most vulnerable to severe illness or death from the virus included, relevantly, persons aged over 65 years, persons with pre-existing medical conditions (particularly those with chronic cardiac or respiratory conditions), immunocompromised persons, and healthcare workers.

1.3 On the evening of 11 April 2020, a staff member from Newmarch House, a residential aged care facility in Kingswood, tested positive for COVID-19. The following day, 12 April 2020, the first resident of Newmarch House tested positive for COVID-19. Between 18 April 2020 and 19 May 2020, a total of 19 residents of Newmarch House died after testing positive for COVID-19. Tragically, these deaths occurred in circumstances where, because of various measures imposed to contain the spread of COVID-19 within Newmarch House and more broadly, the residents were isolated from family members, loved ones, and friends.

2. Why was an inquest held?

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

2.2 The deaths of 19 residents at Newmarch House over approximately one month was, like the COVID-19 pandemic itself, an unprecedented and devasting event. It raised a number of questions regarding the manner of each resident's death or, in other words, the circumstances surrounding their deaths. More specifically, the number of deaths in such a short space of time raised questions about preparedness for the outbreak which occurred at Newmarch House, the nature and degree of communication from Newmarch House to residents and their families, the response to the outbreak from government and non-government personnel, infection control measures, and how residents were cared for. In addition, for some of the 19 residents, questions were also raised about the cause of their deaths. For all of these reasons, inquests were required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss

in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 It is appropriate to repeat the following opening statements made by Senior Counsel for Anglicare Community Sydney and Senior Counsel for NSW Health at the commencement of the inquest:

> Anglican Community Services wishes to extend its sincere condolences to the family and friends of the 19 residents of Newmarch House who passed away during the COVID 19 outbreak into 2020. Anglicare acknowledges that the circumstances in which family members of Newmarch lost their mothers, fathers, grandparents, partners or friends made the loss much greater.
>
> For the residents and their families, the physical separation from their loved ones and intense distress and worry about them was traumatic. Anglicare is sorry for the distress experienced during the outbreak by the residents of Newmarch House and their families and friends.
>
> Anglicare acknowledges that this was a time of intense anxiety and uncertainty for all of those involved in the outbreak. Anglicare wishes to acknowledge the personal sacrifice and compassion of all of those people who support Newmarch House during the outbreak and thank them for their contribution.
>
> […]
>
> New South Wales Health acknowledges the devastating impact that the COVID 19 outbreak at Newmarch House had on the residents, families and staff, particularly the family's ability to be involved in the care and decision making with and for their loved ones.
>
> The loss of 19 lives was tragic. The tragedy was made worse by the lack of effective communication. New South Wales Health is sorry for the distress caused and deeply sorry for the loss suffered by each and every family member and carer.

3. The lives of the 19 Newmarch House residents who died

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of each of the 19 Newmarch House residents who died in a brief, but hopefully meaningful, way.

3.2 **Raymond Jennings** was married to his wife, Beryl, who died in 2015. They had two children, Susan and Glen, three grandchildren, and three great grandchildren (as at July 2022). Ray (as he was known) previously worked as an engineer and manager of a plastics factory. He was known to be physically active in his earlier life and enjoyed tennis, golf and bowls.

3.3 **Ronald Farrell** was married to his wife, Margaret. They had seven children together: Julie, Christine, Francis, Virginia, Mark, Jennifer and Grant. When Ron (as he was known) was 18 years old he joined the Air Force and served in Cairns on the Catalina Flying Boats. Ron later worked as an auctioneer and stock and stud agent. Ron worked in Newcastle, Orange and Forbes and was well respected within the rural community. One of Ron's daughter's describes her father's handshake "*as good as any written contract because of his integrity*". Ron was known to be very active within his local community, and began the first volunteer bush fire brigade at Forestville, where Ron served for many years as Captain, and was heavily involved with his local Neighbourhood Watch program. After moving into Newmarch House in 2013, Ron remained independent, social and active. He enjoyed cooking, carpet bowls, and the fortnightly men's group meeting over toasties and milkshakes. Ron loved his footy, enjoyed watching games on television, and loved being part of the tipping competition at Newmarch House which he won in 2019. One of Ron's daughters describes her father as a gentleman who taught his children the importance of hard work, respect, family and looking out for each other.

3.4 **Edith Brownlee** was born in Taree, married for over 40 years and had four children, 11 grandchildren and 15 great grandchildren (as at July 2022). Before moving into Newmarch House, Edith had been a stay-at-home mother. She enjoyed gardening, reading, maintaining her home, walking her dog and looking after her grandchildren. At Newmarch House, Edith enjoyed reading her monthly delivery of books from Penrith library, and watching TV.

3.5 **Maria James** had three daughters from two marriages. She experienced significant challenges and hardship in her earlier life but managed to raise her children and maintain her mortgage over the family home whilst juggling fulltime work as a nurse and midwife. Maria's greatest loves were her three daughters, her granddaughters, her Catholic faith and gardening. Maria previously worked as a nurse and midwife, and was a valued member of her local church congregation. One of her daughters describes Maria as intelligent, with a quick wit, a wonderful sense of humour, and a great capacity to love. She misses her mother, who she describes as her best friend, enormously.

3.6 **Margaret Brocklehurst** (who was known to all as Peg) had been married to her husband, Victor, for nearly 60 years. They had three children together: Melanie, John and Janet. In her earlier life, Peg enjoyed being a stay-at-home mother and raising her children. After moving to Newmarch House,

Peg enjoyed weekly visits from family members, socialising with others in the dining room, watching TV, and attending special occasions such as barbeque lunches.

3.7 **Keith Smith** was married to his wife, Margaret. Together, they had two sons, Peter and Mark, and a daughter, Tracey. After the death of Margaret in 1988, Keith began a new relationship with Irene. They lived together in South Penrith.

3.8 **Leone Corrigan** was married to her husband, Walter. They had eight children together (Mary, Kevin, Michael, Ronald, Jennifer, John, Bernadette and Donna), 26 grandchildren and 21 great grandchildren (as at July 2022). In her younger years, Leone worked as a silk flower maker and a jeweller, and enjoyed raising her children and maintaining her home.

3.9 **Barry Jehan** grew up in Northbridge and was the oldest of three siblings. He enjoyed a fun and adventurous childhood, swimming at Balmoral, playing on the beach and going bushwalking. Barry had fond memories of going to the opening of the Sydney Harbour Bridge with his brother and grandfather. Barry married his wife, Patricia, in 1959. Together they had two daughters, Mary and Kathleen. He had previously worked as a railway signalman, a job he held proudly for 43 years. Barry and Patricia were devout Catholics and very active within their local church. They believed in kindness and helping those less fortunate. Barry was known to his family and friends as "Mr Fix It", a handyman who was always working on the house and garden, fixing cars and appliances, making toys for his grandchildren and just lending a hand to anyone who needed it. Barry was an avid reader who loved his *Reader's Digest*, he enjoyed photography and researching his family tree, and spent much time listening to classical music. After retiring, Barry was a volunteer bus driver in his local community, had a love of technology and recording videos of family occasions, and enjoyed playing golf and going for walks. At Newmarch House, Barry enjoyed playing dominoes, enjoying visits from his grandchildren, and going on outings with his family, often being near the water, having fish and chips and finishing the day with an ice cream.

3.10 **Shirley Yates** was married to her husband, William, for almost 70 years. They had two daughters, Kay and Leone, two grandchildren and three great grandchildren (as at July 2022). Shirley previously worked as a secretary. Following her retirement, Shirley enjoyed arts and crafts, bingo, going on cruises with her husband, and performing volunteer work at Liverpool Hospital.

3.11 **CA**[1] and her husband had three daughters together. CA previously worked as a seamstress for many years in a factory in Sydney before taking up part-time sewing work at home. Later in life, CA worked as the director of her own childcare centre which she operated out of the family home.

3.12 **Blanche Billinghurst** was married to her husband, Donald, for over 50 years. Together, they had two sons, Paul and Glen. In her earlier life, Blanche previously worked in warehouses and cared for her children. After moving to Newmarch House, Blanche maintained an active social life. She enjoyed visits from, and going on outings with, her family. She also spent much time reading, taking part in trivia and crafts, socialising with other residents in the dining room, watching TV, and talking on the phone.

[1] A non-publication order pursuant to section 74(1) of the Coroners Act 2009 has previously been made in relation to CA and her relatives which prevents the publication of their names and anything which may identify them.

3.13 **David Gee** was born in Aruba in the South Caribbean. He attended boarding school in Jamaica before moving to Wales. When he was 22 years old, David migrated to Australia where he later met and married his wife, Dawn. They had three sons together: Stephen, Russell and Mark. The family built a home in Cambridge Park where they lived for 40 years. David's youngest son described many fond childhood memories of long summer family holidays camping along the coast. David and his wife were loyal and long-term members of Penrith Baptist Church. David previously worked as a machinist and, following his retirement, continued to work part-time as a traffic controller at a local primary school. He and his wife had 10 grandchildren who they absolutely adored. David's daughter-in-law, Sarah, describes David and Dawn as "the place to go home to", and recalls memories of their grandchildren being spoiled with piles of choc chip cookies baked by David.

3.14 **Victor Stone** had a total of 11 siblings, and previously lived with his mother. He worked as a labourer and was known to be intelligent, quick-witted, physically active, and to enjoy walking and placing a bet at the TAB, and eating fish and chips from his local shops. One of Victor's sisters, Libby, describes Victor as a quiet and shy, but funny, person who was full of life and would go out of his way to help others. Victor was known to be fond of working on cars, particularly his beloved Ford Cortina. After moving into Newmarch House , Victor was described as a happy-go-lucky man who disliked confrontation and kept mostly to himself.

3.15 **Ann Fahey** was born in the United Kingdom where she married her husband, William. Ann's family describe her as a proud Liverpudlian with a heart of gold, who was generous, fun-loving by nature, warm, down to earth, and radiating positivity. Ann and William migrated to Australia in 1964 and had a son, Mark, and two grandchildren (as at July 2022). Ann previously worked as a factory worker for a printing company. After moving into Newmarch House in 2017, Ann enjoyed going out for breakfast or lunch with her family, socialising with other residents, and visiting the hairdresser and having her nails painted. The friendships that Ann developed at Newmarch House were some of her most cherished. Her family describe Ann as the person who would speak up for others, lend a shoulder for others to cry on, and welcome everyone to the table.

3.16 **Marko Vidakovic** was born in the former Yugoslavia. He married, but his wife later died in 2014. Marko was previously employed by the military but after migrating to Australia in 1971, he worked as a tiler and later ran his own tiling business.

3.17 **Olive Grego** was born in England and married her husband, Ernest, when she was 18. Together, they had four children, twins Brian and Peter, David and Helen. The family migrated to Australia in 1963, returned to England briefly, before settling permanently in Australia. Following their retirement, Olive and Ernest travelled extensively. Olive moved into Newmarch House in 2018 and enjoyed visits from her family and attending different social events with Ernest, including ballroom dancing.

3.18 **Fay Rendoth** was married to her husband, Kenneth for over 60 years before he died in 2015. They had three children together: Jayne, Gaye and Kim. Fay previously worked as a hairdresser. After moving into Newmarch House, Fay preferred to mostly stay in her room, although she did attend some social events such as going on bus trips and attending a ballroom dancing session.

3.19 **Margaret Sullivan** was the eldest of nine children. She was married to her husband, Lloyd, and they had two sons together, James and Sean. Margaret previously worked as an accountant and was known to be a devout Catholic.

3.20 **Alice Bacon** was born in Belfast, Northern Ireland. She was married to her husband, Charles, and they had four children together: Mary, Alison, Irene and John. In 1965, the family migrated to Australia. Alice previously worked as a carer in a nursing home, and later as a nanny until she retired.

4. Background and summary of key events

Declaration of global pandemic

4.1 On 31 December 2019, the World Health Organisation (**WHO**) were notified of new cases of viral pneumonia that had been identified in Wuhan, China. Investigations revealed that these cases were caused by a novel coronavirus named Severe Acute Respiratory Syndrome – Coronavirus 2 (**SARS-CoV-2**). The respiratory illness caused by the SARS-CoV-2 virus was later designated COVID-19.

4.2 By 20 January 2020, there were 282 confirmed cases of COVID-19 worldwide. The first three Australian cases of COVID-19 were reported by 25 January 2020.

4.3 ON 28 February 2020, a report into the *WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* was published which noted:

> COVID-19 is transmitted via droplets and fomites [fomites are physical objects which transfer infection] during close unprotected contact between an infector and infectee. Airborne spread has not been reported for COVID- 19 and it is not believed to be a major driver of transmission based on available evidence; however, it can be envisaged if certain aerosol-generating procedures are conducted in health care facilities. Individuals at highest risk for severe disease and death include people aged over 60 years and those with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease and cancer.

4.4 On 12 March 2020, the WHO declared a global pandemic.

4.5 By 11 April 2020, 23 people in NSW had died, and 2,857 people had become infected with COVID-19. There were 225 patients being treated by NSW Health with 32 patients in an intensive care unit (**ICU**) and 19 patients requiring ventilatory support.

Guidelines and policy

4.6 By April 2020, the Commonwealth, NSW Health and other agencies had prepared guidance to assist Residential Aged Care Facilities (**RACF**) prepare for a COVID-19 outbreak. On 13 March 2020, the Communicable Diseases Network Australia (**CDNA**) issued a guideline, adapted from previous sources (including influenza) outbreaks containing key advice (**CDNA Guideline**).

4.7 The CDNA Guideline relevantly provided:

> 1.3. Roles and Responsibilities
> 1.3.1. Residential Care Facility
> The primary responsibility of managing COVID-19 outbreaks lies with the RCF, within their responsibilities for resident care and infection control. All RCF should have in-house (or access to) infection control expertise, and outbreak management plans in place.
> […]
> 3.1. Preparation
> […] Australian healthcare facilities will likely be impacted by a COVID-19 pandemic. It is therefore essential for RCF, in coordination with local and state/territory governments, to ensure that they can manage residents with COVID-19 while maintaining the level of care required for all other

residents. This might include caring for residents who would usually be managed in the hospital setting.

[…]

3.1.3. Workforce Management

Facilities should have a staff contingency plan in the event of an outbreak where unwell staff members need to be excluded from work for a prolonged period until cleared to return to work.

[…]

The workforce management plan should be able to cover a 20-30% staff absentee rate.

4.8 A summary of the guidance available at the commencement of the COVID-19 outbreak at Newmarch House (**the Outbreak**) has been usefully prepared by Counsel Assisting and can be found at **Appendix A**.

Dorothy Henderson Lodge

4.9 On 3 March 2020, a COVID-19 outbreak occurred at BaptistCare Dorothy Henderson Lodge Aged Care Home (**Dorothy Henderson Lodge**), another RACF, at Macquarie Park. As will be discussed later in these Findings, the response to this outbreak serves as a helpful point of comparison in several respects, due to the general similarity in patient cohorts, and the attendance of a number of key personnel who responded to the outbreaks at both Dorothy Henderson Lodge and Newmarch House.

4.10 In total, 17 out of 76 residents became infected with COVID-19. The residents who tested positive for COVID-19 were initially all transferred to hospital. The outbreak at Dorothy Henderson Lodge was declared over on 7 May 2020. Six residents died as a result of the outbreak.

Preparation by Anglicare

4.11 Newmarch House is operated by Anglicare Community Services, trading as Anglicare Sydney (**Anglicare**). Anglicare is part of a network of faith-based care organisations that are linked to the Anglican Church, which had international expenditure of about $1.82 billion in 2020.

4.12 Anglicare runs 23 residential aged care facilities in NSW, all of which are required to be accredited by the Aged Care Quality and Safety Commission (**ACQSC**). Anglicare has a Board of Directors, a CEO and a senior management team who oversee those operating Newmarch House.

4.13 Prior to April 2020, Anglicare took a number of steps to prepare for a COVID-19 outbreak in one of its RACFs. These steps included the following:

(a) On 10 March 2020, a Crisis Management Team (**CMT**) was created. The CMT met frequently during the outbreak, reviewed government guidance, and updated Anglicare policies and guidance in relation to a possible outbreak.

(b) On 19 March 2020, Anglicare ordered 70 iPads to ensure that residents could remain connected with relatives and friends throughout an outbreak.

(c) Personal Protective Equipment (**PPE**) stocks were increased and stored at an Anglicare site in Castle Hill. However, due to widespread shortages nationally with the supply of gloves and masks, the procurement manager made attempts to obtain further PPE from Commonwealth supplies. Despite these measures, on 20 March 2020, Grant Millard, CEO of Anglicare, expressed concerns about the availability of PPE to the Anglicare Board.

(d) Refresher training for staff regarding infection control practices was encouraged but not mandated.

(e) In March 2020, a voluntary surge workforce was created because it was anticipated that some staff would be unable to work if there was an outbreak. The workforce was recruited from within the organisation and trained in the use of PPE and infection control. By 1 April 2020, there were 30 employees in the surge workforce, which increased to 40 employees by 23 April 2020.

4.14 At Newmarch House, certain preparations were also made:

(a) On 4 March 2020, screening questionnaires were introduced for all visitors;

(b) From 9 March 2020 all entrances, other than the main entrance, were closed;

(c) From 23 March 2020, the facility was placed into lockdown (the day prior to the publication of a Public Health Order which would have the same effect), with no visits other than from staff or contractors.

4.15 In March 2020, the ACQSC issued a self-assessment questionnaire to approved providers of RACFs, seeking to identify whether they were prepared for a COVID-19 outbreak. Erica Roy, Anglicare's General Manager – Service Development and Practice Governance, completed the questionnaire for Newmarch House on 24 March 2020.

4.16 In the questionnaire, Anglicare indicated that it met all requirements, including having a staffing contingency plan in case to 20 to 30% of staff were able to work. That contingency had been based on the CDNA Guidelines. Anglicare also stated that it had identified ways to reduce transmission through isolating or "*cohorting*" residents. Overall, Anglicare rated its readiness in the event of a COVID-19 outbreak to be "*best practice*".

Preparation by NSW Health

4.17 Pursuant to section 7 of the *Public Health Act 2019*, the NSW Government imposed a series of restrictions on public gathering and movement:

(a) On 16 March 2020, a ban was imposed on gatherings of more than 500 people;

(b) On 23 March 2020, entertainment facilities, pubs and clubs, restaurants and places of worship were closed;

(c) On 24 March 2020 residential aged care facilities were locked down, with no person permitted to enter these facilities other than employees, contractors, and people providing end-of-life support for a resident of the facility;

(d) On 31 March 2020, a general lockdown was introduced with persons directed not to leave their place of residence without a reasonable excuse.

4.18 NSW Health issue guidance for the Aged Care sector, including the Interim Guidelines issued on 12 March 2020.

4.19 On 16 March 2020, the Nepean Blue Mountains Local Health District (**NBMLHD**) issued its COVID-19 Planning Document, which relevantly identified the following criteria for inpatient admission of a person with COVID-19:

> Criteria for admission to the ward for suspected/confirmed Covid-19 (pending a national guideline):
> - Severe respiratory distress
> - SpO2 ≤ 93% on room air
> - Adolescent or adult: respiratory rate > 30 breaths/min
> - Child: respiratory rate < 2 months: ≥ 60; 2–11 months: ≥ 50; 1–5 years: ≥ 40 breaths/min
> - Otherwise considered unwell enough for hospitalisation or significant comorbidities
> - Inability to self-isolate

4.20 NBMLHD also held staff meetings with aged care providers to discuss the development of their Outbreak Management Plans and related issues to prepare for an outbreak.

Preparation by the Commonwealth

4.21 The Commonwealth Government made arrangements for workforce surge capacity in the event of outbreaks in the Aged Care sector. The Commonwealth entered into deeds of standing offers with agencies, including Aspen Medical and online platform Mable Technologies, to provide staff to aged care facilities in the event of an outbreak. On 12 April 2020, Minister Colbeck announced the availability of this workforce.

4.22 The Commonwealth also sought to obtain supplies of PPE, which were to be made available to Aged Care providers through the National Medical Stockpile.

4.23 The Commonwealth also issued guidelines including the CDNA Guidelines. On 18 February 2020, the Department of Health issued the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)*. This Plan did not specifically provide advice for the Aged Care sector and was targeted more broadly at healthcare.

5. Newmarch House

5.1 Newmarch House is a 102-bed residential aged care facility which opened in 2012. It is located in Kingswood in Western Sydney, only a short distance from Nepean Hospital. There were 97 residents in Newmarch House at the time of the outbreak.

5.2 Each resident has an individual room with ensuite bathroom. There are common dining rooms and other shared spaces. The individual rooms are divided into three separate wings, called Blaxland, Lawson and Wentworth. Part of Wentworth, called Wentworth Heights, caters for high-care residents including those with dementia.

5.3 Prior to the Outbreak, Newmarch House had met all expected outcomes of the ACQSC at each accreditation. Comments from the families of some of the residents prior to the outbreak show that it was highly regarded and a desirable place to reside, in particular because of the qualities of the site. The overall experience was that the staff at Newmarch House were conscientious, and fostered a loving and caring environment for the residents.

5.4 By way of example, family members of some of the residents who died during the Outbreak made the following statements:

(a) Susan O'Neill, daughter of Raymond Jennings: "*I knew [Newmarch House] as one of the most respected and sought-after aged care facilities in the Penrith area. Two of my friends had parents who had been in Newmarch and they spoke very highly of the facility and management. I also knew a health care worker who visited Newmarch regularly and who told me that he would not put his own mother anywhere else*";

(b) Karen Brownlee, daughter-in-law of Edith Brownlee: "*During that three years [April 2017 to March 2020] we had no problems with Newmarch House. In fact, I have nothing but respect and praise for the staff. It is not always easy caring for older people on a daily basis*";

(c) Mary Van Put, daughter of Barry Jehan: "*Prior to dad being placed into Newmarch House in a full time capacity, he had stayed there twice in respite care and I found this facility to be lovely and a nice place to visit. Dad was comfortable there and the staff were lovely. I felt relieved placing him there and felt that he would be well cared for*";

(d) Kay Yates, daughter of Shirely Yates: "*Mum had really liked Newmarch House when she had visited many times prior to being put on the waiting list*"; and

(e) Glenn Billinghurst, son of Blanche Billinghurst: "*I continued looking at numerous homes between Springwood and Blacktown before settling on Newmarch House. I considered this the best home as it was well maintained, clean, spacious and modern*".

6. The Outbreak

6.1 On the evening of Saturday, 11 April 2020 (Easter Saturday), a staff member from Newmarch House (referred to as X) tested positive for COVID-19 after undergoing Polymerase Chain Reaction (**PCR**) testing at Nepean Hospital on 10 April 2020.

6.2 X had worked a mix of day and evening shifts on 30 and 31 March, and 1, 2, 4 and 6 April 2020. X had mainly worked in Blaxland wing, but had also worked in Lawson wing on 2 April 2020.

6.3 There is some evidence that X had experienced COVID-19 symptoms on 1 April 2020, but not on subsequent days. There is no evidence that X was aware that they might have COVID-19 prior to 11 April 2020, when a member of X's family tested positive for COVID-19. By that time, X had stopped working at Newmarch House.

6.4 No earlier case of COVID-19 had been positively identified within Newmarch House. Although it is possible that X acquired COVID-19 from an unknown source within Newmarch House, it is more likely that X acquired COVID-19 from a family member. From there, it is likely that the COVID-19 virus was transmitted from X to staff and residents at Newmarch House.

6.5 During March and April 2020, a COVID-19 outbreak occurred at a childcare centre in Blacktown. Samples obtained from the outbreak showed that the virus belonged to a single genomic cluster, identified as NSW 6.0. Genomic testing later confirmed that a member of X's family, and all of the deceased residents and staff for whom genomic testing could be undertaken, contracted a virus belonging to the same genomic cluster. This then suggests it is highly likely that X was the source of the Outbreak and contracted the virus from a family number.

7. Timeline of key events

7.1 The following is a summary of key events during the Outbreak:

7.2 Saturday, 11 April 2020:

Confirmed cases:	1 staff
Key Events:	• Newmarch House was notified of the Outbreak by phone call at 10:40pm. • Residents were to be confined to their rooms

7.3 Sunday, 12 April 2020:

Confirmed cases:	1 resident, 1 staff
Key Events:	• CA became the first resident to test COVID-19 positive, having undertaken a PCR test on 10 Aril 2020. • Dr James Branley, the on-call infectious diseases physician at Nepean Hospital, attempted to contact Newmarch House but was unable to get through. As a result, he later attended Newmarch House in person.

7.4 Monday, 13 April 2020:

Confirmed cases:	1 resident, 1 staff
Key Events:	• CA became the first resident to be admitted under Hospital in the Home (**HITH**). • Temperature testing of staff was commenced consistently, using infrared for monitors. • An infection control CNC from Nepean Hospital (Robert Robinson) attended to review practices, and stated that they were satisfactory.

7.5 Tuesday, 14 April 2020:

Confirmed cases:	4 residents, 6 staff
Key Events:	• Approximately 40 staff (34% of the workforce) were in isolation. Anglicare approached the Department of Health for additional staff and between 16 April and 30 June 2020, a total of 32 staff from Mable were engaged at Newmarch House. • The first PCR test of all residents was conducted. From this test a total of 16 residents were later confirmed to be COVID-19 positive, including Raymond Jennings, Ronald Farrell, Edith Brownlee, Maria James, Keith Smith, Leonie Corrigan, Shirley Yates, Blanch Billinghurst and Victor Stone.

7.6 Wednesday, 15 April 2020:

Confirmed cases:	13 residents, 16 staff
Key Events:	• Daily meetings commenced between Anglicare, the Department of Health, NBMLHD and the ACQSC.

7.7 Thursday, 16 April 2020:

Confirmed cases:	20 residents, 10 staff
Key Events:	• Staff from Mable commenced working at Newmarch House. • Two significant meetings were held regarding the approach to be taken to the outbreak, including whether or not to transfer residents to hospital.

7.8 Friday, 17 April 2020:

Confirmed cases:	20 residents, 10 staff
Key Events:	• A second full PCR screen of all residents and staff was conducted. From this, seven residents were later confirmed to be COVID-19 positive, including Margaret Brocklehurst, David Gee, Fay Rendoth and Margaret Sullivan. • Further PCR testing continued after this date until 18 May 2020. • One resident, who was COVID-19 negative, was transferred to Nepean Hospital following a fall in which she sustained a fracture. • An Anglicare Special Board meeting was held and the Board was advised that 31 COVID-19 cases had been reported, and that 40 staff members had been stood down to self-isolate.

7.9 Saturday 18 April 2020:

Confirmed cases:	27 residents, 13 staff
Deaths	1
Key Events:	• Raymond Jennings became the first resident to die during the outbreak. • By 18 April 2020, 87% of the workforce was in isolation. • The first teleconference was held with GPs who ordinarily attended Newmarch House. Among other things, they were asked to prioritise contacting family members of COVID-positive patients regarding advance care plans.

7.10 Sunday 19 April 2020:

Confirmed cases:	28 residents, 14 staff
Deaths	2
Key Events:	• Ron Farrell was the second resident to die.

	• 50% of the surge team was in isolation due to positive results or close contacts.

7.11 Monday, 20 April 2020

Confirmed cases:	28 residents, 14 staff
Deaths	2
Key Events:	• Newmarch House experienced severe staff shortages this day. • A further PCR test was undertaken of residents. • Anglicare accepted an offer of workforce support through Aspen Medical. Aspen medical deployed an Emergency Response Team to Newmarch House. • A total of 40 staff, including a Clinical First Responder, and 11 Registered Nurses were deployed during the period from 20 April to June 2020.

7.12 Tuesday 21 April 2020

Confirmed cases:	28 residents, 14 staff
Deaths	3
Key Events:	• Edith Brownlee was the third person to die during the outbreak. • Staff from Aspen Medical arrived onsite at Newmarch House. Initially, two nurses and an infection control CNC attended.

7.13 Wednesday 22 April 2020:

Confirmed cases:	30 residents, 15 staff
Deaths	3

7.14 Thursday 23 April 2020:

Confirmed cases:	30 residents, 15 staff
Deaths	4
Key Events:	• Maria James (78) died. • Alseasons hospitality staff commenced at Newmarch House. • A further PCR screen was undertaken of the residents. A total of five residents were later confirmed to be COVID-positive, including Barry Jehan, Olive Grego and Alice Bacon. • Nurses from St Vincent's Hospital volunteered to attend Newmarch House. They attended from 23 to 28 April, and again from 16 to 19 May 2020. • ACQSC issued an administrative direction to Anglicare, requiring Anglicare to appoint an advisor and support team to help manage

	Newmarch House. Anglicare agreed to appoint BaptistCare to fulfill this role. • A webinar was held for families of residents at Newmarch House, facilitated by the Older Persons Advocacy Network (OPAN). Dr Branley and Mr Millard spoke to residents about the outbreak.

7.15 Friday 24 April 2020:

Confirmed cases:	32 residents, 17 staff
Deaths	5
Key Events:	• Margaret Brocklehurst died. • BaptistCare staff attended Newmarch House to support in the management of the outbreak, following the administrative direction from ACQSC. This included nurses Tracey Burling, who acted as Residential Manager; Cheryl Burke, who acted as Clinical Care Manager; and Melanie Dicks. • All residents were discharged from HITH, so that they could have access to care from GPs under the Medicare Benefits Scheme. The residents were reclassified as outpatients.

7.16 Saturday 25 April 2020

Confirmed cases:	34 residents, 19 staff
Deaths	6
Key Events:	• Keith Smith died. • BaptistCare staff directed staff at Newmarch House ceased using the iCare electronic medical notes system, and start using paper records instead, as many agency staff members were not familiar with iCare. • BaptistCare also ceased inductions for new staff, instead training new staff as needed during the day. • Shirley Yates was transferred to Nepean Hospital. She had suffered a fall on 19 April 2020 and it was suspected she had fractured ribs. She remained at Nepean Hospital until her death on 27 April 2020.

7.17 Sunday 26 April 2020

Confirmed cases:	34 residents, 19 staff
Deaths	6

7.18 Monday 27 April 2020

Confirmed cases:	34 residents, 20 staff
Deaths	8
Key Events:	• Leone Corrigan and Shirley Yates died.

7.19 Tuesday 28 April 2020

Confirmed cases:	34 residents, 22 staff
Deaths	12
Key Events:	• Four residents died: Barry Jehan, CA, Blanche Billinghurst and David Gee. • An open letter was sent to Anglicare on behalf of 94 family members of residents at Newmarch House. This raised concerns with communication in particular. • Window visits were also recommenced, with relatives booking visits via an online system.

7.20 Wednesday 29 April 2020

Confirmed cases:	34 residents, 22 staff
Deaths	12
Key Events:	• A further PCR screen was undertaken. • 3 further residents were confirmed to be COVID-positive, including Ann Fahey. These were the last residents to test positive during the outbreak.

7.21 Thursday 30 April 2020

Confirmed cases:	37 residents, 22 staff
Deaths	13
Key Events:	• Victor Stone died. • A second webinar was held between Anglicare and family members.

7.22 Friday 1 May 2020

Confirmed cases:	37 residents, 26 staff
Deaths	13
Key Events:	• Kathy Dempsey (Senior Manager, Healthcare Associated Infections, Clinical Excellence Commission) attended Newmarch House and commenced a review of infection control practices at Newmarch House. She and her team provided advice on an ongoing basis regarding infection prevention and control. She provided reports on 1 and 24 May, and 11 June 2020. A COVID-negative resident was transferred to Nepean Hospital for treatment.

7.23 Saturday 2 May 2020

Confirmed cases:	37 residents, 26 staff
Deaths	14
Key Events:	• Ann Fahey was transferred to Nepean Hospital, where she died later that day. • A COVID-negative patient was also transferred to Nepean Hospital that day. • The process of moving residents to cohort them according to COVID status was commenced. The process took 6 days to complete, and was complex, involving storing residents' possessions and thorough room cleaning.

7.24 Sunday 3 May 2020

Confirmed cases:	37 residents, 26 staff
Deaths	14
Key Events:	• A COVID-negative patient was transferred to Nepean Hospital. • ACQSC issued a Non-Compliance Notice to Anglicare, pursuant to s. 63C(2) Aged Care Quality and Safety Commission Act 2018 (Cth). It identified serious non-compliance with Anglicare's obligations. • Anglicare announced the Family Support Program, which was coordinated by Mr Kinkade.

7.25 Monday 4 May 2020

Confirmed cases:	37 residents, 26 staff
Deaths	15
Key Events:	• Mark Vidakovic died. • Daily PCR testing of all staff at commenced at Newmarch. Staff were tested daily until 11 May. On 11 May daily throat swabs commenced, and from 18 May staff were tested weekly until 12 June. • Public health leadership was transferred from Nepean Hospital to the PHEOC. • Step down planning for the outbreak was also being prepared at this point.

7.26 Tuesday 5 May 2020

Confirmed cases:	37 residents, 29 staff
Deaths	16
Key Events:	• Olive Grego died.

7.27 Wednesday 6 May 2020

Confirmed cases:	37 residents, 29 staff
Deaths	16
Key Events:	• ACQSC issued a Notice of Requirement to Agree to Anglicare, pursuant to s. 63U Aged Care Quality and Safety Commission Act 2018 (Cth), which required Anglicare to undertake action including to appoint Andrew Kinkade as an independent advisor to Newmarch House. • An Anglicare Special Board meeting was convened, which agreed to accept all actions required under the Notice.

7.28 Thursday 7 May 2020

Confirmed cases:	37 residents, 30 staff
Deaths	16

7.29 Friday 8 May 2020

Confirmed cases:	37 residents, 32 staff
Deaths	17
Key Events:	• Fay Rendoth died. • Andrew Kinkade was appointed independent advisor. • A COVID-negative resident was transferred to Nepean Hospital. • BaptistCare staff completed their 2-week period of assistance.

7.30 Monday 11 May 2020

Confirmed cases:	37 residents, 32 staff
Deaths	18
Key Events:	• Margaret Sullivan died.

7.31 Sunday 17 May 2020

Confirmed cases:	37 residents, 32 staff
Deaths	18
Key Events:	• A COVID-positive patient was transferred to Nepean Hospital with chest pain.

7.32 Monday 18 May 2020

Confirmed cases:	37 residents, 32 staff
Deaths	18
Key Events:	• Routine PCR testing of residents ceased, with only symptomatic residents being tested.

7.33 Tuesday 19 May 2020

Confirmed cases:	37 residents, 32 staff
Deaths	19
Key Events:	• Alice Bacon died.

7.34 Monday 15 June 2020

Confirmed cases:	37 residents, 34 staff
Deaths	19
Key Events:	• NSW Health declared the outbreak to be controlled. • Of the 97 residents at Newmarch House, 37 had tested COVID-positive and 19 had died. • 34 staff members had also tested COVID-positive.

8. What issues did the inquests examine?

8.1 Prior to the commencement of the inquest, a list of issues was circulated amongst the sufficiently interested parties in September 2021, identifying the scope of the inquest and the issues to be considered. That list identified the issues set out below for consideration:

(1) Preparedness

Whether Anglicare was adequately prepared for a COVID-19 outbreak at Newmarch House, with regard to the following matters in particular:

(a) What was known at the time of the outbreak about COVID-19, including guidance from State or Commonwealth government agencies;

(b) Applicable policies and procedures;

(c) Applicable decision-making structures and knowledge of the role of Anglicare and government entities in responding to an outbreak in a residential aged care facility;

(d) Staffing levels and training, including surge workforce preparedness; and

(e) Available resources, including personal protective equipment (PPE).

(2) Communication and visits

Whether Anglicare communicated adequately with residents' families and the impact of this factor (if any) on the care and treatment of residents, with regard to the following matters in particular:

(a) The frequency and content of communication with families, both generally (in relation to the progress of the outbreak at Newmarch House and the implementation of measures to contain it) and specifically (in relation to individual residents);

(b) The availability of family visits;

(c) The barriers to effective communication and family visits;

(d) Steps taken to improve communication and family visits; and

(e) The extent, if any, to which communication issues impacted on residents' (or next of kin's) ability to provide informed consent to particular treatment paths or options.

(3) Hospital in the Home

Whether it was appropriate to care for COVID-19 positive residents at Newmarch House under the Hospital in the Home (HITH) model, with regard to the following matters in particular:

(a) The policy and procedure relating to HITH;

(b) How, why and by whom a decision was made to care for residents under HITH;

(c) The capacity of Newmarch House to support HITH, including with respect to: staffing levels; staff training, qualifications and familiarity with residents' care needs; availability of medical and protective equipment; the physical environment; and external resources;

(d) Whether the decision to implement HITH was appropriate at the time of implementation;

(e) Whether the decision to implement HITH was reviewed, or should have been reviewed, in view of the increasing number of COVID-positive residents and the co-morbidities of those residents;

(f) Whether residents and relatives gave informed consent to participation in HITH; and

(g) The adequacy of discussions regarding Advance Care Plans and Advance Care Directives, in the context of the outbreak, and any impact of those plans or directives on the decision not to transfer residents to hospital.

(4) Staffing at Newmarch House

Whether Anglicare provided adequate and appropriately trained staff at Newmarch House during the outbreak, with regard to the following matters in particular:

(a) The staffing levels required, both prior to and during the outbreak;

(b) The impact of the outbreak on staffing numbers;

(c) The surge workforce and its adequacy;

(d) The role of State and Commonwealth government in assisting Newmarch House with staffing shortages; and

(e) The impact of staffing shortages on residents' care.

(5) Infection control

Whether adequate infection control measures were implemented at Newmarch House during the outbreak, with regard to the following matters in particular:

(a) Consultation with expert(s) prior to and during the outbreak regarding the ability of Newmarch House to adequately respond to a COVID-19 outbreak;

(b) What was known at the time about infection control, including any guidance from State and Commonwealth government;

(c) The availability of PPE prior to and during the outbreak;

(d) The use of PPE by staff at Newmarch House, including training and guidance;

(e) Processes implemented for infection control, including cohorting of residents;

(f) The role of State and Commonwealth government in assisting Newmarch House with infection control;

(g) Where relevant, the impact of any lack of PPE or lapses in infection control; and

(h) Measures undertaken to improve infection control.

8.2 Between June 2020 and July 2022, six reviews were conducted in forums outside of the coronial jurisdiction into the Outbreak at Newmarch House. A summary of these reviews has been helpfully prepared by Counsel Assisting and can be found at **Appendix B**. Each of these reviews considered different aspects of the Outbreak, although none focused with any specificity on the individual residents who died. Given the outcomes of these earlier reviews which canvassed many of the issues set out above, it was determined that the inquest would focus primarily on the issues underlined above. Some issues have been dealt with together for convenience.

8.3 In order to assist with consideration of some of the above issues, independent opinions were sought from the following experts as part of the coronial investigation:

(a) Professor Craig French, intensivist;

(b) Professor Joseph Ibrahim, geriatrician;

(c) Associate Professor Tom Kotsimbos, respiratory physician;

(d) Professor Susan Kurrle, geriatrician; and

(e) Professor Raina MacIntyre, epidemiologist.

8.4 In addition, NSW Health obtained an opinion from Professor Catherine Bennett, epidemiologist.

8.5 Each of the above experts provided one or more reports which were tendered into evidence, and also gave oral evidence during the course of the inquest.

Structure of Findings

8.6 These Findings have been divided into two parts as follows:

(a) Part One deals with the common issues set out above relating to the 19 residents who died, and more generally;

(b) Part Two deals with the particular circumstances of each of the 19 residents who died, and specifically the required findings pursuant to section 81(1) of the Act.

8.7 Following the conclusion of the evidence in the Inquest, Counsel Assisting prepared exhaustive and helpful Closing Submissions. Much of the factual and other material contained within these submissions are not controversial and have not been contested by any of the sufficiently interested parties. These portions of the Closing Submissions have been accepted and reproduced in these findings, particularly in Part Two. Where submissions to the contrary have been made by one or more of the sufficiently interested parties, the contested issues have been resolved in these Findings.

PART ONE

9. The initial response by Anglicare to the Outbreak

9.1 At 10:40pm on 11 April 2020, the Nepean Public Health Unit (**PHU**) informed a nurse at Newmarch House that X had tested positive for COVID-19. Melinda Burns, Residential Manager, Anglicare, contacted other staff members to implement the Operational Action Plan.

9.2 At 11:15pm, Ms Burns contacted David Goodhew, General Manager, Villages at Anglicare, to advise of the outbreak. Mr Goodhew notified senior staff and executives (Gavin Pretorius, Eric Aldeguer, Shehan Micheal Wickremasinghe, and Mr Millar) and later sent an email at 12:37am on 12 April 2020.

9.3 The PHU initially provided the following advice to Newmarch House:

(a) All residents were to isolate and remain in their rooms with no visitors;

(b) Staff needed to wear PPE when looking after residents;

(c) Staff who have been in contact with COVID-19 -positive persons needed to self-isolate and get tested.

9.4 Newmarch House was asked to provide staff rosters and a "*line listing*" of all staff and residents. The line listing included details of the infected residents and staff, their location, their symptoms, COVID-19 testing status and results. Newmarch House provided this information to the Nepean Blue Mountains Local Health District (**NBMLHD**) each day from 12 April 2020.

9.5 At 10:30am on 12 April 2020, a teleconference was held between the PHU, NSW Health and Newmarch House. It was confirmed that Newmarch House was in "*full lockdown*" meaning that residents were considered to be close contacts and not permitted to leave with their families. At that stage it was believed that 89 residents and 27 staff members may have been exposed to the virus. Staff were advised to wear full PPE in the residence.

9.6 Later on 12 April 2020, families of residents were advised of the Outbreak. On 13 April 2020, families were advised in a letter that "*no resident will be able to leave the home because of the risk of cross infection*". Although Newmarch House had been placed into lockdown on 23 March 2020, all residents were then to be isolated in their rooms.

10. Did Anglicare demonstrate adequate leadership and governance during the Outbreak?

10.1 Mr Millard had ultimate responsibility for managing the Outbreak. He was responsible for overall leadership and implementing Anglicare's strategic plan, as determined by Anglicare's Board.

10.2 On 12 March 2020, Mr Millard established the CMT in order to prepare for a possible outbreak. The CMT was involved in reviewing and updating policy and guidance. On 12 April 2020, the CMT held its first meeting regarding the Outbreak. Amongst other things, the CMT discussed the possibility of using another Anglicare site. Further CMT meetings were held every one to two days from this point.

10.3 On 9 April 2020, the Anglicare Board met, two days before the Outbreak. It next met on 17 April 2020 at a special meeting, and again on 28 April 2020, and 6, 12 and 27 May 2020. At these meetings, Mr Millard updated the Board on developments as they occurred. Mr Millard also had discussions with Mr Hammond, Chairman of the Board, between these dates.

10.4 Ann Wunsch, Executive Director of the ACQSC COVID-19 Taskforce, stated that the ACQSC found it difficult to obtain relevant information from Anglicare about Newmarch House during daily meetings. Although questions had been asked about where COVID-19 positive patients were located, who was the facility manager, who was leading management of the Outbreak, and what management structures were in place, they were not answered.

10.5 Tracy Burling, the Acting Residential Manager at Dorothy Henderson Lodge who was asked to assume the role of Facility Manager at Newmarch House, said that it was unclear to her who Ms Burns reported to and whether Ms Burns "*was receiving the necessary direct and effective support from a crisis management team or senior executives*". At one of her first meetings after arriving at Newmarch House on 24 April 2020, Ms Burling described Ms Burns as "*overwhelmed*" and said that Ms Burns was unable to tell her how many residents had tested positive for COVID-19, who was infected and where they were located. Ms Burling went on to describe Newmarch House as being "*chaotic*" when she first arrived, and that management "*were neither sufficiently present or taking action to bring the facility back to a state of calm where the outbreak could be effectively contained*".

10.6 Ms Dempsey first attended Newmarch House on 1 May 2020. In a report prepared from this attendance, Ms Dempsey noted the following:

> What was evident from entrance is the many staff members and different agencies on site which creates a level of chaos and crowding, the overall governance to pull each of those agencies under one (1) reporting structure appeared lacking, clinical management/leadership models would also facilitate a consistent and controlled clinical environment.

10.7 Ms Dempsey was asked about the effect of a number of different agencies being present and gave this evidence:

> [A]lthough there were some Newmarch House management on site, there wasn't a clear hierarchy that the clinicians on the floor seemed to know or understand. So a constant theme was the clinicians on the floor didn't seem to know who they needed to go to if they had questions or concerns.

10.8 In contrast, Ms Dempsey gave this evidence about her experience at Dorothy Henderson Lodge:

> It was a completely different environment. What I took away from Dorothy Henderson was that they had clear management structure from on site, you know, regardless of what agencies came in, they clearly continued to manage the site. They had clear direction on scheduling and making sure that staff were aware what their escalation process was. I didn't get that same sense at Newmarch House.

10.9 Ms Burns was the Newmarch House residential manager at the time of the outbreak, and worked almost continuously during the initial phase of the Outbreak before taking sick leave in July. Ms Burns was asked what the situation as like "*on the ground*" and described it in this way:

> It was a traumatic situation. You had really no idea what was going to happen next. You didn't know if you were going to have any staff at all. Staff would appear and then say they didn't know that there was COVID in the facility and they would leave and go home. People who would refuse to look after COVID positive residents. You had no one there to serve meals or heat or cook them. You were just trying desperately just to make sure that the basic needs of the people that you really wanted to provide care for were there, and you wanted to be able to communicate some sort of reassurance to the families, but it was extremely hard to do.

10.10 In her evidence, Ms Burns agreed with the description given by Ms Burling, set out above, regarding an ability to provide basic information regarding a resident's infection status and where they were located within the facility. Ms Burns also agreed in evidence that she was overwhelmed, not receiving necessary direct and effective support from a CMT, and the senior executives of Anglicare.

10.11 Mr Millard appeared to agree in evidence with the suggestion that Ms Burns' role became overwhelmed and overburdened. He went on to give this evidence:

> The role of a residential manager is already, even in peacetime, an extremely challenging role. And, in the midst of a crisis like this, it is overwhelming.

10.12 Later, Mr Millard was asked whether it would have been desirable for senior executives to be present on site to ensure strong management and leadership through a crisis. Mr Millard initially gave this evidence:

> Well, one of the many learnings about COVID response is the criticality of the residential manager pivoting from what might be their normal mode of management to that of a sometimes referred to as a [command and] control posture. That is the case, every outbreak that we have experience, which I think all but one of Anglicare's homes has had at least one outbreak, and that is I think the general position of the Aged Care Quality and Safety Commission that the role of the residential manager needs to pivot to change, to be much more commanding, have a greater presence and more robust style. At that time I don't believe that was in or the experience was it wasn't in the capability of residential manager of Newmarch House at the time, that BaptistCare personnel now all who came in, I think they had proven that they had that, and these were people who BaptistCare themselves flew in to help at Dorothy Henderson Lodge, they were a group of experienced managers.

10.13 Christine Giles was recruited from within Anglicare to the surge workforce to support Ms Burns. She commenced on 17 April 2020. Ms Burns gave evidence that there was no clear definition of her role and that she herself did not have a clear expectation of what her role was but that she was "*doing everything with operations, managing stock, rostering, complaints, ordering, infection control; you name it, everything*". Ms Giles also gave evidence that she reported to three different people (Mr Aldeguer, Mr Goodhew, and Mr Pretorius), none of whom were present on site during the early period of the Outbreak. As to the chain of command which existed at the time, Ms Giles gave this evidence:

> There was a lot of confusion. I was there when staff came on duty and assisted with the allocation, and so was Melinda, and I would I guess there was some difficulties there. I didn't know who was who either because I didn't even know the I didn't know the Newmarch staff. So, it was we were all it was there were some challenges.

10.14 Ms Giles described 20 April 2020 as the "*worst day of [her] career*" and said that "*we just didn't have the staff to be able to do what we needed to do*". On this issue of staffing, Ms Giles gave evidence that she was not receiving the support from senior management within Anglicare that she felt was needed. Ms Giles gave evidence that senior management were not regularly on site until 20 April 2020. Ms Giles explained:

> I guess what I could see was happening on the floor was different they had different priorities. I had they had priorities because they're obviously, they were getting complaints constantly. They were looking at communication and family contact. I was looking at clinical care.
> […]
> But I guess it's different when you're on the floor, in the bubble that we used to talk about, than being outside and understanding. You don't you don't get the you don't get the right feeling when you're external. You can't you can communicate it. You can tell people but, unless you're there, seeing buzzers go off and seeing stressed staff and having no food as well for staff difficult.

10.15 Mr Millard attended Newmarch House for the first time on 13 April 2020 for around 45 minutes, and did not return until "*probably the first week of May*". Mr Millard gave this evidence about the frequency of his attendance:

> The management and leadership structure the organisation has is such that I'm accountable for a a large organisation, as I said. In terms of the delegation of authority and leadership, I had two people beneath me, if you like, who had more direct responsibility for engagement and management of the operation. Early on in the outbreak, I gave an instruction to Mr Pretorius to be physically located at Newmarch House. He did stay there for, at least, three days and then withdrew. I understand the issue was that the site was becoming crowded, space was at a premium, and the space that he was occupying was being used for induction and for bringing in a large volume of new staff to be trained.

10.16 Mr Millard also gave evidence that Mr Goodhew attended "*occasionally*" but that it was "*not his practice to be there every day*". When asked whether the situation warranted senior executives being present on site during the point of crisis, Mr Millard gave this evidence:

> With a bit of hindsight, yes, but at the state of situation as it was, with evolving transmission community, looking at the experience of residential aged care operators in Europe and North

> America, I still think it was the right decision not to place all the eggs in one basket, I think that would've been foolish.

10.17 Professor Ibrahim gave evidence that the "*organisation and leadership had substantial gaps*". As to the issue of whether there ought to have been a greater executive presence at Newmarch House, Professor Ibrahim gave this evidence:

> I think, sometimes, you want the executive out of the way and to allow the people that know what they're doing to deal with the, what is a clinical public health emergency. The, the day to day work of the executive team in residential aged care is not dealing with these types of episodes. They're more focused on the business model, financial model, running a business. They're not they're not equipped to run a health related emergency, so, you know, their, their decision to step back in part makes sense, but it also undercuts the culture and the confidence in the staff, who are actually on the front line.
>
> A better approach would be to rotate or split your management team so that you don't have to lose all of them, should something untoward happen. You need you need the presence from your leaders but you also need your leaders to delegate or allow people who know what they're doing to, to get the job done, and I think a an incident controller was desperately needed rather than relying on the CEO to suddenly be fully equipped and knowledgeable about how to manage a an outbreak in a pandemic.

10.18 On 23 April 2020, the ACQSC issued an administrative direction to Anglicare requiring it to appoint BaptistCare to assist in management of the outbreak. Ms Wunsch gave evidence that as it was contemplated that the number of deaths would continue to rise, it prompted this response from the ACQSC:

> So, the accumulative picture, including an inability to get clarity around who was managing the outbreak, and the difficulties that were just accumulating here and just becoming more critical, led us to make contact with the commission. I made contact with BaptistCare. I'm not sure if I spoke to the chairman, Ross Lowe, first or whether I spoke to Allan Waters first. I possibly rang Allan Waters first from BaptistCare, and then was engaged in a conversation with him and Ross Lowe to request that they provide a team to Newmarch to stand up a capability to manage the home and the outbreak, reporting to Grant Millard.

10.19 **Conclusions:** The evidence established that frontline management personnel at Newmarch House did not have a clear understanding of the necessary chain of command and what overall management structures were in place at the commencement of, and during, the Outbreak. Similarly, frontline management personnel did not receive effective and direct support from Anglicare senior executives. Consequently, Anglicare did not demonstrate adequate leadership and governance during the course of the Outbreak.

10.20 The decision made by Anglicare to not have most of its senior executives physically present at Newmarch House was sensible. Had this occurred, it likely would have adversely impacted the day-to-day operations at Newmarch House which required sufficient physical space, and autonomy for staff to attend to their necessary duties. However, the almost complete absence, or only "*occasional*" presence, of any senior executives at Newmarch House during the Outbreak created confusion for frontline management personnel who became overwhelmed and who were seeking strong executive leadership which was not present. Mr Millard appeared to acknowledge this in hindsight.

10.21 The expert evidence established that a better approach would have been to rotate or divide the executive management team to provide effective leadership on the ground, whilst at the same time preserving the ability of the executive management team to perform its own necessary duties.

11. Did Anglicare communicate adequately with the families of residents?

11.1 During the Outbreak, Newmarch House received over 200 phone calls per day. Mr Millard described the impact of this significant increase in enquiries in this way:

> At the start of the outbreak, the staff at Newmarch House were so busy caring for residents and implementing the new infection control procedures, that they did not have time to adequately communicate with the residents' families. Anglicare engaged offsite staff to take over the responsibility of identifying the appropriate contact person for each resident and their contact details so that they could take messages and update them on their loved one's status.

11.2 Mr Millard gave evidence that 87% of staff members who ordinarily worked, and communicated, with families were moved off site due to being close contacts. He explained at the time that staff shortages were "*never contemplated to be that impactful*". This was replaced by what Mr Millard described as "*broadcast communications*" which were "*relevant but generic*" in nature as the communication did not relate to the information that families were actually seeking, namely the status of individual residents. Some staff gave evidence that they were forced to choose between speaking to families or looking after residents, which Mr Millard described as a "*terrible choice*".

11.3 The communication difficulties resulted in other challenges. For example, Susan O'Neill stated that although she was the primary carer and contact for her father, Raymond Jennings, she did not receive notification that her father had died on 18 April 2020. Instead, that notification was provided by "an agency temp at Newmarch" to Ms O'Neill's brother who lived in Bathurst.

11.4 Prior to the Outbreak, Anglicare had prepared a COVID-19 Communications Strategy. It provided that the communication objectives were to be as follows:

- Provide clear, consistent and timely information on the impact of COVID-19 from internal and external sources.
- Provide streamlined points of contact for stakeholders across Anglicare.
- Manage feedback from stakeholders across Anglicare.
- Anticipate and manage issues from stakeholders across Anglicare.
- Monitor and evaluate feedback to measure success and review overarching communications as required.

11.5 On 12 April 2020, Mr Millard sent an email to the family members of residents, advising them that a staff member and a resident had tested positive. The email provided a 1300 number and email address as methods of contact. From this point during the Outbreak, Mr Millard and Mr Pretorius sent regular emails to families that were of a broadcast nature as described above.

11.6 However, some of the broadcast communications were problematic. For example, a letter sent to families dated 22 April 2020, did not accurately convey the gravity of what had been, and was, transpiring within Newmarch House, or the chaos that existed at the time.

11.7 On 23 April 2020, a webinar was established to provide families with information regarding the outbreak. The transcript of the webinar records Dr Branley stating the following:

> For the vast bulk of people who catch this virus they manage to get through it without too much drama and we have a team at Nepean Hospital that's been looking after numerous patients via a mechanism called our Hospital in the Home system and what that means for the vast bulk of patients is they are looked after in their own home, in a familiar surrounding and we fundamentally believe that care in a familiar surrounding is, is really important to people getting well. But during that period of time when they're being looked after in their home we are monitoring some really key indicators to determine if deterioration is occurring and when that's occurring so that we can intervene with the treatments that we have. And that model has been working very well before the Newmarch experience and we have successfully looked after, after many patients using that model. I guess Newmarch is, is a really significant medical challenge for both doctors and nurses in terms of numerous issues of looking after these patients. We have very much stuck to the same model that we have used for patients not in an aged care facility and as much as possible we've mirrored exactly the same treatment that all of our patients have received. An aged care facility however is, is really challenging and it's particularly challenging because the mortality of this virus in the elderly is much higher.

11.8 Mr Millard gave evidence that he was reassured on hearing these comments and accepted that it was likely that family members were similarly reassured. However, when asked whether it was appropriate to reassure families given the circumstances that he understood existed at Newmarch House at the time, Mr Millard gave this evidence:

> Well, I'm not really in a position to comment about medical care because I'm not a clinician, and if an expert like Dr Branley says that, I , given the position, I would trust and believed what he said, but I don't think it was a comprehensive or fulsome description about the state of care and care delivery. I think it was about the model and medical care, and therefore, perhaps incomplete.

11.9 The difficulties with communication prompted a group of 94 members called *Families and Friends of Newmarch House Residents* to send an open letter on 28 April 2020 which stated:

> It is important to remember that the people residing in Newmarch House are vulnerable, physically and mentally. They have been isolated in the facility since midnight on March 23 2020 with restricted visiting hours enforced from March 18 and fully isolated in their individual rooms since the virus was brought into and later discovered in Newmarch on Saturday March 11. We understand that a staff member and one resident tested positive at that time.
>
> Since then communication from Newmarch and Anglicare has been far from satisfactory. Media outlets were reporting information before Anglicare had advised the residents and families. Many more issues came to light and we, as family members, were left in the dark not knowing what was happening in relation to the residents. Phones went unanswered day after day. Calls were not returned. Details about our individual loved one were not provided regularly. The residents were reporting that the care was inadequate and they were becoming distressed. Many of them were sick and frightened and did not have regular access to their family on the outside which increased their levels of anxiety as well as ours.
>
> The inaction of Anglicare to address our concerns in a way that would be considered satisfactory has resulted in feelings of frustration, disappointment, anger and desperation. Not having plans in place where communication lines were established between Newmarch and the family members to discuss regularly the daily health of a resident since full lock down was mandated by Anglicare from March 23 2020, was the beginning of the ensuing chaos that we are now experiencing.

11.10 During the upgrade, Anglicare make efforts to improve communication with families. The Family Support Program was established, with a team of dedicated nurses to respond to questions from families about the care of their loved ones. Andrew Kinkade was an Independent Adviser appointed pursuant to the ACQSC's Notice to Agree. In a final report dated 30 June 2020 it was noted that the launch of the registered nurse call centre reset communications with families, minimised inbound calls (with a 90% reduction in the first few days) and, as at the date of the report, continued to receive strong positive feedback from families.

11.11 Maryann Curry, the Executive General Manager - Residential Care at Anglicare, stated the following:

> Anglicare deeply regrets its shortcomings in its communication with families during the outbreak. Anglicare acknowledges that in the early days of the outbreak, its communication challenges caused a significant amount of grief and distress for the residents and their families. This was a highly challenging time for everyone, most significantly the residents and their families. However presented very significant challenges for Newmarch House staff with respect to delivering services to residents, which impacted on their capacity to communicate with families. That does not excuse that the communication should have been better. However, it reflects the unique challenges that were experienced at the time.

11.12 **Conclusions:** The increase in enquiries and information seeking from families of residents during the Outbreak was significant and understandable. This increase placed additional demands on staff at Newmarch House who were already labouring under a challenging workload of caring for residents whilst employing infection control measures. It resulted in staff being faced with the difficult dilemma of choosing to respond to an enquiry from a family member or provide care to a resident. Although Anglicare had prepared a communications strategy prior to the Outbreak, the various challenges that the Outbreak posed meant that it was not adhered to.

11.13 Instead, during the early stages of the Outbreak, the communication by Anglicare with residents of families was largely generic in nature, targeted at a broader audience rather than individuals. Whilst the information disseminated was relevant, it did not provide families with the specific information that they were seeking about their loved one. In some cases, the information provided was inaccurate or understated the seriousness of what was occurring withing Newmarch House during the Outbreak.

11.14 Anglicare has frankly recognised the deficiencies described above and acknowledged that inadequacies in communication caused additional grief and distress to family members who were already deeply concerned about the welfare of residents.

12. Did Anglicare take adequate steps to obtain sufficient Personal Protective Equipment?

12.1 Anglicare had attempted to obtain sufficient quantities of PPE prior to the Outbreak, and these efforts were renewed immediately following the commencement of the Outbreak. Mr Wickremasinghe, Anglicare's Procurement Manager, attended the Anglicare Castle Hill site at 12:30am on 12 April 2020, to begin the process of transferring PPE to Newmarch House. Mr Goodhew and Mr Aldeguer also attended the site at 7:00am.

12.2 On the afternoon of 12 April 2020, Mr Wickremasinghe contacted the Australian Government Department of Health and Aged Care (**DOH**) and PHU to obtain further PPE. One of the reasons why there was a very high usage of PPE was because staff were initially advised to wear full PPE throughout Newmarch House and did so for all residents and in common areas. In his statement, Mr Wickremasinghe described the challenges in obtaining PPE in sufficient quantities but stated that to his knowledge, at no stage during the Outbreak did Newmarch House run out of PPE. Overall, large qualities of PPE were supplied to Newmarch House from Commonwealth and State resources.

12.3 There were some references in the evidence to inadequate supply of some items, such as N95 masks and gowns. However, it is unclear on the evidence whether this was a result of inadequate supply or distribution, availability within Newmarch House, or individual use.

12.4 It should be noted that this issue has been considered outside of the coronial jurisdiction including by the *Royal Commission into Aged Care Quality and Safety – Aged care and COVID-19: A Special Report* (**Royal Commission**).

12.5 **Conclusion:** The evidence established that Anglicare appropriately attempted, both prior to the Outbreak and once it commenced, to ensure that sufficient quantities of PPE were available. During the initial stages of the Outbreak, the advice provided to staff to wear full PPE throughout Newmarch House meant that PPE usage was considerably high. Despite this, the available evidence indicates that whilst there may have been temporary shortages of some PPE items at times, at no stage did Newmarch House exhaust its supply of PPE. There is also no available evidence that stock levels of PPE adversely impacted the care provided to residents in any way.

13. Were the efforts of Anglicare to obtain sufficient staff adequate?

13.1 The PHU initially advised Anglicare that all staff who had worked since 23 March 2020, and staff or residents who were close contacts with positive patients, should self-isolate. The definition of who was considered a close contact appears to have changed during the Outbreak.

13.2 Anglicare had originally planned for a loss of 20 to 30% of staff, based on the CDNA Guidelines. Accordingly, Anglicare recruited a surge workforce which was activated on 12 April 2020, and staff were deployed to Newmarch House the following day.

13.3 By 13 April 2020, 66 residents were identified as close contacts, and 32 staff members were isolating for two weeks. By 15 April 2020, 40 staff members were self-isolating. Three days later on 18 April 2020, one week into the Outbreak, 87% of the workforce had been lost.

13.4 Anglicare attempted to obtain further staff from other agencies through the Federal Government's initial workforce contingency measures. On 13 April 2020, Anglicare engaged Mable, an online recruitment platform, to supply staff. Whilst Mable proposed a large number of potential candidates, on assessment by Anglicare some were found to have not worked in aged care before, or to not have appropriate skills and qualifications. Staff sourced from Mable began working at Newmarch House from 16 April 2020, with a total of 32 staff working during the Outbreak.

13.5 The Commonwealth also offered Anglicare clinical staff in the form of an Emergency Medical Response Team from Aspen Medical (**Aspen**). These offers were made on 14, 15 and 17 April 2020, before being finally accepted on 20 April 2020.

13.6 On 15 April 2020, Anglicare reported that 40 out of the 90 Newmarch House staff were self-isolating. During a meeting with the Commonwealth, Anglicare indicated that it was considering staff proposed by Mable, and had sufficient staff for the following day. On 17 April 2020, Anglicare reported that staff proposed by Mable were not sufficiently experienced in aged care. Notwithstanding, Anglicare indicated that it had enough staff that day and over the weekend. However, by 18 April 2020, Anglicare had lost 87% of its workforce. Once the offer of a clinical team from Aspen was accepted, over 40 staff members ultimately worked at Newmarch House during the outbreak.

13.7 Mr Millard gave evidence that Anglicare was referred to Mable which was meant to be "*first port of call, and perhaps Aspen may have been available if that fell over*". As to the three offers of assistance, Mr Millard gave this evidence:

> That may be the evidence of the Commonwealth Department of Health if they said that. Whether that offer was actually heard or received is another matter. It certainly wasn't communicated to me, and given our state of need for staff, I find it remarkable that we wouldn't have seized on that offer.

13.8 At 9:00pm on 16 April 2020, there was only one registered nurse and one care staff looking after all 20 COVID-19 positive residents who were located in different sections of Newmarch House.

13.9 Ms Giles stated the following when she arrived at Newmarch House at about 8:00am on 18 April 2020:

> It was immediately obvious when I commenced my shift that staffing was an issue. The residents' buzzers were going off, there were delays in breakfast and residents were complaining they had not been fed. I was also told that a diabetic resident (who was COVID-19 negative) had not received his normal insulin and had a high blood sugar level.

13.10 Ms Giles gave evidence that the fact that a resident had not received his normal dose of insulin "alarmed [her] a lot". She agreed in evidence that residents were seeking care and assistance and not being responded to, and that as a result of the staff shortage, her view was that care was not being provided as she hoped it would be.

13.11 Dr Mohammed Kakkat, senior hospitalist in geriatric medicine with the NBMLHD Virtual Aged Care Service (**VACS**), gave evidence that on 17 April 2020, with 20 residents testing COVID-19 positive, there was the potential for a crisis situation with a number of these residents declining rapidly. Dr Kakkat explained:

> Remember, all the patients need to, need to assess individually, not a blanket thing, right. And if the patient had so many co morbidities and COVID came in between, so there is more chance to get it worse, right.

13.12 The requirement of substantially more staff than during normal operations was due to:

(a) The additional care needs of the residents and corresponding additional expectations as to what care would be provided, so that Newmarch House began to resemble a virtual hospital ward; and

(b) The increased time required to provide such care, due to the need to replace PPE and comply with infection control practices. RN Emma Cardwell gave evidence that a process of "*cluster care*" would be followed meaning that staff would enter a resident's room and provide whatever care was needed (administering medication, taking observations, ascertaining what the resident's care needs were) to avoid making repeated entries into the resident's room. RN Cardwell went on to give this evidence:

> I just want to make it clear that opening the door to a residents room, you needed to be in full PPE, so I just think it's important that it's clear that it's not a matter of opening the door and putting a tray inside, or throwing the medications inside the room and leaving, which people thinking about these incidents might actually think it's as easy as that, and I just want to be clear that to actually safely do those things, and to protect the staff, there is quite a process to doing those things.

13.13 Mr Millard gave evidence that during normal operations there would have been four or five registered nurses per 24-hour shift. However, during the Outbreak, there was on average 26.5 registered nurses, and sometimes up to 40 registered nurses, per 24 hour shift. Although no timeframe was provided as to when this occurred, it appears that it was sometime after the first two weeks of the Outbreak, namely after 24 April 2020.

Staff shortages on 20 April 2020

13.14 Ms Giles described Newmarch House as being "*extremely understaffed*" on 20 April 2020. She stated:

(a) Many of the roster staff had been contacted by the PHU and advised not to attend work as they were close contacts. However the PHU did not advise Newmarch House of this, and the staff themselves also did not do so, assuming that the PHU had done so;

(b) There was only one enrolled nurse during the day shift, and only three registered nurses on duty, two of whom were working their first shift following their registration. At one stage, there was only one registered nurse available to look after approximately 28 confirmed COVID-19 positive residents.

(c) The entire server staff had been directed to self-isolate, meaning that every available staff member at Newmarch House, including the management team and cleaners, were required to assist in kitchen and serveries. Whilst all residents eventually received their breakfast, it was served very late.

13.15 Dr Branley stated that there was a "*crisis in staffing*" due to insufficient staff being present on 20 April 2020, with a "*very low number of registered nurses*". He and others assisted with basic personal care tasks for the residents on this day. He also said that in his view, "*care and infection control was severely compromised on this day due to the overwhelming workload for the limited staff available*".

13.16 Mr Millard described this as a "*terrible situation*" and gave evidence that whilst "*the focus was on the acute shortage of registered nurses*", the experience of Anglicare was that "*registered nurses and care workers were extremely difficult to find*". However, Mr Millard also gave evidence whilst the situation was "*dire*", "*the crisis in terms of the availability of human resources was substantially resolved either immediately prior to or on the day*" and that BaptistCare and St Vincent's teams arrived around 23 April 2020. This was done at the initiation of the ACQSC which appeared to have lost confidence in the onsite management team at Newmarch House and issued an administrative direction to Anglicare on the same day.

13.17 **Conclusions:** Prior to the Outbreak, Anglicare took appropriate steps to ensure that sufficient staff resources were available based on relevant guideline material at the time. However, changes in the definition of who was considered to be a close contact, with the resulting need for self-isolation, meant that the actual staff shortage exceeded what was anticipated.

13.18 The evidence established that during the initial stages of the Outbreak, and in particular from 17 to 20 April 2020, there was a significant deficiency in the number of staff available. This shortage was the result of the increased care needs of the residents, and the additional time and requirements imposed by the Outbreak to perform what would otherwise be routine tasks such as taking observations or enquiring if a resident had any concerns.

13.19 On 20 April 2020, there was a dire staff shortage which resulted in an overwhelming workload for the staff that were available. This in turn meant that infection control and the care provided to residents was gravely jeopardised.

13.20 Although it appears that three offers of assistance to assist with staff shortages were made by the Commonwealth prior to 20 April 2020, the available evidence is unclear as to whether they were communicated to Anglicare. In any event, with the intervention of the ACQSC, by 23 April 2020 additional staff arrived at Newmarch House to address the previous shortages.

14. Were the infection control measures within Newmarch House adequate during the Outbreak?

14.1 There was no infection control expert consistently present on site during the early stages of the Outbreak. Robert Robinson, an infection control specialist from NBMLHD, attended Newmarch House on 13 April 2020 and reviewed infection control practices, finding them to be satisfactory. Mr Robinson attended again on 17 April 2020 and discussed changes to PPE use with Ms Giles. On 19 April 2020, Felicity Hill, the Quality and Compliance Manager of Anglicare, proposed that Anglicare should seek an infection control specialist. However, that suggestion was not followed up at the time. It was not until Ms Dempsey attended the site from 1 May 2020 that expertise was obtained and delivered consistently.

14.2 RN Cardwell gave evidence that, as an experienced ICU nurse, she was confident in her processes regarding PPE and that it became "*muscle memory*" or "*second nature*". However, she went on to explain that the donning and doffing of PPE would have been a new process for less experienced staff from the surge workforce who had not worked in aged care previously.

14.3 Although residents were meant to be isolating in their rooms from 11 April 2020, several residents left their room during the Outbreak. In a meeting between Newmarch House, NBMLHD and the DOH on 16 April 2020, it was recognised that there were challenges with "*wandering behaviour*" of some residents. For example:

(a) On 20 April 2020, Barry Jehan was found sitting in a lounge room not wearing a mask;

(b) CNC Monica Tucker gave evidence that on occasions, residents attempted to leave their room and when they successfully did so, staff would support the residents back into their rooms;

(c) CNC Tucker also gave evidence that before Alice Bacon tested positive for COVID-19 on 24 April 2020, her morning routine was to leave her room and make a cup of tea in the communal area; and

(d) Victor Stone was also found to leave his room on multiple occasions after testing positive for COVID-19.

14.4 It is possible that incidents of this kind contributed to the spread of infection.

14.5 RN Lorena Bestrin gave evidence that when she first attended Newmarch House on 15 April 2020 she was not required to demonstrate that she was COVID-19 negative. She gave evidence that a temperature testing system had not been implemented by that time, and that it was not until a "*week or two*" after she first started that she was asked to show that she was COVID-19 negative. RN Bestrin also gave evidence that prior to the arrival of the BaptistCare team she worked "*everywhere*" and was not allocated to a specific wing.

14.6 Ms Giles stated that on 17 April 2020 she spoke with Dr Branley and CNC Robinson to express concern about the absence of any delineation between COVID-19 positive and negative residents, and the fact that staff were wearing full PPE in the corridors and offices. According to Ms Giles, both Dr Branley and CNC Giles agreed that changes should be made. Ms Giles also expressed concern about

staff moving between areas with COVID-19 positive and negative residents. Dr Branley and CNC Robinson agreed with her suggestion to close off the staff room and have designated staff break areas to reduce the risk of cross contamination.

14.7 However, this risk of cross contamination was not confined to nursing staff. Jake Price, a member of the surge workforce maintenance team, stated that he entered the rooms of both COVID-19 positive and negative patients, although he recalls being very cautious about using PPE and following correct procedures.

14.8 Dr Branley stated that "*[i]n the initial period the standard of infection control was reasonable, although it was not very well organised*". He noted that staff were wearing PPE, residents were isolated in their rooms and whilst "*[w]andering patients posed a challenge from an infection control perspective*", most of these were in Wentworth Heights (the secure dementia ward) and the issue was addressed by relocation of all COVID-19 patients out of Wentworth Heights, which created a COVID-19 free area.

14.9 However, Dr Branley expressed the view that the "*overwhelming workload for the limited staff available*" on 20 April 2020 meant that "*care and infection control was severely compromised on this day*". Dr Branley considered that wandering patients and some fomite breaches "*gave rise to the potential for virus to be spread via the touching of fomites*".

14.10 Dr Branley considered that whilst the issue of low staffing levels had been rectified in the period from 23 April 2020 to 1 May 2020, there were additional challenges: poor coordination between teams meant teams applied different infection control standards, there was reported use of nebulisers which should not have occurred as this is an aerosol generating practice, and vinyl gloves continued to be used despite Dr Branley's request for Nitrile gloves. As to the first of these matters, Dr Branley explained:

> I remember helping delineate issues when people brought issues, and one of the difficulties in infection control is that issues come to you which are what I would describe as technical breaches, and I think there is a difference between technical breaches and major breaches, and I think if you're using a cohort strategy in individual rooms going back to the red line idea, your red line is at the door of those individual rooms, and so where there are breaches at the door level, I think I would have been prioritising those over whether the trolleys looked tidy in the corridor or not, if I can use that as a broad analogy.

14.11 On 1 May 2020, Ms Dempsey attended Newmarch House. Ms Dempsey and her team reviewed, and provided advice and guidance, regarding infection control practices. Dr Branley gave this evidence before the Royal Commission:

> At Newmarch, there were some very good efforts at infection control. And I think, in reality, the infection control that was implemented early at Newmarch was clearly effective at cutting transmission between residents. It was a source of some degree of angst and a lot of discussion amongst staff about variability in infection control practice. And I think the beauty of having somebody very senior, like Kathy, arrive at a facility in the first couple of days of a large outbreak, can't be understated for establishing those rules, establishing one source of truth, and providing particularly the nursing and care staff with a sense of confidence and a sense of discipline about the

application of infection control. That's not to say that the infection control failed at Newmarch, because, clearly, I don't think it did.

14.12 However, despite this apparent improvement, infection control issues persisted. On 20 May 2020, Felicity Hill, Anglicare Quality and Compliance Manager wrote an email to Anglicare executives (including Mr Millard, Mr Aldeguer, and Mr Pretorius) expressing concern regarding PPE processes and changes implemented at Newmarch House and "*the chaos that has insured [sic]*" since a staff member tested COVID-19 positive. Ms Hill also wrote that Ms Dempsey had stated that the constant changes regarding PPE processes "*is what has got us into a mess in the past*" and that she did not think that she could continue in her role "*if this is what we are going to do and go against expert advice and recommendations*". Ms Hill concluded by expressing concerns that "*[w]e have totally confused the infection control processes in place at Newmarch House which actually creates a greater risk to infection control and ongoing changes and compliance*" and that "*[s]taff are in panic and not sure whether they want to work here now - so we have lost confidence of the staff*".

14.13 **Conclusions:** Infection control at Newmarch House during the initial stages of the Outbreak was reasonable but not well-organised. As Mr Robinson was not issued with a notice of sufficient interest, and was not called to give evidence during the inquest, no adverse finding is made with respect to his involvement regarding this issue.

14.14 The absence of an infection control specialist who was consistently on site resulted in instances in which infection control practices were not adequate. The wandering behaviour of some residents, staff who lacked experience in aged care and the use of PPE, inconsistent infection control practices amongst staff, the absence of delineation between residents who were positive for COVID-19 and those who were not, and the use of nebulisers all contributed to these lapses in infection control and the risk of cross-contamination. This risk was most heightened on 20 April 2020 when the overwhelming demands placed on a limited workforce resulted in a further decline in infection control standards.

14.15 Infection control practices improved after 1 May 2020 following the arrival of Ms Dempsey at Newmarch House. However, the evidence established that despite this improvement, sufficient concerns remained about infection control practices which caused staff to lose confidence in the adequacy of these practices. However, the available evidence does not allow for a more precise finding to be made about the extent to which inadequate infection control may have contributed to the spread of COVID-19 within Newmarch House.

15. Were there any lapses in the care provided to the Newmarch House residents?

15.1 RN Bestrin used the expression "*warzone*" to describe her experience at Newmarch House. She gave this evidence about what her experience was of "*what was going on behind the closed doors of each of the residents*":

> I remember because you're in the day was so busy, I was searching. Sourcing thing, finding things before I left, because I felt that I could never leave that place because there was so much to do. But I had to go home. I would walk around, and it was dark. It was in the evening. I and I would hear hear people because asking for help. The residents. And I just walk and I was shocked because it felt like a horror movie, honestly, because I was walking the corridor and everyone would say, "Help, help, help". And I can still picture that. I've tried my every every nurse every nurse tried their best. I know. But things got better when the the BaptistCare team came.

15.2 A number of the residents' family members also described their observations of the care provided to their loved ones:

(a) Virginia Clarke gave evidence that her father, Ron Farrell, called her on 18 April 2020, and reported that he was hungry because he had not been provided with any food, and that his oxygen machine was not working. Ms Clarke gave evidence that she asked her father if he had pressed his buzzer and he indicated that he had but received no response. As Ms Clarke was unsure if her father had pressed his buzzer or not she was prompted to call Newmarch House. She later received a return call around 11:00pm advising that Mr Farrell had been given something to eat and that he had apparently turned his oxygen machine off himself.

(b) Mark Fahey stated that he spoke to his mother, Anne Fahey, on the phone on 11 April 2020 and that she complained she was not receiving her medication on time (for example, on one occasion she received medication at 10:00pm which should have been given at lunchtime), she was not being showered, and that she was not eating properly (only being given bread for lunch and, on one occasion, not receiving a meal until 11:00pm).

(c) According to clinical progress notes, on 19 April 2020, Keith Smith was found on two occasions kneeling down on the floor with a wet pad, incontinent of faeces and urine, and was helped back to bed.

(d) Glenn Billinghurst stated that when he went to visit his mother, Blanche Billinghurst, on 24 April 2020, she complained of being hungry and thirsty. After bringing this to the attention of a nurse, an attempt was made to feed Ms Billinghurst a "*jelly substance*", believed to be thickened fluids. However, Ms Billinghurst was unable to swallow and appeared to be in pain. Eventually, Ms Billinghurst was provided with a small amount of water that had been trapped in a straw. This prompted Mr Billinghurst to query why his mother had not been provided with intravenous fluids.

(e) Jayne Finlay stated that she received several calls from her mother, Fay Rendoth, on 21 April 2020, who reported that her throat was dry, that she had not received any breakfast, and that by 1:41pm she still had not received any food at all.

(f) Mary Watson gave evidence that she went to visit her mother, Alice Bacon, on 12 May 2020, and found her to be a psychic, showing symptoms of nausea and "*quite dry*" as she was "*licking her lips*" and indicating that she was thirsty and wanted a drink. Ms Watson gave it is that her mother was too weak to go to the bathroom unassisted and obtain a cup of water for herself. Ms Watson gave further evidence that when she visited her mother again on 16 May 2020, she appeared "*visibly thirsty again, licking her lips*". Ms Watson observed that there was no water or straws in her mother's room and asked staff for her mother to be given a drink.

15.3 In evidence, Dr Branley stated the tension between infection control processes and the adverse effects of older persons being kept in isolation was a "*really important issue*" and one that he was "*absolutely*" mindful of. Notwithstanding, Dr Branley gave this evidence:

> I didn't have the solution for it, and I think we still don't have the solution for this. In many ways, infection control and patient wellbeing and mental health and physical health are in they're sort of they're in contradiction with each other.

15.4 Dr Branley acknowledged that one of the consequences of the above issues is that over time deconditioning can occur and that this needed to be considered in the decision-making regarding care and treatment. Dr Branley went on to explain:

> I think the other thing is that, and I'm sure we'll get to this, but part of my job in this equation was to actually spend time and try and talk to the patients because they were deprived of human contact, and holding a patient's hand, talking to them, you know, speaking compassionately to them are things that are really important in terms of that isolation phenomena of infection control. Albeit that you're doing that with PPE on, which is not ideal.

15.5 **Conclusions:** The first-hand experience of family members whose loved ones resided at Newmarch House illustrates that there were instances where the basic care needs of some residents were not attended to, or only attended to after significant delay and repeated prompting. The evidence established that on occasion some residents were not administered regular medication, showered, or provided with nutrition and hydration.

15.6 As already noted above, the significant demands placed on staff, the lack of staff experienced in working in aged care, and the isolating effect of infection control practices all contributed to these lapses in care. These lapses, together with effect of isolation itself, created a risk of deconditioning of residents.

16. The PCR Testing regime at Newmarch House

16.1 PCR Testing commenced on 14 April 2020. It was conducted at Newmarch House throughout the outbreak by NBMLHD including Dr Branley and a team of nurses. Test results were provided to the PHU and in turn to Newmarch House. Over the course of the outbreak, a total of 610 resident tests and 2,660 staff tests were conducted.

16.2 Ordinarily, depending on the time of day, a test result is available about 6 to 7 hours after a sample is received, although rapid testing can allow for results to be available within one or two hours. Dr Branley stated that at the time of the Outbreak, the laboratory was aiming for a 24-hour turnaround, although at times this extended to 36 hours due to the volume of testing.

16.3 Although there was an attempt to fast-track samples taken from Newmarch House, delays were still experienced in results being provided. For example, eight residents who were tested on 26 and 27 April 2020 had still not received their results by 29 April 2020. It was also the case that test results were addressed generically to Newmarch House, rather than being communicated to an identified person or practitioner. Dr Branley explained that the samples were labelled as "*Newmarch House*" in order to fast track the results, but acknowledged that this was "*less than ideal*" when communicating such results.

16.4 In his evidence, Dr Branley described some particular challenges with the swabbing process:

(a) To swab an entire wing would take from around 8:00am to around lunchtime;

(b) Whilst it would have been ideal to have swabbed the entire facility every day for a week this was not practical with the amount of time and staff available;

(c) Many people were unfamiliar with the process of testing and reluctant to take part; and

(d) Some residents had co-morbidities such as dementia which made the physical process of swabbing challenging, resulting in less optimal swabs taken of the tongue, rather than the nose or throat.

16.5 As a result, Dr Branley gave evidence that the staff "*performed the best swab we could get*" and that at Wentworth Heights it was "*incredibly difficult to get 100% of the residents swabbed*". Dr Branley gave evidence that because of these difficulties and challenges it was not always possible to obtain a "*good sample*" which may in turn have produced inaccurate results.

16.6 Facility-wide screening was performed on 14, 17, 20, 23 and 29 April 2020. Dr Branley was asked why an attempt was not made to perform site-wide swabbing on 12 April 2020 and gave this evidence:

> I think swabbing resource, we have to remember the time, you know, April 2020, swabs became very routine later in the pandemic, but doing a swab and doing a correct swab was a skill that many nurses did not feel that they had that skill. Sorry, I've said many nurses, what I mean is often our nursing colleagues feel they need a procedure, and they need to have been trained in it, in order to do it, and that's good, sound practice. Many health care workers at that stage had not been trained to take a swab; I had been doing swabbing for some time.

16.7 Dr Branley acknowledged in his evidence that by 12 April 2020 it was known that COVID-19 was highly transmissible, that the population in an aged care facility were a particularly vulnerable group and that a sizeable outbreak in such a facility could potentially be quite calamitous. When asked why then no attempt was made to do more aggressive swabbing on 12 and 13 April 2020, Dr Branley initially gave this evidence:

> I actually believe we were being aggressive, and I actually think that what we achieved with swabbing in those early days was very good, and we actually managed to identify people reasonably quickly, given the size of the problem. So I don't accept criticism for the way we did swabbing, I think we did the best we possibly could.
> […]
> So my recollection is there was very much a debate at that stage, you just sit tight and you wait till people get symptomatic, and you swab them if they're symptomatic. Now that wasn't the approach that I took, I took the approach to systematically go in and swab aggressively.

16.8 Dr Branley ultimately gave evidence that the inability to swab the entire facility on 12 and 13 April 2020, was simply a staff resource issue, whilst noting that the two dates were Easter Sunday and Easter Monday, respectively. In his statement, Dr Branley acknowledged that staff-to-staff transmission was a large part of the severity and extent of the outbreak at Newmarch House. Dr Branley also accepted that "*the testing strategy for staff could have been more aggressive*" and that in any future outbreak in a RACF he would "*suggest universal testing of staff commence immediately upon the outbreak being identified and be continued*".

16.9 On 14 April 2020, the first attempt was made to test the entire facility. Sixteen residents were confirmed to be COVID-19 positive including Raymond Jennings, Ronald Farrell, Edith Brownlee, Maria James, Keith Smith, Leonie Corrigan, Shirley Yates, Blanche Billinghurst and Victor Stone. Four staff members also tested positive.

16.10 On 17 April 2020, a second PCR screen of Newmarch House residents and staff was completed. Seven residents were found to be positive for COVID-19 including Margaret Brocklehurst, David Gee, Fay Rendoth and Margaret Sullivan. Three staff members also tested positive.

16.11 The PCR screening continued to detect cases among residents until 29 April 2020 when the last of the residents, including Ann Fahey, tested positive. Staff members continued to test positive until 7 May 2020. Dr Branley expressed the view that there were "*two outbreaks going on" at Newmarch House and "the staff outbreak is actually the primary outbreak*".

16.12 Daily staff screening did not commence until 4 May 2020. Dr Branley agreed in evidence that a systematic approach to staff testing was not taken and instead described it as opportunistic.

16.13 **Conclusions:** Although it was recognised by 12 April 2020 that COVID-19 was highly contagious, that the Newmarch House residents were particularly vulnerable, and that an outbreak in the facility could potentially be catastrophic, no attempt was made to test the entire facility until 14 April 2020. Dr Branley's evidence that an approach was taken to "*systematically go in and swab aggressively*" is inconsistent with his other evidence that nursing staff lacked experience at that stage of the pandemic to perform systematic testing of this kind.

16.14 Further, Dr Branley acknowledged that lack of staff resources, and the first days of the Outbreak falling over the Easter long weekend hampered any attempt to perform site-wide testing from the outset. If universal testing of staff had been performed once the Outbreak had been identified, and continued for the duration of the Outbreak, it is likely that this would have decreased the incidence of staff-to-staff transmission. In addition, timelier reporting of results would have allowed for COVID-19 positive cases to be identified more readily. These factors in turn would likely have reduced the extent and severity of the Outbreak.

17. How did infection spread within Newmarch House?

17.1 The most likely index case for the infection was the Newmarch House staff member, referred to as X, who tested positive for COVID-19 on 11 April 2020. By 15 June 2020, when the Outbreak was declared to be controlled, 34 staff members and 37 out of 94 residents had been infected, representing an attack rate of 38%. This was despite preventative lockdown measures being introduced on 23 March 2020. At that time, COVID-19 had a case fatality rate of 10% to 20% in people aged over 80 years, and 30% to 40% if they lived in a RACF. The case fatality rate amongst residents of Newmarch House was 53%.

17.2 The first two PCR tests of the Newmarch House site on 14 and 17 April 2020 identified a total of 40 cases. Nine of the 19 residents who tested COVID-19 positive had initially tested negative. Margaret Brocklehurst, David Gee, Marko Vidakovic and Fay Rendoth had one negative test on 14 April 2022. Barry Jehan, Ann Fahey, Olive Grego, Margaret Sullivan, and Alice Bacon all had two or more negative tests. The last residents tested positive on 29 April 2020, with infections amongst staff continuing until 7 May 2020.

17.3 Professor MacIntyre in her evidence referred to viral load (the amount of virus that a person is breathing out) and viral shedding (the amount of virus coming out from respiratory shock). She gave evidence that there is a "*huge peak of viral shedding*" in "*the two days before symptoms start and the first day of symptoms, and then it tapers off quite substantially*". Professor MacIntyre also gave evidence that a person can still be infectious for a number of days after that, but that the biggest risk is the two days before infection and the first day of infection.

17.4 Professor Bennett gave evidence that the most infectious period of time depends on where the infection is established, in other words whether it is in the nose and throat. She considered that the infectious period could be more variable and probably fluctuates over time.

17.5 Professor Bennett described the process as beginning with exposure when a person acquires the virus in an infecting dose. This is followed by a latent period where a person is incubating the virus and will not be infectious. This is then followed by a pre-symptomatic period where a person becomes infectious leading up to the period when symptoms develop. Professor Bennett gave evidence that the accepted rate was 5 to 6 days on average before symptoms develop, but that this was not evenly distributed. For example, in some cases symptoms might develop within three days, or not develop until the 10, or even 14, day mark.

17.6 Professor MacIntyre gave evidence that with the variant that was causing the pandemic in March 2020, 90% of people would incubate within five days, although it could be up to 14 days, again with uneven distribution. Professor MacIntyre gave evidence that "*it was probably more like three quarters probably had an incubation period of 5 to 6 days*".

17.7 Both experts agreed that there was a seeding event at Newmarch House, meaning that there was introduction of the virus into a particular setting which initiated the Outbreak. Professor MacIntyre described it as looking like "*a classic epidemic growth*" where one person infects two or three people, who then go on to infect 4 to 9 people, and so on with infection growing exponentially.

17.8 Professor Bennett considered that the Outbreak began with a staff member in the period where they were most likely to be infectious (up to 3 days before symptoms developed or before they tested positive) having some interaction with another person, depending on the duration, proximity and nature of the interaction (for example, providing medication, or helping a person in or out of bed). In contrast, Professor MacIntyre gave evidence that she did not place much emphasis on direct contact. Her evidence was that although proximity was important (and with increased proximity comes greater risk), with an airborne infection the risks will be "*everywhere inside of the indoor setting, because it's like cigarette smoke*". Professor MacIntyre gave evidence that once there is infection inside a facility, the risk will be everywhere, particularly when ventilation is not good. She explained that there were "*a lot of other opportunities for transmission, both airborne transmission from accumulated aerosols, and some movement of residents*".

17.9 In her report, Professor Bennett opined that the majority of Newmarch House staff and resident infections were already incubating by the time the outbreak was discovered through the positive result of the index case on 11 April 2020. Professor Bennett went on to note:

> There appears to have been a cluster of staff infected from the index case who then created multiple concomitant exposure episodes for residents and other staff in the days immediately prior to the index case being notified, and for the first few days as staff and patient testing commenced.

17.10 Professor Bennett also explained that regardless of the direction of infection between staff and residents, between 78% and 92% of resident infections were established within seven days of the Outbreak being notified. She went on to explain that all infections were probably being acquired by 23 April 2020, less than 12 days after the Outbreak was called, with the last three resident positive results from swabs collected on 29 April 2020. Professor Bennett went on to express the view that tracking cases and contacts indicated that there were a number of chains of transmission, at least three for residents and possibly more for staff, but no indication of downstream infections that could only be explained by transmission among residents.

17.11 Professor Bennett explained further:

> Asymptomatic cases were reported amongst both staff and residents, and this is a challenge for infection control, and for managing staff in an outbreak. Even with daily testing you will not know a result till at best, the end of the day the swab was taken, and so exposures may have already occurred. The pre-symptomatic period poses the same challenge for those critical two to three days when a person may be infectious before their symptoms develop.
>
> Given the widespread seeding of infections across all three wings before the outbreak was visible, and the high infection rate amongst both staff and residents from the day the outbreak was called, I would deem this to have been effective outbreak management from an epidemiological perspective, especially in relation to protecting residents from a second wave of infections. Of the 69 residents who had not tested positive within the first 12 days of the outbreak, only five (7%) would go on to develop an infection.

17.12 Professor MacIntyre gave evidence that "*infection control measures at the time were driven by a belief*" that transmission was largely through large droplets ("*more like a ballistic event than*

inhalation") when the actual risk was inhalation of contaminated air. This resulted in inconsistencies in PPE use and infection control.

17.13 Professor MacIntyre expressed the view that all cases after 18 or 19 April 2020 were potentially preventable, and referred specifically to Ann Fahey, Olive Grego and Marko Vidakovic, all of whom tested negative multiple times before they tested positive. Professor MacIntyre gave evidence that it was uncertain who the index case was (it could have been a staff member, a visitor, or a resident who was admitted to hospital with a chest infection on 3 April 2020 before returning to the facility) but that if the first case was on 6 April 2020, there would have been a peak of infection around 11 or 12 April 2020, with a secondary or tertiary wave of transmission on 18 and 19 April 2020.

17.14 Ultimately, Professor MacIntyre expressed this view:

> And it's not just about when you identify the cases, it's about everything else that you do. So when the decision was made to use Hospital in The Home for this situation, then, you know, really it should have been there should have been more thorough measures such as testing of everybody, from the day of the first case. This was a, you know, brand new pandemic, and we knew it was very serious. This is, there was only the experience of one other aged care facility prior to this. There was every reason to be highly precautionary, and that included testing everyone. That's particularly the case with older people in aged care.
> […]
> So anyone who knew that should know that it's really important to test everyone early on. So that didn't happen. That was quite delayed before that happened, and then there was also a delay in the reporting of the positive tests.

17.15 As to the issue of relocation of residents, Professor Bennett described it as a perturbation with "*the potential that that could facilitate a higher infection risk for the other residents who haven't yet tested positive*". In addition, the actual process of transport created a risk, and the hospital setting itself created other infection risks. Finally, moving out people who are not infected, or not known to be infected, introduces an additional risk because some of those people would likely have already been infectious or incubating the virus. Professor Bennett explained that this creates "*an infection risk by cohorting those people potentially together at another site, and then increasing your secondary infection rate*."

17.16 In contrast, Professor MacIntyre expressed this view regarding relocation from an infection control perspective:

> [W]e have to treat people as human beings and not as things to be decanted, and we have to think of the whole person and the whole context; we can't just separate out infection control from human beings, we're talking about human beings here. So medical issues aside, from an infection control perspective, infected people, at least most infected people, should have been moved to hospital, should have been transferred to hospital […] Age care facilities are residential facilities, they are facilities that are designed to have a homelike environment where people can live; they are not hospitals, they are not staffed by health care workers, and in normal times you would be lucky if there was even one registered nurse during a shift, and they're not designed like a hospital is, so they're not designed for infection control, they don't have isolation rooms, they don't have negative pressure rooms
> […]

> But in terms of an outbreak, you know, an aged care facility is not designed to handle to to be a hospital, and keeping those infected people in there, together with all the other factors I've mentioned like, you know, the failure to test everyone early on, the delay in the reporting of the positive tests, meant that people who were uninfected were exposed to infection unnecessarily and the outbreak was bigger than it should have been, and then there was sort of cascading failures as a result because, because the setting was not suitable to handle this big outbreak.

17.17 In addition, Professor MacIntyre gave evidence that even if some of the infected residents had been moved out to hospital this "*would have reduced the load within the facility*" in circumstances where "*available resources were not adequate*" and the basic care needs of some residents were not being attended to, or not being attended to in a timely manner.

17.18 **Conclusions:** Given the differences in opinion between Professor Bennett and Professor MacIntyre, two eminently qualified epidemiologists, the available evidence does not allow for a precise conclusion to be reached as to exactly how or when each resident became infected with COVID-19. Professor Bennett gave evidence that the majority of infections were established within the first seven days of the Outbreak. This is consistent with Professor MacIntyre's view that all positive cases after 18 or 19 April 2020 were potentially preventable. Given that five of the residents who died (Marko Vidakovic, Alice Bacon, Barry Jehan, Olive Grego and Ann Fahey) all had two or more negative tests before they tested positive, it is most likely that these residents acquired the virus on or after the date of their last negative tests.

17.19 The expert evidence also established that effective infection control relied upon frequent testing and prompt reporting of test results to Newmarch House. As noted above, this did not occur. It is acknowledged that even with daily testing, results may not have been available until the end of the day and that exposure to the virus may have occurred in the intervening period. However, more frequent testing and prompt reporting of test results likely would have identified COVID-19 positive cases in a timelier manner.

17.20 The decision as to whether to transfer residents out of Newmarch House obviously became an important consideration. It is accepted that the transfer process and a hospital environment created potential further infection risks, and the cohorting of residents of potentially mixed infection status created an additional risk of increasing the secondary infection rate.

17.21 However, the issue of infection control should not have been the only issue relevant to the question of transfer. Consideration also ought to have been given to the needs of those residents who tested positive for COVID-19 and whether their care needs could be adequately met in a residential facility rather than a hospital. Further, if only COVID-19 positive residents, once promptly identified, had been transferred out of Newmarch House this likely would have slowed the rate of new infections.

18. Hospital in the Home

Policy framework relevant to Hospital in the Home

17.22 The NSW Health *Adult and Paediatric Hospital in the Home Guidelines (GL2018_020)* (**HITH Guidelines**) defines HITH in this way:

> NSW Health defines Hospital in the Home (HITH) as a clinical model that provides admitted acute/sub-acute care in the patient's home or the community as a substitute for in-hospital care. Instead of receiving care and hospital accommodation, patients receive hospital level care whilst being accommodated in their own home.

17.23 The HITH Guidelines go on to describe HITH as being an important model of care in this way:

> As in other developed countries, health care spending and demand for hospital beds in Australia is increasing. This demand is due to a growing and ageing population, advances in medical technology and treatments, and increasing consumer awareness of health-related issues.
>
> NSW Health aims to provide integrated services and effective and efficient health care while managing this increasing demand. This means focusing on a person's needs while ensuring effective communication and connections between health care providers in primary care, community and hospital settings. It also means improving access to community-based services in the home or nearby.
>
> Evidence shows that HITH provides the same quality of care as traditional, hospital based care for medically stable patients and has superior outcomes in some cases. It is associated with reductions in mortality, readmission rates and increased inpatient and carer satisfaction while placing no extra burden on carers.

17.24 In addition, the NBMLHD *Nepean Hospital in the Home (HITH) Policy* (**HITH Policy**) provides:

> Hospital in the Home (HITH) is a model of care that aims to achieve the following outcomes:
>
> - Improve patient's experience during episodes of acute illness which would traditionally be managed by a hospital and admission
> - Reduce disruption to family life by relocating treatment to the community or home environment
> - Improve quality of life
> - Reduce risk of hospital acquired infections
> - Provide acute care to reduce cost
> - Improve patient flow

17.25 Clause 1.2 of the HITH Guidelines provide that to be eligible for HITH care in NSW, a patient must meet the criteria for hospital admission under the NSW Health Admission Policy, be an admitted patient under the care of a designated admitting clinician, and "*receive daily clinical care or clinical review from a member of a multidisciplinary team*". In addition, clause 5.3 of the Guidelines provided that to be suitable for HITH treatment, a patient must, relevantly:

(a) "*be competent in managing their condition and know when to escalate their care or have a live-in carer who takes this responsibility*"; and

(b) "*have a suitable and safe location for care outside the hospital*".

17.26 Clause 5.4 further provides, relevantly, that a patient may not be eligible for HITH care if they:

(a) "*require complex care that exceeds the capacity of the HITH service*";

(b) "*are cognitively impaired or physically incapacitated with no live-in carer to take responsibility*"; or

(c) "*demonstrate poor compliance with medical care*".

17.27 Clause 4 describes one of the HITH principles to be patient and family centred and provides that this means:

- Patients/carers consent and are actively involved in their care.
- Patients/carers are informed of their clinical progress and changes in clinical management.
- Patients/carers receive a written management plan and instructions on how to escalate their care.

17.28 Clause 7 describes particular care settings for HITH, including residential care facilities. Clause 7. 3 relevantly provides:

> Residential Care Facilities (RCFs) mainly provide accommodation to elderly residents, who are frail and have multiple co-morbidities. Because of their health status, these residents often suffer acute illnesses and acute exacerbations of chronic illnesses and have a high rate of transfer to hospital.
> […]
> The HITH service should establish a written agreement in regard to the roles and responsibilities of the RCF and the service. RCF staff must be given training and support if they are to assist in the clinical care and management of acutely unwell patients.
> […]
> An initial assessment by the HITH team should take place where possible in the RCF to avoid transferring a patient to hospital. A medical review will determine if the patient can be treated at the RCF or if they should be transferred to hospital for further treatment and assessment.

17.29 Clause 9 provides for care of the deteriorating patient, with clause 9.1 providing the following:

> Patients should be medically stable when admitted for HITH care. However, they are only seen once or twice a day and deterioration can happen rapidly over 24 hours. HITH services must have systems and processes in place to quickly recognise, respond to and escalate care for deteriorating patients.
>
> Medical, nursing and allied health staff must be trained and competent in recognising and responding to signs of deterioration in children, adults and older people. HITH nurses play a particularly important role.
> […]

> Patients/carers should be educated and given written information on recognising the symptoms of deterioration and who to contact.
>
> Vital signs should be recorded on a standardised observation chart such as the Standard Adult General Observation (SAGO) Chart or the age specific Standard Paediatric Observation Chart (SPOC) during home visits and kept in the clinical record. When deterioration is detected, clinicians must follow the agreed escalation plan.

17.30 Clause 9.2 goes on to provide for escalating care and notes:

> HITH services must have a clear system for patients that need urgent review and transfer. This should include documented escalation plans for staff and patients.

17.31 In addition, Clause 9.3 provides for an uncontactable patient and sets out the following:

> All services must have an escalation process if a patient cannot be contacted. Patients are admitted as inpatients and the service must take action when they cannot contact or locate a patient. The escalation threshold is earlier and lower than for non-admitted community patients.

17.32 The HITH Policy sets out the following conditions suitable for HITH:

- Patients requiring daily or BD intravenous antibiotic therapy
- Wound care and dressing changes
- Drain monitoring and removal of same
- Central venous line access, routine care, dressing and blood tests
- Patients requiring clinical review with Infectious Diseases team
- Monitoring of weight and feeding support
- Chronic and complex patients requiring support and follow up
- Patient education and support following discharge

17.33 The HITH Policy also set our certain admission criteria, relevantly:

- Primary carer who is willing and competent to provide care in the home environment where required
- Patient must consent to receiving HITH treatment at home
- The environment must be safe for the patient, their carer and HITH staff.

17.34 In terms of exclusion criteria, the HITH policy describes:

- Patients who decline service
- Patients that are at risk of non-compliance to treatment regime

17.35 In relation to HITH reviews, the HITH Policy provided:

- All patients on HITH will have daily nursing contact
- All patients on HITH will have a medical officer review at least every 7 days short term ID patients will be reviewed on the next available clinic day

17.36 Finally, the HITH Policy also provided for a Clinical Emergency Response System based upon the Between the Flags system. For patients in the Yellow and Red Zone, patient assessment observations were to be completed, the registrar was to be informed and the on call consultant contacted to (in the case of Red Zone patients) confirm instructions regarding ongoing treatment. Additionally, in the case of Yellow Zone patients, consideration was to be given to presentation to a HITH clinic for medical review. For Red Zone patients, arrangements were to be made to transfer the patient to hospital.

17.37 On 31 March 2020, the HITH Society Australasia Ltd distributed the *Role of Hospital in the Home for COVID-19*, a specific guideline in the context of COVID-19. In relation to escalation of care in the context of a deteriorating patient being transferred back to hospital, this guideline provided:

- Use standard escalation procedure for deteriorating patient on HITH.
- Consider specific clinical criteria in patients suspected or proven to have COVID-19:
  - worsening respiratory status eg oxygen saturations <92%
  - poor urinary output or other ongoing concerns about fluid status
  - any other clinical concerns on telehealth or in-person review
- Communication between referring and HITH teams about any divergence from standard escalation of deteriorating patient criteria.

Operational aspects of Hospital in the Home

17.38 HITH was a pre-existing service within NBMLHD and sat within the Infectious Disease Department under the responsibility of consultants within that Department. The HITH service comprised:

- a registrar (Dr Haydar El Jamaly)
- a clinical nurse consultant (Gillian Hennessy)
- two or three junior doctors
- approximately 12 nurses

17.39 Prior to the pandemic, HITH provided clinical review of patients in the community, administration of antibiotics and other interventions. Dr El Jamaly gave evidence that he personally had not been involved in delivery of HITH services to residential aged care facilities prior to the Outbreak, and that he was also unaware of this occurring.

17.40 After the commencement of the pandemic, HITH was involved in delivering care to COVID-19 positive patients in the community. Before the Outbreak at Newmarch House, this consisted of about 150 patients. Around 10% of COVID-19 patients were hospitalised at that time.

17.41 At the time of the outbreak, Nepean Hospital at approximately 13 patients positive for COVID-19 admitted to hospital, with about 11 admitted in April 2020. Ward 5A at Nepean Hospital was designated the COVID-19 ward and had capacity for 28 to 30 patients, including two single rooms and two negative pressure rooms. It did not reach capacity during the period of the Outbreak.

17.42 The process for admission to HITH from the community involved patients being swabbed, positive patients provided with observation packs which contained equipment including a pulse oximeter.

Patients were asked to take observations four times per day and a nurse from HITH would contact the patient once twice per day to check progress, with reviews generally conducted by telehealth. Any concerns were escalated to the Registrar to provide advice or consider inpatient admission. If there were any concerns, a patient was told to present to an emergency department.

17.43 Dr El Jamaly gave evidence about how HITH operated in the community for patients who tested positive:

> [E]verybody who was COVID positive would be virtually admitted in that telehealth system. I would take the first call and explain the program to the patient and family, and not only was I involved in the clinical aspect but also the public health aspects of when they can be cleared back to join the workforce for example, and after I explained the Gillian Hennessy and the staff would send simple observation packs by post or drop it into their home so that patients can do regular obs generally four times a day, and nurses will call every single patient every day to check on them, and any clinical medical concerns fed back to me I assess telehealth wise any concern, call the consultant with a view to admit, or give advice.

18. Did the model of care at Newmarch House comply with the relevant Hospital in the Home guidelines and policy?

18.1 Dr Branley gave evidence before the Royal Commission that he was not aware of any written agreement regarding the roles and responsibilities of Newmarch House and HITH. He also gave evidence that although Newmarch House staff were given training and support to assist in the clinical care and management of acutely unwell patients in the process of implementing the HITH Guideline, this was not done in advance of the Outbreak.

18.2 Many of the residents at Newmarch House were cognitively impaired, became medically unstable and required complex care. The staffing shortages at Newmarch House meant that at times the care needs of residents were not met. In addition, residents did not receive daily care or clinical review from the HITH team, or any regular review until the VACS team commenced regular telehealth on 28 April 2020.

18.3 Further, many of the residents showed signs of clinical deterioration, such as low oxygen saturation levels or fever. Vital sign observations were not recorded on a SAGO chart, but instead recorded in individual progress notes or charts at Newmarch House and Nepean Hospital. It is likely that this affected the ability to identify clinical deterioration. Further, where a patient showed clinical deterioration, there is no evidence of an escalation process being in place, or being followed, or HITH consultants being contacted.

18.4 During his evidence before the Royal Commission, it was suggested to Dr Branley that none of the preconditions set out by Clause 7.3 of the HITH Guidelines had been satisfied at Newmarch House prior to the Outbreak. In response, Dr Branley gave this evidence:

> There were family discussions with the residents about the model of care and about the advanced care directives and about transfer to hospital, so I think those conditions were – were applied as best we could.

18.5 However, the evidence from most family members that they were either unaware that their loved one had been admitted under a HITH model of care, or, if familiar with the term, had no understanding regarding what it meant, or were told it was "*equivalent*" care to a hospital admission.

18.6 Dr Branley gave evidence before the Royal Commission that as each resident tested positive the principles in the HITH Guideline were applied on an individual case-by-case basis. He explained:

> I would highlight that it was more than hospital-in-the-home, in that it was a combined infectious diseases geriatric hospital-in-the-home and virtual aged care service, both of which were existing models of care which we merged into a problem-solving solution for a very difficult problem.

18.7 Dr Branley was then asked whether he agreed that one of the principles of the HITH Guideline was that decision-making regarding a person's treatment required discussion with them about available treatment options, including transfer to hospital. Dr Branley gave this answer:

> I agree that in a perfect world it might have been good to have had individualised patient discussions with every single patient. I think our degree of organisation wasn't up to that level in the first part of the outbreak. But we did need to solve problems and we did need to have a mechanism for doing it and so we chose to, as much as possible, stick to the existing methods we had in place.

18.8 Dr Branley ultimately agreed that the communication aspects of implementation of the HITH Guidelines were "*less than optimal*". He went on to provide this context:

> [T]he other thing I would like to highlight is the difficulty in communicating, particularly critical issues around end of life or severe viral infection issues with families when society was in social distancing lockdown. In ordinary circumstances we would – in non-COVID circumstances we would have the ability to have a face-to-face discussion, and to be able to discuss individual issues much more time efficiently and in a much more controlled fashion. In retrospect, I wish we had had the ability to do that on every single patient and to commit the amount of time to that situation. And I regret that we weren't able to do that in a better fashion.

18.9 Dr Branley in evidence accepted that the principles set out in the HITH Guidelines generally applied to Newmarch House. When asked whether the considerations raised by the HITH Guideline were going to be fulfilled in the context of the Outbreak at Newmarch House, Dr Branley gave this evidence:

> I don't think that document fits what we did at Newmarch House.
> […]
> But on the other hand, I think we faced a terrible situation where we had to look at the tools we had available and those tools weren't perfect so we tried to improve them, and we improved them with a model, as you've pointed out, that wasn't a highly refined developed model with a policy behind it that was appropriate to what we were trying to do.

18.10 Ms Wunsch gave evidence of a case management meeting on 20 April 2020 which considered, amongst other things, whether an outbreak management plan existed. Ms Wunsch was then asked whether there was discussion regarding whether a resident who had been hospitalised should return to Newmarch House. Ms Wunsch gave this evidence:

> Yes, I recall the resident specifically, and he was COVID negative. He had a clinical event that required hospitalisation. He was admitted to Nepean, and then when he no longer needed hospital care, the issue came up about whether about him transferring back to the service. Dr [Melanie] Wroth [Chief Clinical Advisor from the ACQSC], at this point, said, "Are you saying that this is a safe environment for this person to return to?", like, and she was seriously concerned that a person who had left the service would come back into an outbreak situation, and their response.
>
> And I know it's redacted. It was redacted probably because of the Royal Commission. This is a Royal Commission document. It was Dr Anita Sharma who said, "No, Newmarch is an unsafe environment. Residents should stay in hospital." And that's what occurred.

18.11 **Conclusions:** As Dr Branley acknowledged in evidence, the relevant HITH guidelines and policy were incompatible with the response required to the Outbreak at Newmarch House. Two central aims of the HITH Guidelines – to improve a patient's experience during episodes of acute illness and reduce disruption to family life – were clearly not met. This is largely because a viral infection of unknown trajectory, such as COVID-19, was not included in the list of conditions suitable for HITH under the HITH Policy. Further, delivery of HITH in a residential aged care setting presented additional challenges that did not align with the HITH Guidelines. Residents required complex care which exceeded the capacity of the HITH service. Due to their chronic conditions and cognitive impairment, residents lacked the competence to manage their own conditions and the ability to recognise when escalation of care was required, and did not have a live-in carer who could assume this responsibility.

18.12 Although the HITH Guidelines required a written agreement setting out the roles and responsibilities of the HITH service and Newmarch House staff, the available evidence indicates that no such agreement was prepared. This, together with workload demands and the unique challenges which the response to the Outbreak presented, meant that fundamental requirements of the HITH Guidelines and Policy were not complied with. Residents did not receive daily care and clinical review until 28 April 2020. Inconsistent documenting of vital sign observations created challenges in identifying clinical deterioration in residents and the need for medical review and escalation of care. Contrary to the HITH Guidelines, no clear system for patient review and transfer, or documentation of escalation plans for patients and staff, appeared to exist.

18.13 Importantly, the circumstances of the Outbreak did not allow for individualised patient care, and resulted in suboptimal communication with residents and their families regarding available care and treatment options. Again, this was inconsistent with the HITH Guidelines which required patients and carers to be kept informed of a patient's clinical progress and changes in clinical management. As Dr Branley described it, the model of care was essentially a hybrid between an infectious diseases geriatric hospital in the home and virtual aged care service.

18.14 Finally, and perhaps most importantly, one of the prerequisites for HITH under the HITH Guidelines and HITH Policy was a safe environment for the patient, their carers, and HITH staff. The evidence of Ms Wunsch, as described above, suggests that this prerequisite was not met, or not always met. It was correctly submitted on behalf of NSW Health and NBMLHD that as Dr Sharma was not asked about the statement attributed to her by Ms Wunsch a finding is not available that Dr Sharma made that statement. However, this does not detract from the effect of Ms Wunsch's evidence regarding the views of a medical practitioner as to the environment which existed within Newmarch House at the time. As is discussed further below, this statement was made on 20 April 2020, the date by which Dr Branley accepted, in hindsight, that a decision ought to have been made to transfer COVID-19 positive residents to hospital.

19. Virtual Aged Care Service

19.1 The VACS was a multidisciplinary service, including geriatricians, nursing staff, physiotherapy, occupational therapy, dietitians and social work. The service is provided to older patients and accepts referrals from multiple sources. Nurse Practitioner (**NP**) Hailey Carpen gave evidence about the VACS model of care:

> [T]here's three pronged approach. It's a preventive hospital admissions in patients who could otherwise be treated in their home or in a facility to prevent hospital presentation. It's also a service where we try and prevent a decrease in hospital stay by reviewing patients in their homes once they've been discharged, and ensuring that the plans that have been put in place are followed through. And then finally as a third prong, to facilitate admissions if need be. So patients who do need admissions we'll try to bypass the triage system of ED and admit them directly to a geriatric ward.

19.2 Prior to the Outbreak, clinicians from VACS followed up three or four patients at a time. Team meetings were held daily at 8:00am to discuss patients that would be seen by VACS that day. Prior to the pandemic, the usual work of VACS involved reviewing older patients with a range of issues, including behavioural problems relating to dementia, cellulitis, urinary tract infections, respiratory infections and falls.

19.3 Two members of the VACS team were:

(a) Dr Mohammed Kakkat, a senior hospitalist in geriatric medicine who had worked with VACS since he commenced at Nepean Hospital in 2014. Other than one clinic day per week, Dr Kakkat spent all of his time in the community performing home visits and seeing patients in residential aged care facilities. Whilst Dr Kakkat's preference was for face-to-face reviews, he also used telehealth on occasion. Prior to the outbreak, Dr Kakkat saw patients in 29 aged care facilities, including Newmarch House.

(b) NP Carpen had been with VACS since 2016. She had provided care during other outbreaks such as influenza. Prior to the Outbreak, she had attended Newmarch House many times and had a good working relationship with the staff there, including discussing preparation for an outbreak and infection control.

19.4 Nurse Practitioner Carpen gave evidence that prior to the Outbreak, the largest outbreak that she had been involved in concerned a gastroenteritis outbreak which was different in terms of both severity and size compared with the Newmarch House outbreak. Ms Carpen also gave evidence that VACS had not previously provided support for an outbreak of the same scale that occurred at Newmarch House.

20. The rationale for the decision to keep residents at Newmarch House

20.1 At the start of the Outbreak a decision was made that all residents were considered close contacts and could not leave Newmarch House. However, there were discussions from an early stage about whether some of the residents should be transferred out of Newmarch House or relocated within it, with the options including:

(a) Transferring COVID-19 positive residents to hospital;

(b) "decanting" COVID-19 negative residents to another site; or

(c) "cohorting" residents into positive and negative groups within Newmarch House.

20.2 From the commencement of the Outbreak, the ACQSC advocated for decanting or cohorting residents. Ms Wunsch gave evidence that at a meeting on 14 April 2020, when Dr Wroth and Erica Roy from Anglicare were present, she and Dr Wroth "*explained the critical need for cohorting*". Ms Wunsch went on to explain that the ACQSC expressed the view that other steps needed to be taken during the outbreak, including making plans for staffing, PPE, catering, laundry, and provision of equipment. Ms Wunsch explained:

> The approach we were using in that meeting was to introduce an issue, seek their feedback on that issue, and then provide them with information to actively problem solve and support their understanding of what needed to be done, but certainly the tone of the meeting was, "This is urgent. This needs a response." Our concerns in that meeting were that Ms Roy advised that she couldn't answer a number of our questions because she was off site at the head office and she wasn't aware of the detail on the ground in terms of the onsite states of the outbreak.

20.3 On the evening of 15 April 2020, there was a discussion between Mr Pretorius, Ms Roy, Ms Wunsch, Dr Wroth, and Ms Peterson. In an email sent by Ms Peterson to personnel within the DOH and ACQSC following this discussion it was noted:

> The Chief Clinical Advisor of the ACQSC is strongly recommending that infected residents be removed from the site and it appears unlikely that service can manage this itself at speed. Can the department offer a separate location eg through the private hospital funding initiative. Transport will be a consideration and the financial situation needs to be determined. Note that additional positive test outcomes are expected so this issue will grow. This option has not been raised with Anglicare at this point.

Meeting at 9:45am on 16 April 2020

20.4 At 9:45am on 16 April 2020, a meeting took place between NSW Health and the DOH for the purpose of discussing the support needed by Newmarch House and accessing hospital beds if required. In an email sent on 16 April 2020 following the meeting, Amy Laffan, First Assistant Secretary, DOH, recorded the following:

NSW Health:

- Newmarch is getting additional resources; have strong and appropriate entry and exist screening; staff are wearing PPE appropriately and adhering to requirements and procedures.
- Geography of aged care home, that is, individual rooms and bathrooms and individual wings lends itself to keeping residents on site and that it would not be appropriate to move residents.
- Preference is not to decant residents into hospitals given the precedent this would set. Need to find solutions that enable appropriate care to be provided in the facility.
- Looking at Hospital in the Home and 'in-reach' palliative care if needed.

Commonwealth:

- Keen to understand whether hospital beds could be used for residents of Newmarch to ensure appropriate care is being provided.
- Have been informed that positive residents are spread across the three wings of the facility, facility is largely full, moving residents within facility would be difficult and require terminal cleaning. Therefore cohorting residents within the facility may be difficult.
- Aged Care Quality and Safety Commission has assessed that it may be appropriate to decant positive residents from the facility, preference would be to locate decanted residents together.

20.5 Stephanie Williams from NSW Health recorded the following note regarding the meeting:

- Cwth advised purpose of meeting was to discuss Newmarch and way forward including consideration of need to move residents out of the facility.
- Noted 9 infected residents so far and likely more will be identified positive with further results due today
- Cwth noted facility currently quite full and that may be difficult to cohort
- Cwth keen to look at moving out COVID-19 positive residents - potentially relocated as a group
- Meeting between NSW Health/Cwth with the provider later today and wanted to wanted to flag what is available and proceed from there
- Noted Dorothy Henderson Lodge didn't result in decanting and staff were replaced with agency staff
- Need to understand what is place prior to making decision to move residents

20.6 Dr Branley was present at the meeting. He gave evidence that the Commonwealth "*wanted a mass evacuation of 97 patients*", that "*they seemed to only have that as the only option*", and that he opposed this option. Dr Branley gave evidence that he could not recall the Commonwealth agencies proposing that COVID-19 positive patients be moved out of Newmarch House. Instead, Dr Branley gave this evidence:

> No, I remember them non specifically putting a proposal to move the patients out, and it was unclear whether it was positives, negatives, both, and it was unclear what the plan was; that's my recollection.

20.7 Dr Branley was also asked whether he recalled at some point in time the Commonwealth representatives enquiring about the possibility of decanting COVID-19 negative patients out of Newmarch House. Dr Branley answered:

> I recall them arguing that we should move all the patients out of the facility, and we should cohort. So, despite repeatedly asking for an explanation as to what they meant, that was what they kept saying.
> […]
> I did not understand what they were suggesting, because it was unclear to me, except that they wanted to move patients.

20.8 Dr Branley maintained in his evidence that he had no recollection of the Commonwealth agencies recommending that COVID-19 positive residents be moved out of Newmarch House. Instead, Dr Branley gave evidence that his recollection was that "*they wanted the patients moved, all of the patients*". Dr Branley gave evidence that the position he took at that meeting was that in the interest of infection control, the Newmarch House residents should stay in place at the home. Dr Branley agreed that his position "*hardened in the course of the debate that was going on*".

20.9 Ms Williams also recorded the following in her note:

- James Branley provided overview of current situation and what support NBMLHD has put in place:
- Both James Branley Infectious disease specialist and Brad Forssman Director PHU from NBMLHD are involved
- Brad and James were there today
- Relatively new nursing home
- Most cases are in Lawson Ward
- Patients are individual rooms and effectively cohorted –
- Facility has been locked down since Easter
- They are screening the all residents and staff of facility and repeating this
- First full screen occurred Tuesday and 2nd tomorrow
- Expecting the number of COVID-19 positive to rise today when results f [sic] received
- Facility doing their best
- Good front door screening procedures - good wearing of masks and PPE protocol
- Using agency staff
- Believes that keeping them in place is best

20.10 Dr Branley gave evidence that it was possible that he said the matters recorded by Ms Williams, and that they reflected his views at the time. When asked whether his recollection was that the Commonwealth agencies had not presented a coherent plan, or a plan with sufficient detail, Dr Branley gave this evidence:

> So I go back to saying I can't, I can remember more about the emotion of this meeting than about the substance, but my thinking on that meeting afterwards and now is that what they were suggesting was dangerous.

20.11 Dr Branley spoke to Kay Hyman, Chief Executive NBMLHD, following the meeting and gave this evidence about the conversation:

> I recollect having a meeting, well a conversation with Kay rather than a meeting, and I found it incredible that the level of discussion we were at was around cohorting, because we'd been attempting to cohort for some time.

20.12 In a file note prepared by Ms Hyman dated 16 April 2020 the following was recorded:

> JB
> Concern re facility desire to t/fer
> Not u/standing IC principles
> […]
> Ann/Lisa – C'wealth pushing for removal of cases

20.13 Dr Branley gave evidence that seeing the file note did not refresh his memory of the nature of the conversation he may have had with Ms Hyman. Instead, Dr Branley gave this evidence:

> What it does jog my memory for is the confusion, and even when I read this note now, there seems to be lots of different pushing and pulling in different directions. I'm not quite sure I've read that note correctly, but I think it was confusing.
> […]
> The different players who were suggesting ways that they would do it, without actually being involved at the facility. I mean, I think what we needed was a small group of decision makers who were actually across what was happening at the facility, who were actually prepared to come down to the facility and help, but people on the phone making all sorts of suggestions, I found it confusing.

20.14 In an email sent at 11:01am on 16 April 2020, Ms Laffan wrote the following:

> This morning's meeting didn't go exactly as planned. I started by charging ahead on the need for decanting access to hospitals; NSW made it clear they thought decanting was a bad idea.

20.15 In reply to Ms Laffan's email, Janet Anderson PSM, ACQSC Commissioner, wrote:

> One comment from me for now: I am very conscious of the risk of over-reading a position in this dynamic environment, but we must be vigilant in calling out the elephant in the room if ever we sense it might be present. To be clearer - if there is a view sitting behind the NSW Health position that aged care residents with COVID-19 should always be cared for in situ and should not be transferred to a hospital in any circumstances, then WE MUST CALL THIS OUT as an intolerable and unsupportable assumption. [original emphasis]

20.16 When asked about the contents of Ms Anderson's email, Ms Wunsch gave this evidence:

> I can say that it was a very it's consistent with the Commission, the broader Commission's view that all residents of New South Wales have should have the same access to hospital admission on the basis of need and that that should be as available to a person who was at a current resident of an aged care service.

Meeting at 12:00pm on 16 April 2020

20.17 A further meeting on 16 April 2020 was held at 12:00pm with representatives from Anglicare, the ACQSC (Ms Wunsch and Dr Wroth), DOH (Ms Peterson) and NBMLHD (Dr Branley) present. At the time of this meeting it was known that 20 residents and 10 staff members had tested positive for COVID-19.

20.18 According to notes of the meeting (made by Ms Williams and the DOH), Dr Wroth and Ms Wunsch again proposed moving residents: moving COVID-19 positive residents to hospital, cohorting of residents, or moving COVID-19 negative residents out of Newmarch House. It was noted that there was a desire to avoid deconditioning of residents that had been isolated for a significant period of time. It was also noted that there was a risk of ongoing exposure of residents who were still negative for COVID-19 and "*knowing that even a really robust and proactive public health intervention has been able to prevent infections and other facilities*". There was also discussion regarding the potential use of other care homes and private hospitals to manage people with lower care needs.

20.19 Dr Branley stated that he advocated against a plan to relocate all residents that had not tested positive for COVID-19. He went on to state:

> At that meeting I advocated against this plan. This plan had a significant risk of disseminating the virus to other locations because the extent of the outbreak had not been defined, and residents that had tested negative to that time could still be incubating the virus.
>
> Had this occurred at the time it was raised we would have moved at least seven residents who were incubating COVID-19 at the time and would have potentially seeded this to other facilities. The experience of the Ruby Princess was very fresh in all of our minds.

20.20 According to notes made by the DOH, Dr Branley advised against decanting residents, and indicated that Newmarch House was an advantageous facility from an infection control point of view as it had single rooms and had been locked down for quite some time. Dr Branley also reportedly expressed concern about residents in the dementia ward being difficult to move due to their significant cognitive impairment, and that although residents that had tested negative for COVID-19 could be moved from the facility, the chances of them testing positive over the course of the first week would be high.

20.21 According to Ms Williams' notes, Dr Branley provided an overview of the HITH model as follows:

- Just had a NBMLHD meeting aged care, HITH, palliative, ICU on how support can be provided in situ
- Advance care directives to know what care patients are seeking
- General terms HITH - 4 parameters - oxygen saturation, guidelines for clinical care and regard support when 92% saturation below - support with oxygen - advance care directive will provide guidance for intubation etc.
- Mostly oxygen is main care
- Then decision about intubation and ventilation (not as part of HITH)
- 87% mortality for intubation
- 8-hour shift looking after ventilated patients
- HITH can provide palliative care for patients who need this
- Aged care services has VACS (Virtual Aged Care Services) VMO and NP who go to the facility - who will deliver care
- HITH ring each day for the observations and plot the course for each patients
- Sometimes 2-3 times per day
- Make decisions about oxygen
- Competent team of palliative care clinicians

- Patients who need ventilation - decision made by senior ICU specialist
- ED process hub coordination - transport hub and respiratory physicians

20.22 According to the DOH notes, Dr Branley spoke of the possibility of removing a "*selected group*", that is decanting residents about whom there was confidence that they were negative for COVID-19 because, for example, three swabs had been taken. It should be noted that Ann Fahey, Olive Grego and Alice Bacon were all tested three times, returning negative results on each occasion, but not decanted after their third negative swab.

20.23 Mr Millard was asked whether Anglicare went into the meetings on 16 April 2020 with a position regarding how it wanted its COVID-19 positive residents to be looked after. Mr Millard indicated that residential aged care facilities do not employ doctors and could not recall "*ever having a discussion about an organisational position on such a matter*". Mr Millard went on to give this evidence:

> We don't provide medical advice or provide nursing care amongst our services, so we always look to medical practitioners for advice and input on on matters like that. So, the decision about the best clinical care and the location for that we would be looking for the advice from others on that.

20.24 However, according to the notes taken by the DOH, Mr Pretorius indicated that it would be of assistance to families knowing that their loved one is in a hospital, and that this would also be "*an advantage to their level of care*".

20.25 Ms Wunsch gave evidence that the ACQSC raised the need for cohorting, based on experiences overseas, and that one opportunity that might be explored was residents positive for COVID-19 being transferred to a private hospital. Ms Wunsch also gave evidence that there was discussion regarding moving COVID-19 negative residents to other aged care facilities, and exploring the possibility of moving both COVID-19 positive and negative residents off-site. When asked about the response to these proposals, Ms Wunsch gave this evidence:

> That the risks associated with either option were too great because there would be community transmission associated with the infected being, in a sense, uncontained when either positives or negatives were moved from Newmarch. The, that the risk would go to the hospital, or the risks would go to the aged care service. And my memory is that the discussion about negative residents that were then negative, testing negative, was that they still potentially were incubating the virus or could potentially be positive, and that the risks were too great, that the service itself presented as a positive opportunity to contain the virus, contain the outbreak because it was single rooms and ensuites, and that the that was the preferred model, and that the service could provide what was needed for residents within the Newmarch facility.

Contact with the Minister

20.26 Dr Branley gave evidence that he felt that the meetings on 16 April 2020 was "*wasted time*" and that he did not think it was a "*productive use of time*". He considered that he, Ms Giles, Ms Dempsey, Mr Robinson and other people on the ground in the facility "*knew the basics*" of infection control. When asked what this meant, Dr Branley gave this evidence:

> Well the basics are when you have an infection, when you have a very contaminated, you know, if that's the word to use, I suppose, site, you don't move things around.

20.27 Following the 12:00pm meeting, Dr Branley briefly ceased his involvement at Newmarch House due to a lack of clarity regarding decision-making responsibility, what his role was and who he was answerable to. When asked whether he recalled leaving the meeting in exasperation, Dr Branley gave this evidence:

> I do – I obviously recall that because it was an emotional event and I I don't I, effectively, offered my resignation and the the point of that was not to obtain an outcome, but you've always got to consider whether you're part of the problem, and I started to think maybe I'm not seeing this the way I should be seeing it and maybe, if there is a plan that I'm not seeing here, maybe implementing that plan can be done by other people. But I wanted to divorce myself from an unclear plan.

20.28 Dr Branley also gave evidence that he would have been happy to have withdrawn at that stage, and wondered whether "*that isn't the right way to have gone*". When asked to elaborate, Dr Branley gave this evidence:

> I don't question anyone's motivation in this, it's just a difference of opinion as to how to operationalise your ideas, and yes, I had my ideas, and I wanted to operationalise them, and I thought we could do it, I didn't know we could do it, but maybe I was part of the problem.

20.29 When asked whether his feelings of exasperation and wanting to withdraw were inconsistent with a collaborative approach, Dr Branley said:

> I agree with you, and if I was not listening to other people at the time, I apologise. I was pretty tired and pretty stressed, and you know, we were working in a fairly intense environment. Now that doesn't excuse being short with people or not being overly collaborative, but I had enormous respect for the people on the ground that I was working with, and we were actively trying to come up with the right way of doing things. Now, in a difficult situation, being told very simple things simplistically over and over again in what I felt was an aggressive way might have made me, you know, a little irritated.

20.30 Dr Branley's indicated intention to withdraw was communicated to Mr Millard who expressed concern about this. Mr Millard spoke to Minister Colbeck and gave evidence about what he outlined:

> I relayed to him that I was not in a position to decide whose advice was to be followed, but one thing I did know was that we need clarity about role and who is to be followed, who is to make the call in leading this, and Dr Branley was the expert. He was an epidemiologist. I believed he was highly regarded. He was in the home. He was present. There were no Commonwealth resources present. There was no one else.

20.31 On 17 April 2020, Dr Branley was requested by representatives from NSW Health and Anglicare to "*re-engage as an advisor*" and to return to Newmarch House "*primarily as a subject matter expert in infectious diseases*".

Meeting on 17 April 2020

20.32 On 17 April 2020, there was a further meeting between representatives of NSW Health and the DOH. The option of moving COVID-19 negative residents to a separate off-site facility was discussed. The following consensus was recorded:

- It was agreed NSW Health, the Aged Care Quality and Safety Commission and the Department of Health would identify an appropriate facility to house residents offsite. It was also agreed to investigate whether the private hospital agreement might provide a vehicle for an offsite location.
- It was agreed to not progress with early cohorting of Newmarch residents at this time based on existing evidence from early testing, but that this would be reassessed in the coming days.
- Medical consensus was that the risks of cohorting residents offsite at this stage outweighed possible benefits.

Further discussions about transfer, decanting and cohorting

20.33 Despite the agreed position on 17 April 2020, the issues of transfer, cohorting or decanting residents was revisited multiple times. Ms Wunsch gave evidence that there were repeated discussions "*right up until early May*" regarding the possibility of other aged care service providers providing services to Newmarch House residents, and the potential to access Minchinbury Private Hospital. However, these options were never taken up. Notwithstanding, it remained the view of the ACQSC that residents who had tested positive for COVID-19 should be moved offsite. Ms Wunsch went on to explain:

> The recommendation remained the view of the Commission throughout the outbreak. However, we were not the decision maker, and the convening of an expert medical group through the Department of Health initiated this group of experts to convene to discuss the outbreak and the approach, and that group confirmed the approach that was put in place and was maintained throughout the outbreak. And as I said earlier, that did not mean that the alternatives were not considered multiple times and routinely in relation to individuals and their needs, and the commission re prosecuted that those arguments in relation to individuals throughout the management of the outbreak at case meetings. That included representatives of Anglicare and New South Wales Health and the Commonwealth.

20.34 A total of 12 residents were transferred to hospital during the outbreak. Six of these residents were positive for COVID-19, but it does not appear that any were transferred for treatment of COVID-19. Instead:

(a) on 17 April 2020, a COVID-19 negative resident was transferred to Nepean Hospital after sustaining a fracture following a fall;

(b) on 24 April 2020, a COVID-19 positive patient was admitted to Nepean Hospital following an ankle fracture, and was later transferred to Springwood Hospital on 18 May 2020;

(c) also on 24 April 2020, a COVID-19 positive patient was transferred to Nepean Hospital for treatment of a urinary tract infection and a urinary retention before being discharged on 2 June 2020;

(d) on 25 April 2020, Shirley Yates was transferred to Nepean Hospital for suspected fractured ribs after suffering a fall six days earlier on 19 April 2020. Ms Yates remained at hospital until her death on 27 April 2020;

(e) on 1 May 2020, a COVID-19 negative patient was transferred to Nepean Hospital for treatment of epididymo-orchitis before being discharged on 5 June 2020;

(f) on 2 May 2020, Ann Fahey was transferred to hospital for imaging investigations after suffering a fall days earlier, and in the context of her son appearing on an evening news television program voicing criticisms towards Newmarch House;

(g) on 3 May 2020, a COVID-19 negative resident was transferred to Nepean Hospital following a deterioration in her condition, for later being discharged to Springwood Hospital on 22 May 2020;

(h) on 7 May 2020, a COVID-19 negative patient was admitted to Nepean Hospital for hypoglycaemia before being discharged on 3 June 2020;

(i) on 8 May 2020, a COVID-19 patient was transferred to Nepean Hospital at her family's request before later being transferred to Springwood Hospital on 13 May 2020;

(j) on 16 May 2020, a COVID-19 positive patient was transferred to Nepean Hospital for hypotension and cholecystitis;

(k) on 22 May 2020, a COVID-19 positive patient was transferred to Nepean Hospital for treatment of anaemia; and

(l) on 23 May 2020, a COVID-19 negative patient was transferred to Nepean Hospital for breathing difficulties before being discharged on 2 June 2020.

20.35 Some families also considered moving their loved ones out of Newmarch House after lockdown commenced and prior to the Outbreak. For example, Mark Gee, the son of David Gee, sent an email on 15 March 2020 to Leanne Hinton, Anglicare Care Manager. In the email, Mark Gee expressed concerns about his father being isolated for a long period of time and the consequent effect this would have on his health, if Newmarch House were to go into lockdown. Mark Gee requested advice on what his options were. Ms Hinton replied by email on 16 March 2020 providing details of David Gee's daily care needs.

20.36 On 27 March 2020, three days after Newmarch House went into full lockdown, Mark Gee sent Ms Hinton a further email with questions regarding bringing his father home. Later that day, Ms Hinton sent a reply email indicating that David Gee could be brought home but that consideration needed to be given to a number of things such as David Gee only being entitled to 52 days of social leave. Ms

Hinton suggested speaking to David Gee's GP to obtain further advice. Mark Gee spoke to the GP who indicated that his father "*was getting all the care he needed inside Newmarch*" and that the general impression he received was that his father "*was better off staying at Newmarch".*

20.37 Dr Manoj Dharmaratnam, a GP at Newmarch House, recorded the following progress note entry for Marko Vidakovic at 10:00am on 24 April 2020:

> It has been decided that all residents at New March house [sic] will be treated at New March house [sic] and they will not be transferring them to the hospital in the event of them deteriorating further. All medications and comfort measures will be given to them at the facility.

20.38 Dr Sharma was asked whether this consistent or inconsistent with the understanding as to how the model of care at Newmarch House was to operate. Dr Sharma gave this evidence:

> I would say it was we didn't say that the patient will not be transferring them to hospital. So, what VACS stood for was if the patient could be treated in the residential aged care facilities, and respecting the Advance Care Plan, then they would send stay in the hospital. However, if the need was to transfer them to the hospital, I would transfer them to the hospital, depending on their clinical need and case by case situation.

20.39 Dr Branley was asked about the deleterious impacts of keeping residents at Newmarch House and asked for his response that these impacts could be better managed in a hospital setting. Dr Branley gave this evidence:

> I acknowledge all of what you said is true, however, and we can speculate how this occurred, I think we got into a black and white situation and I think the nuance was a hybrid, it was a half/half.

20.40 When asked what he meant by "*a black and white situation*", Dr Branley gave evidence that the decision-making centred around whether to transfer all the COVID-19 positive residents, or all the COVID-19 negative patients, or the entire facility, rather than focusing on individualised care. Dr Branley went on to have give this evidence:

> And I think on reflection the point is well taken, and if I was doing this again I would selectively, and I would try and still be selective, rather than have a blanket transfer all these or transfer all those, and I think that is consistent with some of the expert witness we've listened to over the last couple of days. I think that that would be ideal in my view.

20.41 On 1 May 2020, the process of cohorting commenced following the arrival of Ms Dempsey. BaptistCare staff had begun planning the process, which was complex.

20.42 Dr Bradley Forssman, Director of the Public Health Unit at NBMLHD, gave evidence that despite the decision being made that all residents were to remain in Newmarch House, there was no public health order which expressly prevented COVID-19 residents from leaving Newmarch House. All residents were considered close contacts and Dr Forssman gave evidence that it was the preference of the PHU that the residents not leave. Dr Forssman gave evidence that there was a possibility that there could have been a public health order issued to an individual "so it wouldn't be a blanket thing" and it would be an "up the chain sort of decision as to what would happen".

Barry Jehan

20.43 On 19 April 2020, John Van Put sent an email to Mr Goodhew asking whether Mr Jehan could be transferred to a different facility or taken home if he remained COVID-19 negative. Mr Goodhew sent a reply email later the same day stating:

> [T]he instruction to us from the Public Health Unit of NSW Health is that no resident may leave the home. This is to reduce and contain the risk of spread. I understand as a public health order it may be legally enforceable.

20.44 On or about 22 April 2020, Gavin Taylor, Mr Jehan's grandson, contacted the PHU to enquire about the relevant public health order. In order to respond to Mr Taylor's enquiry, Dr Forssman spoke to Sarah Allan from the NSW Health Public Health Emergency Operations Centre. Ms Allan sent Dr Forssman an email outlining the position regarding the public health order and later confirmed that the text of the email could be forwarded to Mr Taylor. The email stated:

> I have double checked and there is no broad Public Health Order that relates to close contacts.
>
> However under the Public Health Act, we can issue an order on an individual if they are a contact and we think that they will breach isolation. If they were to breach this order, the penalties would apply ($11,000 for an individual or 6 months imprisonment).
>
> Close contacts must remain where they are isolated, expect for medical care or emergencies. As you noted, there is risk of transmission to the family members if they were to drive the family member to their home (and possibly within the home).
>
> This situation has arisen in other aged care facilities with outbreaks and we gave this same advice to the families in those situations.

20.45 On the evening of 22 April 2020, Dr Forssman spoke with Mr Taylor about the email. Mr Taylor stated that Dr Forssman advised that Mr Jehan did not have an enforceable public health order against him and that he could leave Newmarch House. However, Mr Taylor went on to state that Dr Forssman questioned why he wanted to remove Mr Jehan, expressed concern that there was a risk to the greater public if Mr Jehan were removed (despite being negative for COVID-19), indicated that he would consider issuing a public health order on Mr Jehan to prevent him from leaving, and outlined the potential penalties of a fine or imprisonment. Dr Forssman gave evidence that he could not remember the details of the phone call.

20.46 Dr Forssman later forwarded an email to Mr Taylor which repeated the content of the email from Ms Allan. Dr Forssman gave evidence that the advice of the PHU would still be that residents should not leave the home, but that he expressed regret about sending the portion of the email that related to possible penalties.

20.47 In evidence, Dr Forssman agreed that the impression formed by Mr Taylor that NSW Health "*did not want any resident leaving Newmarch House as they felt it was too much of a risk to the public to allow them to leave and potentially spread the virus*" was an accurate impression of the position of the PHU.

Dr Forssman gave evidence that this position was not informed by consideration of the pressure on hospital bed vacancies.

Residents moved out of Newmarch House

20.48 At around this time the ACQSC formed the view that, in the absence of a public health order, there was no authority to prevent people from leaving Newmarch House. On 22 April 2020, Ms Peterson sent an email summarising the outcome from a Case Management Meeting that date which included the following:

> There is confusion in the Service on appropriate management of requests from families who wish to remove COVID negative residents. All Commonwealth and State Government representatives agreed that families should be advised of the potential risks around removing the resident in terms of ability to provide appropriate care and care arrangements in the event that the resident becomes COVID positive. However, the final decision rests with families and residents.

20.49 Ms Wunsch was asked about the period leading up to early May 2020 and whether a clear position was ever reached at a high level meeting about whether residents would be permitted to leave Newmarch House and in what circumstances. She gave this evidence:

> [I]n the absence of a public health order, there was no authority to prevent families from taking people home, but that it had to be managed in a way that provided families with full information about how this could occur that would be in the interest of the resident moving home, and the families understood what they would have to stand up in terms of a capability to support that person at home, which included things like access to medications, an understanding that they would need to isolate themselves at home for a period of 14 days, or that they had to take into account that other household members also would need to know that there was potential risks for them.
>
> So, this was a these were discussions about how this could be effected because there was a the commission's view was that this should be an available option for families that were seeking to do this, provided they had appropriate information to make an informed decision and they could do it safely.

20.50 As the Outbreak progressed, a process was developed for discussing, on an individual basis, whether residents could be moved out of Newmarch House. Ms Wunsch gave evidence that Dr Wroth developed a fact sheet or information guide to assist communications between families and Anglicare which set out the risks and requirements associated with a resident leaving Newmarch House.

20.51 By 2 May 2020, there were five families that expressed an interest in moving their loved one out of Newmarch House. Two families eventually proceeded with this course. There were discussions with these families regarding advice from the PHU and requirements for families caring for residents to quarantine for 14 days.

20.52 **Conclusions:** What emerges from the available evidence is that the decision of whether to keep residents at Newmarch Hospital or not was clearly a vexed one. Beyond that, a sufficiently clear picture does not emerge regarding the precise rationale regarding this decision-making process. Generally speaking, Dr Branley advocated against transferring residents out of Newmarch House due to the associated risks from an infection control perspective, and his belief that it was unclear what cohort of residents were intended to be transferred. In contrast, the DOH and ACQSC advocated in favour of transferring residents out of Newmarch House in order to prevent deconditioning of residents, allow access to hospital care for residents who required it, and prevent infection of residents who had tested negative for COVID-19.

20.53 Dr Branley's evidence is that he found the contrary view of the DOH and ACQSC to be confusing because it was non-specific; that is, it was unclear to Dr Branley whether the transfer of residents out of Newmarch House meant all residents, or only those who had tested positive or negative for COVID-19. This is despite contemporaneous notes which suggest that the position of the DOH and ACQSC was that all COVID-19 positive residents should be transferred out of Newmarch House. By 16 April 2020, it is evident that the differences in opinion resulted in feelings of exasperation and a desire to withdraw on the part of Dr Branley, who acknowledged that this was inconsistent with a collaborative approach to the issue.

20.54 It appears that a consensus position was reached on 17 April 2020 to not attempt to cohort residents on site, whilst consideration would be given to the availability of alternative sites where COVID-19 negative residents could be transferred. Although a number of possible sites were identified, these options were not utilised. Further, despite this apparent consensus on 17 April 2020, the issues of transfer and cohorting continued to be revisited several times until early May 2020, with no genuine consensus position being reached.

20.55 Quite apart from the merits of each approach in favour of, or against, the transfer of a cohort of residents out of Newmarch House, it appears that neither approach centred on the needs and wishes of individual residents, and their families. Rather, a blanket approach was taken to the different options regarding transfer or not in the sense that each option considered an entire cohort: all residents, all COVID-19 positive residents, or all COVID-19 negative residents. Instead, consistent with the HITH Guidelines and HITH Policy regarding review, escalation and consideration of transfer, the individual needs of each resident ought to have informed the issue of transfer.

21. What was the model of care implemented at Newmarch House?

21.1 The model of care implemented at Newmarch House comprised elements of HITH and VACS, operating in a manner that evolved during the outbreak. Dr Branley described the situation in this way:

> Each of the hospitals around Sydney were developing models, and it was a very fertile space for trying to get this right, and everyone called their model something different. So, we used the Hospital in the Home model, but essentially, we were doing a version of what all hospitals were doing at that stage. Many hospitals were calling this COVID care in the community, virtual COVID care. These were models designed to reduce physical contact unless necessary. So, they were designed to monitor and reduce nurse to patient contact if possible, but it didn't mean that that was exclusively without physical contact.

21.2 Dr Branley gave evidence that this was "*not a standard HITH model*" but rather an "*augmented HITH model*" or "*an insertion team really*", with involvement from VACS, intensive care, respiratory and palliative care teams. Dr Branley gave this evidence about his thinking at the time:

> What was in my head was we should smash HiTH and VACS together and have a joint control room at the hospital and a joint control room down at Newmarch, and we should mirror each other and share information. That plan spectacularly failed.
> […]
> So, what was being proposed that we smash together services who had all done some preliminary planning about COVID and we have a cooperative insertion model to look after the COVID positive patients in in the facility.

21.3 When asked what he meant by "*smash together*", Dr Branley explained:

> Well, hospitals are somewhat siloed, and people do their own planning people were doing their own planning in different departments for this facility, and I think this Court's heard about the Step up plan was, I think, Anita's plan. And we had a HiTH COVID plan and bringing elements that were familiar with the disease and familiar with elderly residents and familiar with the possible complications seemed to make sense to me.

21.4 Dr Branley also gave evidence that the approach that was actually implemented did not correspond to the plan that he thought was going to be implemented. Since about 2019, there had been prior collaboration between HITH and VACS. Dr Branley gave evidence that he had previously overseen an approach like this before (involving an influenza outbreak which had avoided patients going to hospital) but not to the scale of the Newmarch House outbreak. Dr Branley gave further evidence that by 20 April 2020 the two arms of the clinical approach (HITH and VACS) were not integrated effectively. He said:

> Yes, and we didn't have a shared understanding throughout all the elements, and I think it was a systems issue rather than an individual's issue. It's hard to implement things quickly, and it's one of the faults in my thinking at the time.

21.5 Dr Branley asked Associate Professor Arancha Sud, an infectious disease physician at Nepean Hospital, to discuss with Dr Sharma how HITH and VACS could develop a working relationship during the outbreak. This collaboration resulted in the development of a flowchart for management of COVID-19 positive patients.

21.6 According to Dr Sharma, the model of care that was implemented at Newmarch House was reflected in four documents:

(a) Flow of RCF Patients Positive for SARS CoV2 (**Flow Chart**);

(b) VACS *COVID-19 Step Up Plan*;

(c) COVID-19 Rapid Response Team; and

(d) NBMLHD *Service Provision to Newmarch House Residents*.

21.7 The NBMLHD *Service Provision to Newmarch House Residents* was created some time into the outbreak. Dr Sharma gave evidence that she had not seen the COVID-19 Rapid Response Team previously.

Flow of RCF Patients Positive for SARS CoV2

21.8 As a first step, the Flow Chart provided:

- HiTH Registrar/JMO calls the facility to convey result and advise isolation for patient and contacts; to be nursed in single rooms
- Note made of phone call in EMR
- Notification forwarded to the RCF notification list on email which includes Public health, VACS and Palliative care teams by Micro registrar

21.9 Whilst available clinical records indicate that calls were made by the HITH Registrar/JMO, it is unclear whether notification emails were sent to the PHU and VACS, as well as to Newmarch House.

21.10 For patients that are medically stable, the Flow Chart provides:

- Admit to HiTH
- Facility advised to record temperature, respiratory rate, blood pressure and oxygen saturation twice a day
- Daily phone call by HiTH nurse along with VACs to check well being and observations.
- VACS team to ensure advanced care plans for all positive residents and liaison with the facility GPs, families along with oversight of other medical condition/s

21.11 The evidence established that:

(a) each of the 19 residents were admitted to HITH. However, on 20 April 2020, all residents were discharged from HITH to allow for access to care from GPs under the Medicare Benefits Scheme; and

(b) daily phone calls did not occur due to difficulties contacting Newmarch House during the early stages of the outbreak.

21.12 The Flow Chart further provides that the "*Palliative Care team [is] to be informed by VACS of the advanced care plan via email*". In addition, for unwell patients (with escalating temperatures, shortness of breath or oxygen saturation below 93%), the "*Facility [is] to consult the advance care plans for the patient*". If a patient is to be managed at Newmarch House, then the GP and VACS are to be contacted, with the COVID Supportive and Palliative Care Team contacted by a GP or VACS if needed. For patients for active treatment, Newmarch House is to call Nepean Hospital, with patients to be brought to the Emergency Department by ambulance if deemed appropriate.

21.13 The evidence also established that:

(a) the involvement of the palliative care team does not appear to have commenced until more than two weeks into the outbreak, with the clinical record indicating that a palliative care physicians (Dr Jayanthi Kathiresan) attended a telehealth meeting on 28 April 2020; and

(b) Dr Sharma confirmed that none of the 19 residents were transferred to hospital on the basis of their COVID-19 positive status and signs of deterioration.

Step Up Plan

21.14 In the last two weeks of March 2020, the NBMLHD Executive approved the Step Up Plan, with the model of care being adopted promoting hospital avoidance. The Step Up Plan provided that referrals to VACS would be triages to telehealth consultations to face-to-face home visits, and that visits to Newmarch House would be arranged within 24 hours.

21.15 However, VACS telehealth consultations did not commence until 24 April 2020, nearly two weeks into the Outbreak, and face-to-face visits by a VACS practitioner were extremely limited and did not occur until sometime after 17 April 2020. Indeed, Ray Jennings, Ron Farrell, Edith Brownlee and Keith Smith did not see a VACS clinician at any time.

21.16 The Step Up Plan also provided that there was to be liaison with the Palliative Care Team to provide support and management during the end of life phase. However, as noted above, there was no palliative care team involvement until 24 April 2020.

21.17 The Step Up Plan further provided:

(a) The VACS team were to provide intravenous fluids and antibiotics, and to assist and support the aged care facility staff;

(b) That there was a list of equipment to be carried by VACS clinicians, including IV fluids, IV cannulas, blood collecting equipment, swabbing equipment and antibiotics.

21.18 In certain cases the progress notes do not clearly indicate whether subcutaneous fluids were administered to residents, when and in what quantity. For example, in the case of Alice Bacon, a progress note entry on 15 May 2020 records:

> Add Subcut fluids 500mls over 24hours

21.19 However, it is unclear whether this entry relates to an order for fluids as opposed to administration of fluids, particularly having record to Dr Branley's entry in the progress notes on 14 May 2020:

> IV S/C fluid (depending on availability)

21.20 Dr Kakkat gave evidence that he had no specific memory of any other patient who was offered intravenous or subcutaneous fluids but thought that he "*supplied three or four bags fluid [sic] additionally*". However, Dr Kakkat gave evidence that he had no memory of recording this anywhere.

21.21 It is also unclear whether two VACS clinicians physically present at Newmarch House, Dr Kakkat and NP Carpen, routinely carried the list of equipment prescribed by the Step Up Plan. Dr Kakkat gave evidence as to his belief, although he could not be sure, that he delivered IV fluids and cannulas to Newmarch House on 14 April 2020, the first day that he attended, and that he left this equipment with the receptionist at the front counter. When asked whether he had any memory of later obtaining and using this equipment, Dr Kakkat gave this evidence:

> I don't think I used anything, I don't know.

21.22 In addition, RN Tucker gave evidence that whilst there were some fluids on site delivered by the Outreach teams, she could not recall when this occurred, and that fluids were not routinely kept on site unless requested.

Outbreak Management Plan

21.23 Nepean Hospital prepared two versions of an Outbreak Management Plan for Newmarch House, one dated 19 April 2020 and the second dated 21 April 2020. The 19 April 2020 version provided the following:

> **Clinical Management**
>
> - All residents and staff who are confirmed as COVID-19 cases are admitted to NBMLHD Hospital in the Home. Dr James Branley is providing clinical management to all admitted residents and staff.
> - Newmarch House will provide Dr Branley with access to Advance Care Directives for residents admitted to hospital in the home.
> - Clinical input will be provided as needed by Senior Staff Specialists from NBMLHD Geriatrics and Palliative Care.

21.24 In contrast, the 21 April 2020 version provided:

Clinical Management

- All residents and staff who are confirmed as COVID-19 cases are admitted to NBMLHD Hospital in the Home (HitH)
- The HitH service will lead the COVID related management and provide clinical support to all staff
- The Virtual Aged Care Services (VACS) Team is providing clinical management to all admitted residents.
- The VACS team with the GP and Newmarch House staff will update Advance Care Directives for residents admitted to hospital in the home.
- Clinical input will be provided as needed by Senior Staff Specialists from NBMLHD Palliative Care.

Application of the model of care

21.25 The ability of HITH to monitor patients was ineffective. Instead, VACS were required to conduct reviews by telehealth.

21.26 Dr Branley was asked whether the approach that was implemented at Newmarch House did not meet his expectations. He gave this evidence:

> Yes, clearly, what I thought on that day had to be modified and modified and modified. And, you know, the best plans often, you know, when tested, need to be adapted and need to be, need to be changed. And, at at this stage, I was still thinking that HiTH would have the ability to monitor the patients, which didn't turn out to be the way we thought it would. HiTH then had to adapt and use, use VACS as its primary mechanism, if, if you like. And, so, things didn't go to plan.

21.27 Dr Branley gave evidence that whilst the communication between VACS and the facility "*seemed to be pretty goo*d", and that the communication between HITH and VACS "*wasn't too bad*" but "*wasn't as good as [he] would have liked it to be*", "*what was a spectacular failure was that the communication between [HITH] and the facility failed*".

21.28 Dr Sharma gave evidence as to her belief that all patients positive for COVID-19 were being reviewed in person by Dr Branley and Dr Kakkat on site. However, clinical records indicate that despite both doctors being present at Newmarch House daily during the first two weeks of the outbreak, there were only a limited number of in-person reviews of the 19 residents by either clinician. When asked whether VACS and HITH had the capacity to deliver appropriate care up to 28 April 2020, Dr Sharma gave this evidence:

> I can't comment on that. I didn't think about it. We were just going and doing what we could do the best. Now, putting it that way, whether we had enough staffing to look after the patients, if you look at the Advance Care Directive, which some most of them we did, the family didn't want them to go to the hospital. So, we followed them, sending to the hospital would be against the patient's and family's wishes. So so, it's really difficult to comment for me to make a comment on that, whether there were adequate staffing or not. But first two weeks was not as good as the third week when we had the nursing, the medical staff, the video conferences became regular, and on the 30th on the Wednesday, I think it's the 27th, was it Wednesday 27 April, there was the locum doctor who started in the facility we had enough staffing that could cater for the needs of all the patients.

21.29 Dr Sharma gave evidence that from when the surge workforce was brought in, she had no concerns about staffing skills. However, Dr Sharma also gave evidence that she did not know the skill mix of the surge workforce, did not have any understanding as to the number of registered nurses that would be providing care under the dual HITH/VACS model, and did not have any understanding of the ratio of registered nurses/carers to patients positive for COVID-19.

21.30 The clinical records indicate that the HITH/VACS teams did not have a clear understanding of the care provided to residents by Newmarch House staff. For example, the progress notes in relation to Barry Jehan record an enquiry made by his family as to the frequency of the care provided to Mr Jehan. In response to this query, the notes record Dr Sharma indicating that provision of the exact details of the frequency of care could not be provided.

21.31 Dr Kakkat gave evidence that he observed the practice of a nurse or nursing assistant walking along the corridors every 30 to 60 minutes, knocking on the residents' doors, asking if the resident was OK, observing for signs of distress or breathlessness, although they would not necessarily fully assess a resident at that time.

21.32 Ms Giles was asked whether she had any recollection of this type of observation happening with any regularity and gave this evidence:

> It's depends on the time, period of time. Initially that wouldn't have really been possibly, probably. When we had optimal staffing it wouldn't have been a problem and I tried to get staff to make sure that when they went in and saw a resident they did everything for that resident while they were in the room. They were checking residents regularly, I do know that. They were checking residents regularly. I think that initial period the serious staffing issues that I experienced were between 17 and 21 April. After that staffing improved. I actually sent through what I felt were the required staffing levels to my boss to try and improve the situation, and the staffing levels did improve.

21.33 Ms Giles also gave evidence that on occasions she was asked for a resuscitation trolley or an electrocardiogram machine, and had to indicate that Newmarch House was an aged care facility and did not have such equipment available. In addition, Ms Giles gave evidence that intravenous treatment was not something that would usually be undertaken in an aged care facility, and that there were insufficient staffing levels to provide intravenous therapy. Ms Giles gave evidence that she recalled an occasion when Dr Sharma wanted to perform a blood transfusion on a resident who had very low haemoglobin but Ms Giles considered that, in her experience, there were "*risks for the resident*" that there was a "*high risk of anaphylaxis*" and that she did not "*feel that that the home was appropriate environment*" for that infusion.

21.34 It also appears that Anglicare had a misunderstanding as to what the model of care comprised. According to the Minutes of a Special Board Meeting on 17 April 2020, the Board was advised:

- Newmarch House is receiving specialist medical services from Nepean Hospital under its "Hospital in the Home" service, effectively making the home a virtual ward of Nepean Hospital.
- Professor James Branley, an infectious diseases specialist at Nepean Hospital has taken over medical management of all COVID-19 positive residents.

21.35 Mr Millard gave evidence about his understanding, as at 16 April 2020, about what the HITH model would entail:

> Well, I had no pre existing knowledge of what the HiTH program was. I subsequently found out well, there is a document about it. We were not provided with any documentation about it. The way it was conveyed to us was residents would be housed and cared for in the residential aged care setting. There would be medical resources delivered as was necessary. Now, I I to be clear, I think that was probably as much conveyed as inferred from Hospital In The Home. That was our understanding.
>
> There would be not just equipment, but there would be personnel provided. Probably a brave assumption, in hindsight, and something that clearly ought to have been drilled down to an understood, well, what would be the extent of the the provision of assistance, but it sounded highly attractive. And I I don't mean this in any sense critical because we were we were desperate for advice and expertise and and assistance and, anything I say, I do not, in any way, wish to denigrate Dr Branley or Health, who did an amazing job in the circumstances, but I think we had an expectation that probably more would be delivered than, eventually, what was received.

21.36 **Conclusions:** Initially the plan for the model of care to be implemented at Newmarch House consisted of a hybrid of HITH and VACS based on information sharing and joint management structures at both Newmarch House and Nepean Hospital. In the words of Dr Branley, this "*plan spectacularly failed*" as HITH and VACS were not integrated effectively, resulting in systemic shortcomings, and the actual plan that was implemented did not correspond with what had been envisaged.

21.37 Instead, the model of care that was implemented was reflected in the Flow Chart, *COVID-19 Step Up Plan*, Rapid Response Team, and NBMLHD *Service Provision to Newmarch House Residents*. However, the care provided to Newmarch House residents was inconsistent with the terms of these governing documents. For example, daily phone calls between HITH and Newmarch House did not occur, it is unclear whether notification emails regarding a resident's infection status were not sent to VACS, Newmarch House and the PHU (as required by the Flow Chart), the involvement of a palliative care team does not appear to have commenced until 28 April 2020, more than two weeks into the Outbreak, VACS telehealth consultations did not occur until around this time, and accordingly there was a significant period during which there was no liaison between VACS and the palliative care team (as required by the *Step Up Plan*).

21.38 It was submitted on behalf of NSW Health and NBMLHD that as the residents were in their homes, consent was only required if they were to be transferred to hospital. It was also correctly submitted that this highlights the importance of appropriate advance care planning, an issue dealt with further below. However, as Counsel Assisting correctly submitted, consent is required for any form of medical treatment, including the model of care which existed at Newmarch House, and any proposed alternative clinical management, such as transfer to hospital.

21.39 In addition to the above, HITH lacked the ability to monitor patients and became dependent on VACS, noting the limitations associated with when telehealth consultations commenced, as has been described previously. Only a limited number of reviews were performed of the 19 residents who died and the evidence established that regular reviews of patients, as part of the delivery of appropriate care, did not commence until after 28 April 2020.

21.40 There was also misunderstanding by VACS clinicians regarding what medical equipment was available at Newmarch House, and what types of therapies could and should be performed. This misunderstanding was also replicated on the part of the Anglicare, with Mr Millard giving evidence that prior to April 2020 he had no previous understanding of HITH. As a result, Anglicare did not have a clear understanding of the model of care that was being implemented, and instead its expectation of the level of care that would be provided was higher than what was actually delivered.

22. Adequacy of the recording of, and responses to, patient observations

22.1 The available records indicate that observations and vital signs were recorded in different locations:

(a) Progress notes;
(b) A dedicated Vital Signs chart;
(c) An Accident and Incident form;
(d) Nepean Hospital notes;
(e) Line Listings sent by Anglicare to NBMLHD.

22.2 From 24 April 2020, a change was made to recording handwritten notes, although some clinicians continued to make entries in the electronic record. By way of example, the administration of mediation, including Schedule 4D and Scheduled 8 drugs, continued to be recorded in both handwritten records or in electronic medication charts.

22.3 Dr Kakkat gave evidence that during the period when written records were being kept, requests were made of Newmarch House for the records to be faxed or emailed so that a clinician could review them prior to conducing a telehealth assessment. If no such record existed, Dr Kakkat gave this evidence as to what occurred:

> That time, we will ask them, then they will tell us, or if it is not done, we will tell them to do it and tell us immediately.

22.4 RN Cardwell gave evidence that vital sign observations were relevant to monitoring the progression of COVID-19 in a patient infected with the virus. She gave evidence that recording vital signs is a key aspect of nursing and that other clinicians would similarly record observations that they made. As to the primary purpose for recording such observations, RN Cardwell gave this evidence:

> It's to see patterns, it's to look for abnormalities that you may want to intervene and action. You may want to ask questions, you may want to escalate to someone more senior, or who can initiate further tests, or investigations, or who may interpret them because they've got a higher level of knowledge, and then, you know, explain why that abnormality exist.

22.5 Given that neither Newmarch House or the Nepean Hospital team recorded observations on a SAGO chart, this likely made it difficult to identify trends in a patient's clinical progress that may have warranted review, escalation or intervention.

22.6 The expert conclave was asked about what they would regard as appropriate in terms of observations of COVID-19 positive patients in an aged care facility. Professor Kurrle gave this evidence:

> If we're talking just residents, normal day to day, vital signs are not normally measured, unless there is an indication for it. However, coming into COVID, clearly there were reasons to measure, particularly as has already been outlined, the oxygen saturation in the blood, and importantly, pulse and blood pressure, and also temperature.
> […]

> A lot depends on who is carrying out the measurements, remembering that staffing in residential aged care on the whole does not have very much health care training, and often their familiarity with these machines is somewhat restricted […] so it is really important that vital sign observation is done by someone that knows how to do it and documents it correctly.
>
> It is difficult, because of issues around infection control, staff numbers, staff skill, even sometimes the cooperation of the resident themselves. So doing vital signs is not nearly as easy in a residential aged care facility as it might be, say, in a hospital setting where people are trained, the patients are usually by their beds, and they are happy to accept having these things done to them.

22.7 As to the frequency of observation, Professor Kurle gave evidence that observations should be done four times per day (with this increasing in a hospital setting). Professor French gave this evidence:

> I guess I can speak from a hospital experience, I have no experience in residential aged care. The frequency of observations depends upon the patient's severity of illness, and also the treatment goals for that individual patient. So for the majority of persons with COVID in an acute care hospital, they would be having observations, from my expectation, at least four hourly, and then more frequently should their clinical condition worsen, and then ultimately, when their frequency of observation gets a level of maybe needing observations two hourly or hourly, that is almost a sign then that they need to go to a higher acuity of environment, such as an intensive care unit.

22.8 Professor Kotsimbos expressed agreement with Professor Kurrle and Professor French, and added:

> I think the whole point of observing and measuring is you have a model, why are you doing this, and what are you going to do about it, and that is the critical thing here. If the reason you're doing it is to catch a signal of worsening, you don't expect it to be worsening quickly, then a couple of times a day is fine. If you do see worsening, and you're going to do things about it, you have to escalate the measurement.

22.9 The clinical records show that whilst observations were recorded, they do not indicate that escalation occurred when observations fell outside the normal range. For example, if a resident was observed have oxygen saturations of below 93%, then according to the Flow Chart, this warranted escalation for medical review, the patient's Advance Care Plan being consulted, and represented one of the criteria for inpatient admission. In some instances, whilst supplemental oxygen was provided, there was no escalation for review.

22.10 Further, some patients were recorded as being dehydrated, but there is no indication that fluids were administered. Professors Kurrle, Kotsimbos and French all agreed that fluids are an important part of supportive care to maintain homeostasis. Professor Kotsimbos explained:

> They're important, probably, on at least three levels. One is in, it, if we, we need fluids. We have fluid losses and, if we're sick, then not having enough fluid becomes a problem for our circulation and in terms of our physiology. That's the first thing. In a COVID setting, those losses are greater. Other things are happening. There's hypoxia. It compounds the problem.
>
> And the the last thing is that being adequately hydrated is a very is a much more comfortable way to be than not being adequately hydrated. And, particularly when you're not in a position to hydrate

yourself and, particularly, if you're taking medications, maybe for other reasons that may make you lose extra fluids.

22.11 Professor Kurle went on to note:

> I think the use of subcutaneous fluids was mentioned, but I'm not sure they were actually available at, at Newmarch House at the time. I would note that they are regularly used in outbreaks of gastroenteritis to keep people in residential care rather than them coming into hospital because fluid intake is just so important.

22.12 **Conclusions:** The expert evidence established that the frequency with which observations are taken of a patient is dependent on the severity of the patient's illness and their treatment goals. For a patient with COVID-19 being treated in an acute hospital setting, it would be expected that observations would be taken at four-hourly intervals, and more frequently if their condition deteriorated. If such deterioration was observed, this would warrant escalation for medical review.

22.13 The taking of observations in the setting of HITH at Newmarch House presented particular challenges such as managing infection control issues, limited staff facing workload pressures, staff who may be inexperienced in the taking of observations, and resident patients who may not be compliant with having observations taken. However, the importance of taking accurate and frequent observations, regardless of whether taken in a hospital or residential aged care setting, remained unchanged.

22.14 To this extent, the evidence established that observation records at Newmarch House were not always available to a clinician prior to reviewing a patient. Observations were also not taken on an observation chart of the kind that would be found in a hospital setting which likely made it challenging to identify clinical trends that warranted escalation and medical review.

23. Was there adequate communication between HITH/VACS and Newmarch House?

23.1 As has been noted several times already, the shortages in staffing resources had a number of implications within Newmarch House, with communication one of the areas being directly affected. RN Bestrin described the communication difficulties in this way:

> I also remember the phone ringing, all the phones. They were everywhere. But we we didn't have time to answer the phone because we were so, the, concentrated on looking after the patients. So, that's why nobody was able to pick up the calls and we had no receptionist the first week. The Service Manager wasn't there, initially.

23.2 Further, RN Sidney recorded two progress note entries regarding her attempts to contact Newmarch House to request updates on all COVID-19 positive residents, including their observations and current conditions. On 18 April 2020, RN Sidney recorded this note:

> Have been in contact with care manager Leanne Hinton in regards to updates on all positive covid19 residents. We required their observations, status and current condition but have so far been unable to obtain information. Was informed that the AN from each ward would contact us in regards to their current condition however no contact has been made at time of report have also had a call from public health to see if we had been able to contact nursing home as they are having the same sort of issues trying to obtain information. Will attempt to contact Newmarch House again tomorrow.

23.3 On 19 April 2020, RN Sidney then recorded this entry:

> Have attempted to call nursing home on three different numbers with no answer. one of the people called was the case manager Leanne Hinton who also didn't answer the phone so a message was left for her to contact outreach when possible. no return call ATOR. have also called the VACS on call to find out if there is anyway of getting information on the residents and she advised that If there was anything major with any of them she would advise us. if possible could we get a system in place where the RN from each ward where the residents are located call outreach and just give a quick update on each patient when that RN has time to do so. or even one person from the nursing home give outreach a call with an update on each patient.

23.4 Dr El Jamaly was asked about whether he could comment on how long it took for COVID-19 test results to be communicated to HITH staff and gave this evidence:

> […] Newmarch was in chaos, and it was very difficult to get them to answer the phone, and sometimes I would actually yeah, like, most of the time, nursing staff would answer, but sometimes administrative staff would answer.

23.5 NP Carpen was asked about the ability of the VACS team to contact Newmarch House and obtain information about patient observations. NP Carpen initially gave this evidence about her attempts to contact Newmarch House:

> We tried to make contact. It was difficult, and since I had access to the notes, then we would simply look at the notes to be able to see what was going on.

23.6 NP Carpen was also asked about her understanding of what the HITH clinicians were doing at Newmarch House, and gave this evidence:

> I'm not aware what they were doing at Newmarch House. Whilst I was at the hospital there were clinicians from Hospital in the Home who were seeking to get the observations from the Newmarch House residents, as they were having difficulty contacting them, and since I had access to the Newmarch House notes we were then able to look at the observations together.

23.7 In contrast, Dr Kakkat gave evidence that prior to the Outbreak he had obtained a list of phone numbers of staff at Newmarch House. During the Outbreak, Dr Kakkat used this list in this way:

> For me, there was no difficulty to contact Newmarch House because I had 20, 20 or 21 numbers with them. So of course the common number nobody will pick up and we have to call one by one because sometimes the nurses may be busy. I know the structure of the nursing home and the people may be working in one ward. So I'll try all the numbers one by one. Some of them maybe not on duty, the mobile numbers, so one will be taking call. Then I will tell them to transfer to the other ward or tell them to call me back.

23.8 **Conclusions:** It is apparent that the effectiveness of communication between Newmarch and HITH/VACS was variable. The demands placed on limited staff at Newmarch House meant that patient care needed to be prioritised, resulting in calls from HITH/VACS clinicians going unanswered. This meant that information regarding a resident's infection status, and information regarding a patient's clinical progress could not always be communicated in a timely manner. These impediments to clinician-to-clinician consultation resulted in greater reliance upon information contained in progress note entries. However, as has already been described above, there was also variable practices with respect to the documentation of such entries.

24. Was there adequate attendance by the VACS Team at Newmarch House?

24.1 Once the Outbreak commenced, VACS ceased to see patients in the community and focused on patients at Newmarch House.

24.2 Dr Kakkat attended Newmarch House almost every day from 14 April 2020, but did not attend on weekends. Dr Kakkat gave evidence that in the first two weeks of the Outbreak he attended Newmarch House every afternoon but clarified these attendances in this way:

> I was attending but I didn't say that I was seeing the patients, right.

24.3 Further, Dr Kakkat gave evidence that in the first two weeks he thought "*much of [his] time*" was focused on writing up medication charts for residents. On many days, he attended only to deliver equipment, such as cannulas or fluids (leaving them with the receptionist), or to chart medication. Dr Kakkat gave evidence that whilst he was available by phone, he had no specific memory of ever attending Newmarch House in person after receiving a phone call. Dr Kakkat also gave evidence that he mainly attended on COVID-19 positive patients and that he only saw COVID-19 negative patients "*one or two times*". Dr Kakkat also gave evidence that if he reviewed a resident, he would make a record of this in the progress notes. Additionally, Dr Kakkat explained:

> If they have Advance Care Plan, as I told you before, there is a small file I am keeping with a short description of the deceased and the patient because I am on call and at night somebody may deteriorate or somebody may crash or somebody may call me, so I have to answer the question. So I am I was keeping the details in a short file. So in that there will be written Advance Care Directives in place or something like that.

24.4 The clinical records show that Dr Kakkat conducted eight face to-face consultations with residents who died during the Outbreak (Margaret Brocklehurst, Leone Corrigan, Shirley Yates, CA, Blanche Billinghurst, Victor Stone, Fay Rendoth and Margaret Sullivan). Each was a single consultation with no face-to-face follow-up. The clinical records show that for the first two weeks of the Outbreak, Dr Kakkat attended Newmarch House on 17, 20, 21, 22 and 23 April 2020.

24.5 On 17 April 2020, five residents (Raymond Jennings, Ronald Farrell, Maria James, Leone Corrigan and Margaret Billinghurst) were reviewed by the VACS team including Dr Kakkat. Counsel Assisting submitted that the limited notes recorded of the review are suggestive of a remote records review rather than a face-to-face consultation conducted by Dr Kakkat. It was submitted on behalf of Dr Kakkat that such a conclusion relies on the drawing of an inference that is not supported by the evidence. Counsel Assisting submitted that whilst the records support a conclusion that Dr Kakkat attended Newmarch House on 17 April 2020 and made progress note entries, it does not necessarily follow that Dr Kakkat conducted face-to-face consultations with each resident. This is particularly so having regard to Dr Kakkat's own evidence, described above, regarding the nature of his attendances at Newmarch House.

24.6 The progress note entries do not indicate that Dr Sharma conducted any bedside review of the 19 COVID-19 positive patients, although she participated in telehealth reviews when they commenced.

24.7 NP Carpen gave evidence that she attended Newmarch House on two or three occasions, probably on 17 and 22 April 2020. On one occasion she documented anticipatory medications for COVID-19 positive patients, and reviewed some patients with Dr Branley on one day. As noted above, NP Carpen had remote access to the Newmarch House medical notes and was able to review them until access ceased on around 24 April 2020. The records themselves show limited entries by NP Carpen, other than her remote review of notes or her participation in telehealth reviews.

24.8 VACS commenced conducting telehealth reviews on 24 April 2020, with more regular reviews commencing on 28 April 2020. NP Carpen, whose role was a scribe, described the review process in this way:

> So, the VACS team was sitting at the hospital in front of a computer. The team in the nursing home would take a device into a resident. We would talk to the resident Dr Sharma would talk to the resident and find out about their symptoms, obtain the observations from the nursing staff at the time, and come up with a plan. The GP who was in the Home at the time would do the auscultating of the patient and providing findings back to the team.

24.9 The telehealth reviews were largely focused on discussions around not transferring patients to hospital. Other than recording the prescription of anticipatory medications, the available records do not indicate that any thorough medical assessment was performed, or any treatment or management plan formulated. For example, the available records do not indicate that any comprehensive geriatric assessment was conducted for any resident.

24.10 Professor Kurrle gave evidence agreeing with Professor Kotsimbos and Professor French that the care provided to residents was predominantly supportive (both for COVID-19 as a respiratory infection and for any underlying condition). However, Professor Kurrle went on to explain that older persons required management within a "*comprehensive geriatric framework*". When asked if this can be provided by way of a VACS-type service in a residential aged care facility, Professor Kurrle explained:

> It can be provided that way and, indeed, happens at, with current geriatric outreach services. It is a little more difficult when you do not physically assess the patient. So, a virtual VACS a Virtual Aged Care Service would not be able to provide that comprehensive geriatric medical assessment with the same degree of accuracy as would occur in a face to face assessment.

24.11 CNC Monica Tucker, a CNC in palliative care, was asked about the advantages and disadvantages of telehealth consultations. In terms of advantages, CNC Tucker gave this evidence:

> Well, you can see more people so you actually have an advantage and you can get the information from multiple people at the one time so things like observations, you can actually see if that person is showing, exhibiting any signs of respiratory distress, that type of thing. So and then you can you know, in that situation you can doff, redon, see another person. So, you are probably able to see more people in a space of time with if it's an organised telehealth with enough information, you know, lined up so that that we're available to do that, which is part of my role in Newmarch House.

24.12 However, CNC Tucker described the disadvantages in this way:

> In the aged care setting it's quite difficult and challenging due to sensory deficits for the residents. So while you can visually see, it's very difficult to communicate to ask someone for how are they feeling or what are their symptoms because of hearing impairment or sight impairment or an elderly person being able to use technology.

24.13 Ultimately, CNC Tucker gave evidence that "*if there were any residents of concern, a face to face approach from a palliative care team would be optimal*".

24.14 It should be recalled that the Flow Chart provided that the palliative care team would be informed. However, the available records indicate that the palliative care team was not involved prior to 28 April 2020.

24.15 On 29 April 2020, CNC Tucker sent an email to Dr Alan Oloffs, the Director of Palliative Care at Nepean Hospital stating:

> Further to our conversation today we would welcome the palliative care team to review any residents of concern at Newmarch House.
> […]
> Telehealth does have its limitations and review at the bedside would be our preferred palliative approach from an experienced palliative care team such as yours.
> […]
> The original information I was given was that the outreach VACS team were seeing the residents, crisis medication were put in place by the NP and doctor on the VACS team is liaison with the outreach palliative care team, they would feed back to you any concerns and your team would recommend and further management from a palliative care approach.
> James from infectious diseases is also heavily involved in managing this resident group so I guess and geriatrics so maybe there needs to be a meeting/catch up on ongoing approach to care.
> If there appears to be a misunderstanding we apologise as your team has always been welcome to come and review the residents in the home.

24.16 CNC Tucker gave evidence that her email was conveying her understanding of the way the system was supposed to operate, that it was her preference for Dr Oloffs and his team to review patients at the bedside, and that this had not been happening until that stage. CNC Tucker explained:

> My take on it was that given the circumstances, I was touching base with palliative care to because there had been a phone call that there was you know, to call this person, and I had followed up with the phone call, and during that phone call, had said that from Newmarch House side of things, we would more than welcome a palliative care team.

24.17 **Conclusions:** One advantage of telehealth consultations performed as part of a VACS is the ability to see a greater number of patients. However, the utility of such consultations is partly dependent upon complete and accurate observations being available to the clinician conducting the assessment. As noted already, this did not always occur at Newmarch House.

24.18 However, there are also disadvantages associated with use of a VACS in a residential aged care setting. Due to the sensory deficient of some patients, it may be difficult to communicate with patients in order to identify symptoms and issues of concern. Further, the expert evidence established that a virtual aged care service would not allow for a comprehensive geriatric medical assessment to be performed with the same accuracy as face-to-face consultations.

24.19 Against this backdrop, the available evidence identified particular issues with both the attendance of VACS clinicians at Newmarch House and the performance of telehealth consultations. As to the first of these matters, when Dr Kakkat attended Newmarch House in the first two weeks of the Outbreak, he did not always see patients. Whilst Dr Kakkat conducted in-person consultations with eight of the residents who died, none resulted in any further in-person follow up and progress entries were not always recorded in relation to these consultations.

24.20 As to the second of these matters, the available records indicate that telehealth consultations did not occur regularly until 28 April 2020 and that they did not result in a thorough medical assessment or formulation of a management plan. In this context, it appears that the Newmarch House residents were not managed within a comprehensive geriatric framework of the kind described by Professor Kurrle.

24.21 It was submitted on behalf of NSW Health and NBMLHD that the palliative care team attended meetings with general practitioners and were available for consultation by clinicians by at least 20 April 2220. It was further submitted that as no evidence was called from any member of the palliative care team, no conclusion can be reached regarding their involvement. However, the email and evidence of CNC Tucker demonstrates no active involvement by members of the palliative care team prior to 28 April 2020. Notwithstanding, CNC Tucker's email does not suggest that there was any departure from the previous willingness of the palliative care team to assist with review of residents in the home.

25. Was clinical leadership and responsibility clearly identified under the model of care at Newmarch House?

25.1 RN Cardwell gave evidence about communication with a medical team "*overseeing Newmarch and the management of the outbreak*". When asked whether she assumed there was a medical team at Nepean Hospital, RN Cardwell said:

> If there was a change in a resident, remembering this was early in the outbreak and the processes to me weren't entirely clear about who to escalate to, I went through the pathway that was familiar to me which was to go to the resident's GP whom if there's a change in a resident that wasn't consistent or wasn't expected, as I said before, you know, that hadn't been communicated that we were expecting this to happen and there was a management sort of approach in place, I feel obliged to let a medical doctor know for their guidance as the treating practitioner for that person. So a change in a resident, that to me is the natural next step is to contact a doctor.

25.2 RN Cardwell also gave evidence that she understood Dr Branley to be an "*infectious diseases specialist from Nepean*" who was "*providing guidance to Newmarch House*". When asked if she understood that he was the lead clinician for HITH for every COVID-19 positive resident, RN Cardwell said:

> No, I understood him to be an infectious disease specialist from Nepean. The specifics of his role I I didn't go into, and I I don't think I entirely asked what the criteria of his role was in relation to Newmarch. I knew him to be a medical specialist from Nepean.

25.3 RN Tucker expressed uncertainty about the respective roles of a resident's GP and the medical team from Aspen and how they fit in the "*chain of command*". When asked whether it was her understanding that the VACS team were responsible for the clinical care of all residents, RN Tucker gave this evidence:

> [B]ecause the GPs at that point in time weren't about to come in because of the outbreak because they were seeing other patients in their own practices, so the risk for them to go into the community was high. So, at that point in time, on a number of occasions, I had seen the VACS team or had been aware that they had communicated with the GPS. So, the I had been told by Dr Sharma that they were in control of managing that, the COVID outbreak, and to go through them for any medical concerns.

25.4 NP Carpen was asked about her understanding of who was making clinical decisions regarding the patients' care after telehealth commenced, and gave this evidence:

> So, it was the geriatrician who was running the telehealth for that day, which often was Dr Sharma. Dr Kathiresan was the palliative care doctor. She joined the video conferences. And Dr Kakkat was there on some occasions. Not every time because he was at Newmarch House.

25.5 NP Carpen also gave evidence that she thought Dr Branley provided input regarding treatment decisions after telehealth commenced. When asked who was making decisions before telehealth commenced, NP Carpen gave this evidence:

> So, I think it was Dr Sharma in consultation with Dr Branley when she needed to, and Dr Kakkat as well in the within the sorry, this is after telehealth. So, Dr Kakkat also making decisions as well.

25.6 Ms Burns gave evidence that in the event that a resident's health deteriorated, the resident's treatment would be escalated to the VACS team, namely Dr Sharma or NP Carpen, and also the resident's GP.

25.7 Ms Giles was also asked who clinical concerns would be escalated to and gave this evidence:

> So there were COVID positive residents that came under Hospital in the Home and in the early days things changed, but in the early days they would be escalated to either James Branley or Anita Sharma. Anita Sharma would be the go to person for COVID positive. COVID negative residents, we would contact the GP and get directions from the GP, their personal GP in the home, and we would liaise with them, but they didn't physically come in to the home, so that was communication via phone.

25.8 Ms Giles went on to explain that towards the end of April 2020, locum doctors who had started on-site would see patients both negative and positive for COVID-19.

25.9 RN Bestrin gave evidence that Dr Branley was "*overseeing the care of the positive residents*" and Ms Giles was the "*in-charge clinician*", with Dr Kakkat and NP Carpen assisting with the care and management of the COVID-19 positive patients.

25.10 Dr Kakkat gave evidence that at the commencement of the Outbreak, he thought Dr Branley was the lead clinician in relation to management of the COVID-19 positive residents but that he was "*not sure what happened later*". Dr Kakkat also gave evidence that there was no division of care between the roles of HITH and VACS in providing care, and that apart from Dr Branley and Dr Sharna, Dr Natalie Fox (geriatrician) and Dr Kathiresan were also providing care to the COVID-19 positive residents.

25.11 Dr Sharma was also asked about her understanding of the model of care to be delivered at Newmarch House and whether there was a lead clinician. She gave this evidence:

> It was a collaborative team, so because of Dr Branley's expertise in COVID 19 management and his infection control. So, he was the, he was overall, the clinical lead and I was leading the comprehensive geriatric management for day to day care of the residents.

25.12 Dr Sharma was also asked what she would do if she had a query regarding a patient's management and said:

> If it was in relation to a COVID related problem, I would escalate to [Dr Branley], but if it was related to management, is an outcome of COVID related to older people's, you know, complex issues, for example, if they had delirium or they have any behavioural problems, then I would manage the patient.

25.13 Blanche Billinghurst's son, Glen Billinghurst, gave evidence that he did not feel he had complete information regarding her mother's treatment. When asked whether he had any opportunity to raise this with anyone, he gave this evidence:

> No. I felt like there was no lines of communication that I could I didn't know who the doctor was to communicate with, I felt like there was no lines of communications for me to do that.

25.14 Dr Branley gave evidence that he did not see it as part of his role to direct infection prevention control procedures and measures, although he did give some directions about these matters "*intermittently throughout the outbreak in a problem-solving type fashion*". Instead, Dr Branley gave evidence that from 12 April 2020, he "*saw it as [his] role to assist*" "*the facility, the residence, the management*". Later in his evidence, Dr Branley said that it was also became part of his role to provide medical care to residents, although this was "*a rapidly evolving situation*". Dr Branley explained that the "*evolution could be described as [him] delegating that role*" to the HITH and VACS teams. Dr Branley also agreed that it was part of his role to provide medical care to other practitioners who were involved in caring for the residents, including members of the HITH and VACS teams.

25.15 Dr Branley went on to make decisions regarding escalation of treatment for deteriorating patients. When asked whether this was a role that he undertook throughout his involvement in the outbreak, Dr Branley gave this evidence:

> I think there was an evolution from me being the first person on the ground to there being more people on the ground as time went by, and I reduced my clinical input and I obviously had other roles that I was doing which VACS weren't able to do, so we divided work somewhat.
> […]
> I guess I would phrase it that there were situations where issues would get elevated to me and I might express an opinion.

25.16 When ultimately asked about his understanding as to who was the lead clinician regarding the management and treatment of COVID-19 positive patients at Newmarch House, Dr Branley gave this evidence:

> Look, I will own that responsibility. I think I was certain public [sic] with the families that I was the lead clinician responsible and I do accept responsibility. Sorry, can I just clarify for the Nepean team.

25.17 Dr Branley explained that his reference to the Nepean team meant HITH and VACS, and went on to give this evidence:

> I think if you are in this situation and you want to lead in this situation you need to own the responsibility and I've never walked away from that.

25.18 Finally, when asked whether he discussed the responsibility of lead clinician with the other medical practitioners, or if this was spoken about, Dr Branley gave this evidence:

> No, and there are sensitivities in teams. Each team had developed their own plan and owned their own plan, and I had asked them to work together, but I think in the act of asking them to work together I assumed that role.

25.19 **Conclusions:** The varying views expressed by clinicians and staff at Newmarch House, members of the VACS team, and family members starkly illustrates a lack of clarity during the course of the Outbreak as to the clinical chain of command at Newmarch House and who, if anyone, bore ultimate responsibility for clinical decision-making. The general view appears to be that whilst Dr Branley had responsibility in relation to issues related to COVID-19 and infection control, Dr Sharma had responsibility for the day-to-day comprehensive geriatric management of the residents.

25.20 However, the evidence of both Dr Sharma and Dr Branley themselves highlights some considerable confusion about this issue. Whilst Dr Sharma described the model of care as a collaborative team approach, she nominated Dr Branley as the overall clinical lead. Dr Branley initially gave evidence that he would only express opinions about matters that were escalated to him, but later said that he accepted responsibility as the lead clinician during the Outbreak. Despite this, Dr Branley's own evidence is that his apparent responsibility as lead clinician was never discussed or raised with the other clinicians involved in the model of care at Newmarch House.

25.21 This confusion regarding leadership adversely affected communication with family members who had difficulty identifying how, and to whom, concerns could be escalated. Equally, clinicians were uncertain about the appropriate escalation pathway regarding the clinical management of a patient.

26. Was the prescription of anticipatory/crisis medications appropriate?

26.1 Anticipatory (or crisis) medications, namely morphine and midazolam, were prescribed to each of the 19 residents who died. Ms Giles gave this evidence as to her understanding as at 18 April 2020 of how this medication came to arrive at Newmarch House:

> I was told that they'd been ordered by the VACS team. They weren't that they were ordered by the VACS team. They just all arrived, because I haven't really I didn't really get told that they were all arriving. They arrived at 8 o'clock or something that night 9 o'clock that night, and then I had to try and block them all up.

26.2 Ms Giles also described her reaction to the arrival of this medication:

> I guess we don't normally order crisis medication or that medication until we've got somebody who's dying. So, the fact that I had all of this medication arrived, I thought at the time I thought I thought oh my god, there's an expectation that every one of these residents is going to need this medication, and that took me that hit me for a sixer, to be honest, at the time. I yeah. But I'd also heard it on the media about people dying left, right, and centre overseas. So, I guess it just hit me hard at that time.

26.3 NP Carpen gave evidence that she charted anticipatory medications for several residents and that Dr Sharma made the decision to prescribe them. NP Carpen gave this evidence regarding the charting of anticipatory medication:

> So, anticipatory medications have been used by registered nurses for a long time, where they use their assessment skills to determine if a resident needs a particular medication, and so it would have been no different in this case. With COVID, the use of anticipatory medications in these patients would be just as clinically indicated as other patients who didn't have COVID who were possibly at, you know, approaching end of life or in distress.

26.4 NP Carpen went on to give evidence as to her understanding of why anticipatory medications were prescribed to COVID-19 positive patients:

> I think mostly they were prescribed because of the uncertainty of the way each patient, or each person would react to becoming COVID positive, and so if they needed the medications, they were there.

26.5 Dr Kakkat gave evidence that prior to the Outbreak, his practice would be to have a discussion with a patient's family before prescribing anticipatory medications. However, Dr Kakkat also gave evidence that he had no recollection of personally having such a discussion with a family member, or palliative care specialist, prior to prescribing anticipatory medications during the Outbreak. Although Dr Kakkat also gave evidence that when a patient was in a critical condition, he assumed that Dr Sharma would have such a discussion with a family member, he acknowledged that the progress notes (for Raymond Jennings) did not reflect such a discussion of having taken place.

26.6 Dr Kakkat gave evidence that following review by the VACS team, anticipatory medications may be prescribed if needed. He maintained that the prescription would not be made just from a reading of a patient's progress notes and said:

> We need to assess the patient, and as I told you before, we need to assess the patient, and prescription is individually based, not a blanket based. It is individually. If indicated, we have to prescribe.

26.7 When asked why the medication was prescribed in anticipation of symptoms being present, as opposed to being responsive to present symptoms, Dr Kakkat explained:

> If the symptoms occur, that is the PRN, right. Now, we know that these symptoms can occur in this patient, right, so the trajectory is going like that so if these symptoms occur we don't need to run around that time, so we have a plan. That is the plan. This is a plan. This is not a must you must give the anticipatory medicines or crisis medication; this is a plan so if this happens, do this.

26.8 The available evidence indicates that each of the 19 residents who died were prescribed anticipatory medications soon after their COVID-19 positive result was known, and often prior to any symptoms being exhibited. Professor Kurrle was asked whether she wanted to make any comment about this practice, and gave this evidence:

> There could be the issue of supply, and there needed to be a prescription so that the pharmacy could supply the medications. That could also be a reason. But they were in Hospital in the Home, and one assumes that means fairly regular attention to these sorts of areas. So yes, I'm glad you brought it up that it happened quite often. It may have been a decision they made early on, that they would do that for all the residents.

26.9 When asked whether, from a clinical perspective, there are potential problems with prescribing anticipatory medications in this fashion, Professor Kurrle said:

> Where there's appropriate palliative care, talking to my palliative care colleagues about this, they would not consider prescribing it until it was clear they were going to be needed, because it can change people's attitudes to care if someone clearly is being prescribed Morphine and Midazolam, and Glycopyrrolate, which are, you know, to ease the passing of somebody.

26.10 Whilst acknowledging that prescription of end-of-life medications in an aged care setting was outside his scope of practice, Professor French offered this view:

> [I]f you are prescribing end of life medications, and signalling your intent to transition to that the focus of treatment is transitioning to palliative care, there needs to be communication good communication of that with the staff, but also with the patients' families as well, so that they're understanding what the trajectory is going to be.

26.11 Professor Kotsimbos agreed with the views expressed by Professor Kurrle and Professor French and went on to explain:

> [P]rescribing something and making the decision to do it to actually give it, is very tightly linked. It has to be very tightly linked, because otherwise you run the risk of a whole lot of unconscious biases playing into the decision making that can follow on […]
>
> So the two have to be coupled; the prescription and the thinking of using them have to be coupled to avoid the two risks; the risk of giving it too early, and the risk of giving it too late.

26.12 When asked about to elaborate on the risks he described, Professor Kotsimbos gave this evidence:

> [I]f we're in an active supportive mode, and we give it too early, then we're not really in an active supportive mode, and if we give it too late, because it's all confused and we're not really communicating, then the patient has suffered more than they had to.

26.13 **Conclusions:** The available evidence indicates that usual practices regarding the ordering, prescribing and charting of anticipatory medications prior to the Outbreak were not followed during the course of the Outbreak. Anticipatory medications were ordered in bulk, they were prescribed in instances shortly after a resident tested positive for COVID-19 and absent any symptoms at that stage which might provide a clinical indication for prescription. Further, Dr Kakkat's evidence is that he could not recall having any discussion with a family member or palliative care specialist prior to prescribing anticipatory medications.

26.14 In the case of the Newmarch House residents it appears that anticipatory medications were prescribed in a blanket fashion, despite Dr Kakkat's assertions to the contrary. Indeed, Dr Kakkat's own evidence regarding departures from his usual practice prior to the Outbreak provides support for this conclusion. Further, the available evidence suggests that prescription of anticipatory medications did not occur following consultation with palliative care specialists or with a clear understanding of a patient's clinical trajectory.

26.15 The expert evidence established that premature prescription of anticipatory medications in this manner is inconsistent with supportive care of patients and can alter views about a patient's clinical trajectory, and impact the mode of care of provided to patients.

27. Were appropriate discussions had regarding Advance Care Plans for residents?

27.1 Most of the 19 residents who died had Advance Care Plans in place prior to the Outbreak. Only Margaret Brocklehurst, Shirley Yates, David Gee, Victor Stone, Marko Vidakovic, Olive Grego and Fay Rendoth did not have Plans in place. When the Outbreak commenced and residents began to be admitted to HITH, these Plans were revisited.

27.2 Each of the Anglicare Advance Care Plans began with this statement:

> It is important that you, your family and your Doctor are always involved in decisions that affect your care at the end of your life. Considering the extent of treatment and intervention you would wish for at this time gives you and your family peace of mind for the future. It is important that your wishes have been discussed with your loved ones, your doctor and those caring for you. We would like to be able to follow and respect any instructions or wishes that you have.
>
> Please be assured that your Advance Care Plan can be changed at any time by communicating your change of wishes to those involved in your care.

27.3 RN Bestrin commenced at Newmarch House on 15 April 2020, and on this day she believes that Dr Branley asked her to obtain Advance Care Plans for the residents. RN Bestrin gave evidence that she could not locate a Plan for all 97 residents and that she was instructed to begin contacting families to discuss their wishes. As a result, RN Bestrin's evidence was that she contacted about 10 families.

27.4 Dr Dharmaratnam had been the regular GP for 34 Newmarch House residents prior to the Outbreak but did not attend Newmarch House during the Outbreak. Dr Dharmaratnam gave evidence that Dr Sharma asked him to obtain Advance Care Plans for the residents and that he spoke with a number of families in order to do so. Dr Dharmaratnam gave this evidence about his understanding of why he was asked to have these discussions:

> I think it was in regards to a hospital transfer, mainly, that they were they had decided that they are going to do the management in the facility, so hospital transfer was not an option at that stage.

27.5 Dr Dharmaratnam described the discussions with families in this way:

> I did reveal to them that, unfortunately, your family member has tested positive at at the facility. And the Nepean Hospital specialists and team is is taking care of your family member. And, as per instructions, we just need to go through your Advance Care Directive, which you've already gone through and I I did tell them I totally understood it's a difficult time to ask this question and, if they're not comfortable, they don't need to reply. They don't need to make a decision. That is how I I do for every patient, even now, when I do it with anybody. So and then I would ask them about resuscitation. I'd speak to them about intubation, inotropic management, CPR, hospital transfer, and antibiotic usage.

27.6 Dr Dharmaratnam gave evidence that his understanding was that the only difference between treatment within Newmarch House and treatment in hospital was:

> That was my only understanding that they would get every other treatment, as in if there is a need to get steroids or any medications, we could give it at the facility, but the only thing which would be lacking probably would be the life support measures which I just spoke about.

27.7 Dr Dharmaratnam also gave evidence that he could not recall having a conversation with families about the differences in staff present, monitoring, observations, and the way that doctors may be available in case of any deterioration of a patient.

27.8 RN Bestrin described the timing and circumstances of obtaining the Advance Care Plans in this way:

> I said that that was the worse time to be organising those Advance Care Plans because it was a very sensitive time, and I feel it was a very it was the wrong time to do it, but I had to do it. So, I started contacting families, and I tried to be as gentle as I could be, considering the circumstances.

27.9 Dr Dharmaratnam also gave evidence that he found the process very difficult, and that it would have been difficult even under normal circumstances.

Discussions with family members

27.10 The Advance Care Plan for Barry Jehan contained a tick next to a box indicating:

> I DO want to be transferred to hospital if medically indicated.
> […]
> Please call Mary before sending him to hospital to evaluate treatment & hospital admission in accordance with his condition.

27.11 Dr Dharmaratnam spoke to Mary Van Put, Mr Jehan's daughter, on 24 and 25 April 2020 to inform her of her father's COVID-19 diagnosis. Ms Van Put gave this evidence regarding her recollection of the conversations:

> I know for certain that we weren't asked about as per his advance care plan we wanted him comfortable at home, being Newmarch, until the need for hospital treatment required and then we would wanted him to go to hospital, as per his plans.
> […]
> The first call, when he rang us and it was just my husband and I on the phone, he was talking about the hospital comfort of in Hospital in the Home. The care for the Hospital in the Home, and we said that we would want him to be made comfortable as much as possible in the home, but if it was required, we wanted him to go to hospital as per his advance care plan. And at that time it seemed like he said the Dr Sharma should be involved in this conversation. It was like being cut off.

27.12 In contrast, Dr Dharmaratnam gave evidence that he could not recall Ms Van Put saying that she wanted her father transferred to hospital in accordance with his Advance Care Plan. Dr Dharmaratnam recorded that Mr Jehan was "*not for resuscitation, ionotropes, intubation/ventilation or hospital transfer*".

27.13 RN Bestrin gave this evidence as to her understanding of the term "*medically indicated*":

> That means that if it's recommended by the doctor, that the patient will be better off in hospital having active treatment because it's not a kind of it could be like an infection that can't be treated. It's not that he had cancer, and he had no remedy, you know.

27.14 Dr Dharmaratnam gave this evidence as to his understanding of the meaning of, "*transferred to hospital if medically indicated*":

> What I understood from that is if we do not have the capacity to manage at the nursing home any clinical condition, then we transfer them to the hospital.

27.15 Dr Kakkat was asked about his understanding of the phrase, "*I do not wish to be transferred to hospital except to maintain comfort*", and gave this evidence:

> If we can offer some, something to comfort the like patient had a fracture, she's in pain, so if the fracture is fixable, then they need to go to hospital. That can reduce her pain.

27.16 On 16 April 2020, Dr Dharmaratnam and Dr Kakkat spoke to Susan O'Neill, the daughter of Ray Jennings, and asked her what her father's end of life plan was. Ms O'Neill gave evidence that she confirmed that her family did not want Mr Jennings to be taken to hospital, which was his wish, and that he be treated at Newmarch House under palliative care. When asked what her key priorities were regarding her father's treatment, she gave this evidence:

> That he would be kept comfortable in his familiar surroundings. Dad always hated hospitals, and I thought if he had COVID and he was not going to recover, I wanted him to stay where he was.

27.17 When asked whether HITH was discussed in this conversation, Ms O'Neill said:

> No. It wasn't discussed. I think they mentioned it and it kind of went over my head at the time. I caught it but there was certainly no discussion about what it was or did I agree to it or anything.

27.18 A progress note records her wishes as, "*he is not for intubation, CPR or ICU admission. He is to be managed by hospital in the home treatment*".

27.19 Ms O'Neill also gave evidence that she did not receive any explanation regarding the symptoms of her father's illness, his management forward, and the supportive measures in place in the event of worsening symptoms. She gave evidence that she was told she would receive a return call to answer questions about her father's care but did not receive such a call.

27.20 On 23 April 2020, a teleconference was held with all GPs associated with Newmarch House. It was chaired by Kate Tye, Senior Manager Primary Care, Nepean Blue Mountains Primary Health Network. The notes from that teleconference record the following:

> Kate – queried hospital transfer process and are GPs to liaise with VACS initially before calling Ambulance? Dr Sharma advised spoken to almost all residents and they do not want to be transferred to hospital. Medications are written just in case, so the resident is provided with what they need. Clinical risk assessments are conducted as most patients with COVID have underlying chronic conditions, nothing more can be done in hospital that the nursing home can't do.

27.21 Dr Sharma gave evidence that she undertook more of a supervisory role and that others were also involved in conversations with residents' families. However, Dr Sharma described the nature of the conversations that she had in this way:

> [W]e would record whether they want the wishes of the family and the resident, whether they wanted to be transferred to the hospital, or they had the advance care directive for not for resuscitation, intubation and ventilation. I also would offer them what is available in the hospital because at that point of time there was no cure or treatment for COVID 19. The only treatment was supportive care and in the nursing home we were providing the clinical care, supportive care, the supportive treatment, that is if they had fever we gave them Panadol, if their oxygen situation fell to 94% we gave them oxygen, low saturation and low flow oxygen. These were the things that we can offer in the nursing home. However, the things that were offered in the hospital was high flow oxygen that could not be offered in the nursing home, and also intubation and ventilation. So when we spoke to the patient we would ask the patient and the family the wishes of the resident and the family, whether they were happy for us to transfer you know, if the patient's condition got worse, should we be transferring them to the hospital. My overall impression was the majority of the family did not want their loved ones to go to the hospital. They were happy with the clinical care in the nursing home with what I have outlined.

27.22 Dr Sharma gave evidence that she could not recall saying that "*nothing more can be done in hospital the nursing home can't do*". When asked if she held this belief during the Outbreak. Dr Sharma gave this evidence:

> It's difficult to say yes or no. It's not exactly saying that. It all depends on, like I said, case by case. It's a generalised statement here stating that nothing more can be done in hospital than the nursing home can't do.

27.23 Dr Sharma also gave evidence that she could not comment on whether there was any basis for such a "*generalised statement*" being made given her assertion that VACS was delivering individualised care to residents.

27.24 Dr Sharma went on to give evidence that most of the patients had multiple comorbidities, such as cognitive impairment and dementia, and that sending them to hospital would be unsafe if they could be managed at Newmarch House. When asked to elaborate, Dr Sharma explained:

> So if we were going to send these patients from their usual environment to a hospital environment, which was not familiar, dealing with unfamiliar staffing, if there was increased morbidity and mortality because just giving an example of a patient who had dementia, they become more destabilised, they became more challenging behaviour, which they became agitated, aggressive, physically and verbally aggressive, requiring more treatment than normal. We preferred this patient to be treated in the normal environment to avoid that. Having this challenging behaviour in the hospital could result in a fall or our patients could go there and, given the COVID situation, would lie there for a long time, risk of pressure areas, and that was the basis that we wanted patients to be treated in the nursing home if it was safe and we could give that treatment in the nursing home to avoid them going from their normal environment, normal people who are looking after, to an unfamiliar environment.

27.25 Dr Dharmaratnam's understanding was that the residents were all to be treated within Newmarch House. On 24 April 2020, the progress notes for Marko Vidakovic record an email being sent to the Public Guardian stating:

> As discussed with yourself, Mr Vidakovic has been tested positive for Covid 19. He is under the care of the 'hospital at home team' led by doctors from the Nepean hospital VACS team. It has been decided that all residents at New March house will be treated at New March house and they will not be transferring them to the hospital in the event of them deteriorating further. All medications and comfort measures will be given to them at the facility.

27.26 When asked whether this email was consistent with her understanding of how the model of care was to operate, Dr Sharma gave this evidence:

> I would say it was we didn't say that the patient will not be transferring them to hospital. So, what VACS stood for was if the patient could be treated in the residential aged care facilities, and respecting the Advance Care Plan, then they would send stay in the hospital. However, if the need was to transfer them to the hospital, I would transfer them to the hospital, depending on their clinical need and case by case situation.

27.27 Dr Sharma gave evidence that this was consistent with an information letter dated 15 April 2020 sent to GPs regarding the VACS model of care during an outbreak.

Expert evidence

27.28 Professor Ibrahim gave evidence that it is well-described that how health professionals present information to patients will influence their decisions. Presenting the same information will affect a decision made by a patient depending on whether the information is framed positively or negatively. In the context of Newmarch House, Professor Ibrahim explained further:

> What I was seeking to explain here is that if I am employed by the Nepean Hospital and have been told to attend Newmarch or or any hospital and I've been asked to attend to work in the Hospital in The Home program, then I am going there with the assumption that this is the only option available to me because that's what we are doing. And my question would go, then, to, similar to the staff that were sent by Aspen or or anyone else is what direction were they given and, when they spoke to the resident and their family, was it clear from what point of view they were coming from?
>
> And so, the residents are vulnerably [sic], particularly given that situation, as are the family about what is going on.

27.29 Professor Ibrahim gave evidence that the minimum requirements of informed consent are that the options are set out, the perspective of the person giving the advice is made clear, and that the advantages and disadvantages are detailed, with a discussion about the impact on others such as co-residents. Professor Ibrahim also gave evidence that the level of uncertainty in this particular situation required regular review and the ability to revisit decision-making about the treatment path forward.

27.30 In this context, Professor Ibrahim expressed the view that there was "*an absolute lack of nuance with the Advance Care Plans*". He explained:

> You have persons with dementia who may not understand the nuance or subtlety of the instruction, and how that information is conveyed. And you're talking in generalities about what you might want, rather than the specifics. And so you get a sense of what a person might want, but the Advance Care Plan does not include a section about the impact of your decision on others, which I think is highly pertinent in COVID. That if I wish to remain in place, so I understand this places others at risk, and do I require the co residents' consent for that? And we then end up with an Advance Care Plan that gives us a broad overview, but not the specifics for that individual. And I think the push for all residents to have an Advance Care Plan through CDNA, and the general mood of the country at the time, again sends the message about write an Advance Care Plan, because that way we won't take you in hospital, and you'll be able to die peacefully.
>
> So I think the Advance Care Plan does not sufficiently describe what a person might want, or the benefits of hospital, which may be transfer to hospital; protects others; protects my family; and I get the tests that I need which will tell me whether supportive treatment or not is worthwhile or not. The time to make a decision about what care I want should be made with the advantage of more information, rather than second guessing what's going on. Is my pneumonia, is my breathlessness due to COVID, or is it due to heart failure? Can you treat my heart failure? Well, go ahead. Or it's all COVID, and there is nothing else to do. So I think there's an absolute lack of nuance in the advanced care plans.

27.31 This was also a matter raised by Professor Kotsimbos who expressed this view:

> Often the assumption, a lot of these Advance Care Plans are tick box exercises, do you want hospital transfer, and when the discussion is happening, hopefully there is a discussion, sometimes there isn't, it's in the setting of well, you don't want to go to hospital, you don't want to be transferred if there's nothing they can do. So that's how the informed consent gets played out, but sometimes there is something they can do, and so we've ticked a box that says, "not for hospital transfer", but we've left out that other nuancing qualifier, which is of course I don't want to be transferred if there's nothing that can be done. But if it was said to them that there is something that can be done, perhaps it would not be that box that was ticked.

27.32 Professor Kurrle expressed the view that residents were not told correct information, namely that they would receive the exact same care at Newmarch House as in Nepean Hospital, and that they should have been told the difference and what their options were. Professor Kurrle also explained:

> Clearly, you are looking at informed consent, and so the person has to be given all the options. I don't think that occurred in a lot of these cases, and therefore it wasn't true informed consent, so the person wasn't making a decision, either the person themselves, the resident, or more often their person responsible who can make medical decisions for another person. If they weren't given all the information, then it's simply not informed consent.

27.33 Professor Kotsimbos agreed with Professor Kurrle and also offered this view:

> So when an Advance Care Plan is made generally, that generally holds, but when the specific situation is so different to what was perhaps imagined when the discussion occurred, that Plan should be revised and the right information that covers all the various possibilities, both in terms of what can happen at the home and what can happen at the hospital needs to be conveyed so true informed consent can occur.

27.34 Professor Kurrle expressed the view that a VACS clinician should be speaking with a resident or their family member "*about the options and making very clear the advantages and disadvantages of them*". Both Professor Kotsimbos and Professor French took a more generic view and considered that the "*person that is most responsible for the patient and is most aware of all the options*" and "*who is able to give the accurate information*" should be responsible for providing the information.

27.35 All of the experts agreed that from their review of the clinical records, it was not possible to reliably discern who had clinical responsibility for the patients: Professor Kotsimbos explained:

> There was no clear chain in command of of command. And the potentially I would even go one step further. The people that, perhaps, had the the biggest appreciation of all the options weren't necessarily the people having these discussions.

27.36 Whilst acknowledging that it is a fraught area, each of the experts agreed that Advance Care Plans should not be made in a crisis situation, with Professor Kotsimbos describing the pressure for such plans to be made "*on the spot*" becoming "*a self-fulfilling prophecy*". There is a risk that such discussions in this situation could impact the attitude of the treating team and the affect decisions to be made regarding treatment. Professor Kotsimbos went on to explain:

> An Advance Care Plan Directive is most useful when you have a very clear prediction of what is likely to happen, and you may lose your voice when it's happening, and so you state it before it happens. When the situation changes, clearly that prediction doesn't hold, and the Advance Care Plan in that setting isn't as relevant, and it should always inform goals of care and resuscitation plans in the setting of any event, but particularly in the setting of an event that wasn't predictable.

27.37 **Conclusions:** Discussions regarding a resident's Advance Care Plan with family members lacked sufficient information, detail and clarity regarding the differences between the models of care available at Newmarch House and in hospital. In addition, the timing of such discussions during a crisis situation was not appropriate and risked influencing decision-making regarding a patient's treatment.

27.38 Dr Dharmaratnam's evidence is that the context in which he was asked to discuss Advance Care Plans with family members was that hospital transfer "*was not an option at that stage*", and that his understanding was that the only difference between the models of care at Newmarch House and at hospital was that the latter could provide life support measures. Similarly, Dr Sharma's view was that the only differences in care was that high flow oxygen, intubation and ventilation could be offered at hospital and not at Newmarch House. Further, in her evidence, Dr Sharma expressed a preference for treating residents at Newmarch House because, in her view, it allowed for the residents to remain in a familiar environment and avoided potential destabilisation in hospital. The understanding of Dr Dharmaratnam and views of Dr Sharma are therefore likely to have unfortunately influenced decisions made by family members regarding transfer to hospital, and the understanding of residents and family members regarding when transfer was "*medically indicated*".

27.39 In addition to the above, other factors prevented informed consent from being given. First, the expert evidence established that the Advance Care Plans lacked sufficient nuance regarding the question of whether a resident was to be transferred to hospital or not. Second, the circumstances in which such consent was initially obtained was very different to the circumstances which existed during the Outbreak. This required revision of the Advance Care Plan and provision of correct information regarding the difference between care at hospital and at Newmarch House, and provision of all the options available, which did not occur. Third, the available evidence does not make clear that the persons who were most responsible for the patients, most aware of the options available, and most able to provide accurate information were the ones who were involved in these discussions.

28. Should the decision to not transfer residents to hospital have been reconsidered?

28.1 During the Outbreak, no residents were transferred to hospital for treatment of COVID-19. Some residents were transferred for treatment of other conditions, including two of the residents who died.

The relevance of resident co-morbidities

28.2 Thirteen residents (Raymond Jennings, Edith Brownlee, Keith Smith, Leone Corrigan, Barry Jehan, CA, Blanche Billinghurst, David Gee, Victor Stone, Ann Fahey, Marko Vidakovic, Olive Grego, Fay Rendoth) suffered from dementia of varying severity. Marko Vidakovic was the only resident who had a Dementia and Mental Assessment completed during the Outbreak, following a request from the Public Guardian.

28.3 Only three of the 19 residents who died did not have hypertension (CA, Marko Vidakovic, Margaret Sullivan). Five residents had heart disease (Edith Brownlee, Maria James, David Gee, Fay Rendoth, Alice Bacon). Five residents were insulin-dependent diabetics (Margaret Brocklehurst, Keith Smith, Leonne Corrigan, Barry Jehan, David Gee). Two residents had chronic obstructive pulmonary disease (Ronald Farrell, Maria James).

28.4 Almost all of the residents who died had mobility issues and 15 of the residents were falls risks (Ronald Farrell, Margaret Brocklehurst, Keith Smith, Leone Corrigan, Barry Jehan, Shirley Yates, CA, Blanche Billinghurst, David Gee, Victor Stone, Ann Fahey, Marko Vidakovic, Olive Grego, Fay Rendoth, Margaret Brocklehurst). Some were incapable of moving independently from their bed. Fifteen of the residents required assistance with activities of daily living (ADL) including bowel movements, feeding, showering and dressing (Raymond Jennings, Maria James, Margaret Brocklehurst, Keith Smith, Leone Corrigan, Barry Jehan, Shirley Yates, CA, Blanche Billinghurst, David Gee, Ann Fahey, Marko Vidakovic, Olive Grego, Fay Rendoth, Margaret Brocklehurst).

28.5 Dr Branley gave evidence that the comorbidities of the residents at Newmarch House "*were really quite intense*" and that this "*does feed into mortality very directly*".

28.6 On 21 March 2020, the WHO published *Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19*. This guidance described the response to COVID-19 in Long-Term Care Facilities settings to be based on early recognition, isolation, care and source control (prevention of onward spread for an infected person). In terms of source control, the guidance provided:

> WHO recommends that COVID-19 patients be cared for in a health facility, in particular patients with risk factors for severe disease which include aged over 60 and those with underlying co-morbidities. A clinical assessment is required by a medical professional with respect to disease severity, for the potential patient transfer to an acute health facility. If this is not possible or indicated, confirmed patients can be isolated and cared for at the LTCF.

28.7 Dr Branley gave evidence that he "*wasn't sitting around, reading [this] document*" as at 21 March 2020. Instead, when asked whether there were any significant publications shaping his thinking

about COVID-19, Dr Branley referred to the ADID Guidelines and Ozbug, "*a collegiate online group for infectious diseases physicians across Australia*".

28.8 The ASID Guideline provided:

> Where possible patients with a provisional or confirmed COVID-19 diagnosis should be managed out of hospital (e.g at home or in a stepdown facility), as per local jurisdictional policies.
> […]
> Consider admission if any of: haemodynamically unstable, hypoxaemia (SaO2 on room air <94%), reduced platelet count, comorbidities or unsuitable home environment.

28.9 Dr Branley agreed in evidence that many of these features were present in the patients at Newmarch House. He also agreed that the Guideline did not stipulate to avoid hospitalisation at any cost.

28.10 The *Nepean Hospital Infectious Disease Department COVID-19 Planning Document* dated 16 March 2020 provided:

> The function of the fever clinic is to rapidly assess and triage patients for Covid-19. Criteria for transfer to emergency include:
> - Respiratory distress
> - Hypotension
> - Otherwise considered unstable
> - Clinical concern
>
> Criteria for admission to the ward for suspected/confirmed Covid-19 (pending a national guideline):
> - Severe respiratory distress
> - SpO2 ≤ 93% on room air
> - Adolescent or adult: respiratory rate > 30 breaths/min
> - Child: respiratory rate < 2 months: ≥ 60; 2–11 months: ≥ 50; 1–5 years: ≥ 40 breaths/min
> - Otherwise considered unwell enough for hospitalisation or significant comorbidities
> - Inability to self-isolate

28.11 Dr Branley was asked whether the presence of comorbidities in an older patent militated in favour of hospitalisation as this represented a more complex picture that required management. Dr Branley gave this evidence:

> I think there's two other factors that need to be considered, and I'll accept the point you're making is correct. However, there's also the patient's wishes, and in the absence of the patient being able to make that wish, there's also the family's wishes or the designated person. But there's another issue, which is the ceiling of care. What is appropriate medical care to warrant a transfer, and when do we enter a situation where the mortality is really quite probable, and when should we look at compassionate care in that setting, in the setting of a virus that has no treatments that are available?

28.12 Dr Branley also agreed that there is an ethical dimension to this issue and was asked about whether the ceiling of care could be "*automatically lowered*" just because the residents were elderly patients. He said:

> No, but we can quite confidently say the mortality is significantly raised, and that's a discussion that hopefully needs to occur honestly and openly with the families and with the patient, if possible.

Expert evidence

28.13 Professor French, Professor Kotsimbos and Professor Kurrle all concluded that four of the residents (Barry Jehan, Blanche Billinghurst, Margaret Sullivan and Alice Bacon) may have had a better outcome if they had been transferred to hospital, and one resident (Ann Fahey) had a worse outcome because she was transferred to hospital. For the remaining 14 residents, the experts concluded that hospital transfer most likely would not have affected the ultimate outcome.

28.14 Dr Branley gave evidence that he advocated against the transfer of residents to hospital as this plan "*had a significant risk of disseminating the virus to other locations because the extent of the outbreak had not been defined and residents that have tested negative to that time could still be incubating the virus*". Dr Branley agreed that it was necessary to balance this consideration against containing the spread of the virus within the facility.

28.15 Dr Branley also expressed concern regarding the impact of transferring COVID-19 positive patients to hospital. He gave this evidence before the Royal Commission:

> I think in summary, it's really balancing that person-centred care of the elderly resident with society's public health need to not spread this. We know that, internationally, residential aged care facilities and hospitals have acted as the big amplifier and spreader of the virus throughout society.
>
> If we move elderly residents to a hospital and they have cognitive issues and they are walking out of a four-bed bay at Nepean Hospital into the corridor and needing to be physically restrained within the COVID space that's not as ideal as an aged care facility that has individual rooms, doors on those rooms and residents can be contained, from an infection control point of view, much better than a hospital. In New South Wales, we have, to my knowledge, no hospitals with 100 per cent single rooms. There are a couple in Australia but there are very few hospitals where you can move patients to completely single room profile to actually maintain that infection control. So you do put your health care workers at risk by major movements of large cohorts of positive or negative patients that may still be positive.

28.16 Each of the experts was asked to express a view about the reason(s) for sending a person to hospital. Professor Kotsimbos expressed this view:

> The main reason to go into hospital is because the hospital is going to provide a level of care that's going to make a difference to you.
> […]
> So the reason we send people to hospital, and we saw if for some of the patients in the nursing home at Newmarch, was because we think there's a reversible factor at play that we can help with.

28.17 Professor Kurrle expressed agreement with this and went on to offer this view:

> We're not necessarily talking cure; if we were talking cure for everyone that went to hospital, we'd be abject failures, I'm afraid. It's the level of care, and is it appropriate for that person to go to hospital because the level of care they receive there will be what they need […]

28.18 In her report, Professor Kurrle expressed the view that the HITH model was unable to provide a hospital level of care for COVID-19 residents for the following reasons:

- The NH [Newmarch House] environment was not designed for health care but as a comfortable home like environment. Surfaces including flooring were soft and not easily adapted for infection control measures.

- Other than RNs, NH care staff are not health care trained. For HITH to have been equivalent to admission to Nepean Hospital, all staff would need nursing training ie Certificate III (assistant in nursing), Certificate IV (enrolled nurse), nursing degree (registered nurse).

- There needed to be adequate staffing numbers to provide personal care, assistance with meals, administration of medication, observation of vital signs.

- In hospital when deterioration of a patient was detected, medical staff could be called immediately to assess and manage the patient. This was not able to occur in a timely manner at NH. Although there was geriatric medicine expertise available through VACS as a virtual service, this did not appear to influence management of residents in the same way as it would have if they had been admitted to an acute aged care ward, where a comprehensive geriatric assessment would have occurred and there would be involvement of a multidisciplinary team with regular review by medical staff, and access to other specialist advice (including respiratory medicine) as needed.

- There was no immediate access to pathology testing or imaging services at NH as there would be in Nepean Hospital.

- Medications required for patients are usually immediately available in hospital. In contrast there were instances described where there was not medication available for NH residents.

- There was not the linen or laundry service available to provide clean sheets, and clean clothes for residents.

- Oxygen was used at a very low flow rate (usually 2 litres per minute) and using low flow nasal prongs rather than high flow nasal prongs or an appropriate mask. On at least one occasion the oxygen cylinder being used by a resident was empty. There was not adequate staffing to ensure that residents requiring oxygen kept their nasal cannula/mask in place, with examples of staff entering a resident's room to find the resident without oxygen.

- Residents were not able to be properly isolated – there were examples of residents walking out in the corridors, and residents walking into other resident's rooms.

- In hospital it would not be common to prescribe crisis or end of life medications before the patient developed symptoms, or before review by a palliative care team. Consultation with the resident's person responsible should also occur to gain consent. There was minimal documentation of consent.

- To have a HITH model work well, there needs to be close communication with staff in the facility and the HITH team. This did not always occur with NH as often when the HITH team attempted to contact NH staff, there was no answer to their telephone calls. Their reviews used the observations recorded by NH staff in the electronic record where access was available.

28.19 Dr Wroth was also of a similar view and explained that residential aged care facilities *"are first and foremost the home of the resident*" and have a different layout, environment and furnishings compared to a hospital. Dr Worth went on to state:

> In hospital the main and core focus is on clinical care. The layout, infrastructure and available expertise supports clinical care. The design of hospitals has IPC at the fore. Accordingly, it is easy to move people from one area to another just by swapping beds. The systems are in place prior to any infected patient arriving in the hospital, and each bed area has oxygen, suction, space for equipment and an emergency call system. Staff are trained for the roles they perform and are used to working in a health care environment. In this environment, there is immediate and ongoing access to clinical assessment, medication, intravenous access and support, medical equipment, airway and defibrillation support, and a range of specialist advice and support. These things are not easily provided in a residential aged care facility, and even where available (on an "in-reach" basis) in a continuous and timely manner. Staff are also trained, monitored and supported to maintain effective IPC and PPE, and the bulk of the relevant workforce is clinically trained, unlike personal care workers. It is easier in this setting to transfer extra staff to support increased care needs as required.

28.20 Professor Kotsimbos, Professor Kurrle and Professor French were all asked to assume that during the first period of the Outbreak there were significant staff shortages, a lack of equipment to measure observations at administer fluids, and issues regarding timeliness of personal care, food and medications. Professor Kotsimbos gave evidence that *"it would be an unreal expectation that Newmarch House could provide the level of care it purported to be able to provide*" to the residents. Professor Kurrle agreed and gave this evidence:

> That lack of equipment shows that however you look at it Newmarch House was not a hospital, and could not provide the Hospital in the Home level of care that even a very basic level of care that would be required. But we have to remember, Newmarch House is these people's home and it was never designed to be a health care facility.

28.21 Professor French also agreed and added:

> Assuming that the number of staff was insufficient and the amount of equipment available was insufficient and hearing that other staff including medical staff were having to provide personal care to patients, it seems extremely unlikely that the environment at Newmarch House would be considered functionally equivalent to a general hospital ward.

28.22 In his statement dated 24 July 2020, Dr Branley opined that "r*esidents who tested positive for COVID-19 received treatment comparable with what they would have received in a hospital*". Dr Branley gave evidence that this is the view he held at the time the Outbreak was on foot, and was a view that he communicated to staff at Newmarch House. However, when asked in evidence on 11 August 2022, whether he stood by this statement, Dr Branley gave this evidence:

> I have modified my views after listening to my colleagues in the last few days. It's sometimes hard to admit you're wrong.

28.23 Professor French gave evidence that, in hindsight, the uncertainty within the broader medical community, and underlying anxiety and fear, influenced decision making at the time so that the concern regarding the risk of spread of infection may have been given more weight than it was entitled to.

28.24 Professor Kotsimbos gave evidence that whilst it might have been reasonable to manage the Outbreak within Newmarch House when there were "*only a few cases*", once there was "*a lot of cases*" and problems associated with staff infections, staff shortages, the quality of staff and fearful staff, "*it should have been quite obvious relatively quickly that that was not going to be something that could be a workable solution to the problem at hand*". Professor Ibrahim similarly expressed the view that the decision-making regarding admission of patients to HITH should have been reviewed and discussed.

28.25 Professor Ibrahim gave evidence that it was ill-conceived to seek to effectively treat Newmarch House as a virtual hospital ward due to: the skill level of the staff, vast majority of whom were not qualified nurses; the lack of medical equipment and the capability to use it; the lack of access to rapid medical review; the lack of access to therapeutic agents such as fluids, and diagnostic tools such as x-rays; and the GPs who know the residence and had been their primary care providers.

28.26 Professor Ibrahim was asked whether the policies which provided that transfer to hospital should only occur where medically indicated requires attention to the individual case. He said:

> It does in part, but not wholly. One of the fundamental issues is that the writing and the information provided fails to acknowledge the risk to others, and so that in normal circumstances, the individual makes decisions about their care with their health providers. With COVID, your decision when you're in a communal living arrangement has significant impact on your co residents, who may not know what your condition is, and have no say in what you're doing, but their decision directly impacts on your health and directly impacts on the staff's health. So the notion that this should be individualised, I think, is far too simplistic.

28.27 Professor Ibrahim was also asked whether hospitalisation should have been pursued in order to take pressure off the system. He said:

> [T]he short answer is yes. The longer answer is what stage of the pandemic are we in, what are the resources that we've got in terms of health across our region and our State, what are the other consequences that we can't see that aren't in front of us that need consideration, which is why my central argument has been that preparation for the pandemic required a multidisciplinary group to be able to look at these elements and come to a considered decision, and then relay that to the community, that there is no one right way of doing things. If Nepean had capacity, and there wasn't demand, then I think they should have taken the residents. If Nepean was swamped, and every other hospital in the State was swamped, and our ICUs were full to bursting, then we needed different plans about what we would do in that situation.

28.28 Professor Kurrle gave evidence that HITH is a model of care for very specific conditions or illnesses (for example, where patients require intravenous antibiotics or anticoagulants) that is used in the community relatively successfully but is much more difficult to do in a residential care environment. HITH is a model of care that requires patients who are medically stable and able to look after

themselves with a degree of independence and cognitive awareness. Professor Kurrle described VACS as being "*very much a telehealth service*" and that with the risk of virtual services there is always the risk of "*missing things*", and that a comprehensive geriatric assessment requires the assessment to be done face-to-face. Ultimately, Professor Kurrle gave evidence that her approach would have been to bring residents from an aged care facility into hospital, and she expressed this view:

> The Hospital in the Home does not work with infectious diseases, particularly in people who are cognitively impaired, and in large groups like that, and when you don't have staff that are health care trained to look after these people who by definition are quite sick.

Consideration given by Anglicare

28.29 Mr Millard accepted in evidence that Anglicare had a responsibility to know what was happening in Newmarch House, and to review advice that was being received in those circumstances. However, he gave evidence that there was very limited time to reflect or seek a third opinion as decisions had to be made immediately. Mr Millard was asked whether he was saying that there was no opportunity to evaluate the advice that was being received. He said:

> Yes, I think that's right. It's that cognitive load or whatever it is, but everyone was myself included this was punishing hours, crazy media engagement. Gavin Pretorius went to hospital twice with heart issues. Everyone was under extreme pressure during this time and I it doesn't absolve us of our responsibilities, but contextually there is very limited capacity to do that.

28.30 Mr Millard also gave evidence that the "*only other voice that we were hearing*" during interdepartmental conferences was whether there should have been cohorting of residents or transfer of residents off-site. When asked whether there was ever a moment where, in the period between 11 and 24 April 2020, he considered raising the issue of whether HITH was not working Mr Millard said:

> I believe that, at the time, the position being well, made clear to us that residents were not to be transferred out of the a home. That there was really no choice but to participate in what was being done. I I'm clearly, we had a we had a voice. Mr Pretorius, you've already referred, expressed a view that this was a I wouldn't say we're hostage to a situation, but it was this was the way it was going to be and and we had to do our best to participate in it.

28.31 Following this, Mr Millard recalls that there was increased confidence in the testing regime, staffing levels and that planning to cohort residence was progressing. He gave this evidence regarding that period of time:

> Did I consider that we should just pull the pin or say we are not going to participate in this any further? No, I did not form that opinion and I can't say that I actually seriously did that once we were engaged in this exercise.

28.32 With the benefit of hindsight, Mr Millard gave evidence that it is "*unequivocally*" his position that HITH is a model of care that should not have been pursued because:

> If I had my time again, though, and would have had greater knowledge about what we were stepping into, I I never would have accepted that we should have cared for these people or tried to run a hospital. It was we shouldn't have done it.

28.33 Mr Millard gave this further evidence:

> The impact of conducting that model of care in the residential aged car setting was significant. I'm I'm not in a position to comment whether the health outcomes may have been different for residents but, nevertheless, the experience for the residents and their families and, indeed, the staff Anglicare staff operating that model of care was unacceptably brutal, and it should never have happened. Was the decision right to agree and acquiesce, at the time? Now, I'd say it shouldn't have been agreed to.

28.34 Mr Millard offered this final reflection:

> If we had the time again, I would have sought to have had all the positive residents transferred to hospital and I think the substantial reason for saying that is because the overwhelming problem that Newmarch House confronted was the chaotic situation and the staffing problems and I believe it would have been a much better solution to have transferred diagnosed positive patients off site to a hospital environment at a minimum that would have given staff working in the home, families, and residents some confidence that it was a less compromised situation in terms of potential for infection and contamination.
>
> And it would have allowed the home more readily to stabilise staffing and get into a even a different model of care. But, with hindsight, that should have been done.

28.35 On 20 April 2020, there ought to have been some reconsideration of the viability of the model of care, when staff shortages became acute and at which time case numbers had risen dramatically. The circumstances of that day would not have provided confidence that the model of care could adequately meet the residents' needs.

28.36 In relation to 20 April 2020, Dr Branley gave this evidence:

> It certainly was a day where I'd not only considered a change of approach but I requested a change of approach.

28.37 Dr Branley accepted that, as clinical lead, it was within his authority to change the approach. However, Dr Branley gave evidence that he had conversation with Mr Goodhew who asked him, "*Should I push the red button?*". Dr Branley gave evidence that he did not know what this meant but that he should have clarified this with Mr Goodhew. When asked whether Mr Goodhew provided any guidance about what the "*red button*" was, Dr Branley gave this evidence:

> Well, he said something to the effect of and once again my memory is not perfect, but something to the effect of, "We have a plan ready to go." I had the impression that there was a secondary plan that they were ready to activate, and I assumed it was because they had had the wisdom to see that my plan wasn't working.

28.38 Dr Branley accepted that he had proposed the model of care but described himself as the adviser (whose advice was accepted) and that he "*did not see that [he] was the decision-maker at any stage*". Dr Branley gave evidence about his offer to stand down (on 16 April 2020) and being brought back into the fray, and asked where he accepted he was the obvious person to make decisions about whether patients had to be hospitalised. He said:

> Yes, I'll accept that at that point I probably should've hospitalised patients.

28.39 Dr Branley gave evidence that he thought he was suggesting that a different course be taken by stating that the current model was not working. There then followed this exchange:

> Q. Did you provide any concrete suggestions about what should happen, besides saying this isn't working?
> A. I'd come off one of the worst days in my life and I was not I was out, there was no petrol in the tank.
>
> Q. You're saying you were overburdened as well?
> A. Yes.
>
> Q. You had a hospital sitting 1.7 kilometres down the road, right, and you knew intimately what the level of resourcing was in that hospital, right?
> A. Yes.
>
> Q. You knew if the system was overburdened that was an option, taking the strain off the system, moving the COVID positive patients to hospital?
> A. If it seems simple now, it didn't feel simple at the time.
>
> Q. Right. Is that a call that you could've made?
> A. I made the call I thought to the decision maker and I said we need to do things differently, and I believed I was making that call.
>
> Q. So that Mr Goodhew is not a doctor?
> A. I don't mean I was making the call to send them to hospital, what I mean is I was putting up my hand and saying…
>
> Q. Change course?
> A. … change course, and I was led to believe that there was another plan which would bring a lot of resources into the equation, and that turned out to be true.

28.40 Dr Branley later acknowledged that "*perhaps [he] made the wrong call*" when the option was not taken on 20 April 2020 to transfer patients to hospital. However, Dr Branley did not see that this was his decision to make and said that he felt that he was "*in the middle in the hierarchy of decision makers" and that he did not feel that the "command overall was sitting with [him]*".

28.41 Dr Branley was asked whether, having heard the expert evidence, he accepted whether he had made the wrong call about the hospital option:

I'm trying to express that I've actually, you know, listened to what they've said, and there's a lot deeper thinking than I had on 20 April, and once again, it was a distressing day, and you know, we were all tired, and it was hard to be thinking clearly and making the right decision, and maybe I made the wrong decision, and maybe I should have said let's send them all to hospital, but once again, the concept of send them all to hospital worries me, because you are moving people who don't want to go to hospital, and that has been an equipoise position that, you know, I'm conflicted about. But in retrospect, I should have gone back to Newmarch and done a round of the positives and picked people and sent them to hospital; that's what I should have done on that day, but I was exhausted.

28.42 **Conclusions:** As a group, the 19 residents who died had significant co-morbidities ranging from coronary disease to mobility issues to requiring assistance with activities of daily living. According to guidance material published by the WHO, the 19 residents fell within a cohort of patients for whom it was recommended that a clinical assessment be performed for potential transfer to hospital. No such assessment was performed at Newmarch House and Dr Branley was unaware of this guidance material.

28.43 However, Dr Branley was aware of similar guidance material published in Australia which similarly recommended consideration of hospital admission for patients with, amongst other things, co-morbidities or living in an unsuitable home environment. Although Dr Branley agreed that on this basis the 19 residents met the threshold for consideration of hospital admission, he referred to the fact that the wishes of the respective residents, and their families, also needed to be taken into account. However, as has been demonstrated earlier, it cannot be said that informed consent was always obtained from the residents regarding the question of transfer to hospital.

28.44 Another matter which Dr Branley considered relevant to the decision to not transfer the COVID-19 positive residents to hospital was the potential for lapses in infection control and dissemination of the virus. Dr Branley noted that at Newmarch House each of the residents had their own room, and that residents could not be similarly accommodated this way at hospital. However, residents were not locked into their rooms at Newmarch House and some exhibited wandering behaviour. Further, as has already been established, Nepean Hospital staff were more skilled and qualified in infection control practices compared to members of the surge workforce.

28.45 The expert evidence established that the goal of hospitalisation is not necessarily curative but to provide a level of care that will make a difference to patient and so a patient can receive the level of care that they need. In this regard, the expert evidence also established that HITH could not be considered functionally equivalent to a hospital ward and could not even provide the basic level of care that the residents required due to: staff shortages, the absence of equivalently trained staff, the inability of patients to be assessed and managed in timely manner, and the lack of immediate access to pathology and imaging services, high flow oxygen and required medication. Although Dr Branley was initially of a contrary view, during his evidence he expressed agreement with the expert evidence.

28.46 Further, the expert evidence established that the HITH model of care was incompatible with an infectious disease like COVID-19, and that certain prerequisites for HITH (medically stable patients able to care for themselves with a degree of independence) were similarly incompatible with the circumstances at Newmarch House. It is acknowledged that uncertainty within the broader medical community at the time, and underlying anxiety and fear about the effects and spread of COVID-19, likely contributed to the decision not to transfer residents to hospital.

28.47 Confusion regarding decision-making responsibility prevented any opportunity being taken to revisit the question of whether to transfer residents to hospital. On the one hand, Anglicare considered it only had a participatory role and deferred to medical advice given by the clinicians. However, Mr Millard gave evidence that the exigencies at the time precluded the seeking of any other opinion and any considered reflection. On the other hand, Dr Branley did not consider that he had any ultimate decision-making responsibility at the time. This proposition is more difficult to accept given the evidence, including Dr Branley's own evidence, regarding his strong advocacy against the prospect of transfer to hospital.

28.48 Notwithstanding, Dr Branley eventually acknowledged in evidence that as the clinical lead, he had authority to change the approach taken. However, this acknowledgment was not without, on Dr Branley's version, some qualification. Although Dr Branley referred to a "*secondary plan*" available to Anglicare that could be activated to replace his approach, there is no evidence of any such plan. In any event, Dr Branley acknowledged that if such a plan was available he took no action to clarify what it might have entailed.

28.49 Dr Branley conceded, in hindsight, that by at least 20 April 2020 a decision should have been made to transfer the COVID-19 positive patients to hospital. He also conceded, again in hindsight, that the decision not to do so was wrong. The descriptions provided by Dr Branley that his decision-making was affected by being overburdened and exhausted can be accepted. However, the expert evidence established that even so, once there was more than a few COVID-19 positive cases, and the staff shortages and inexperience was apparent "*it should have been quite obvious fairly quickly*" that the HITH model of care was no longer viable and that COVID-19 positive residents ought to have been transferred to hospital. At the very least, there ought to have been review and discussion regarding the decision to not effect such transfer. The eventual consequence was maintenance of the HITH model of care beyond a point where it could possibly make a difference in outcome for some of the 19 residents who died.

29. Action taken by institutions since the Outbreak

29.1 The institutional interested parties each provided substantial material regarding the changes they have made to their processes and guidance since the time of the Outbreak. The evolving nature of the pandemic, and in particular the availability of effective vaccines, has resulted in different approaches, and some changes that were proposed or adopted after the Outbreak have since been overtaken by new initiatives.

Anglicare

29.2 Anglicare has made changes to its structure and organisation. The composition of the Board was altered to increase the number of members with clinical experience and public health expertise. New roles have been created at an organisational level, including the Head of Infection Prevention Control and Outbreak Management and the General Manager - Quality, Safety and Risk. An infection control lead has been established at every residential care home since December 2020.

29.3 On 18 August 2020, Anglicare's Board developed a remediation action plan to address the operational, clinical, contractual, governance and leadership shortcomings identified following the COVID-19 outbreak and Newmarch House. Anglicare's COVID-19 Prevention and Response Team (formerly the Crisis Management Team) initially oversaw the implementation of the plan and maintained a supervisory role over COVID-19 matters until August 2021. Since that time, daily COVID-19 Management Meetings have been held.

29.4 Anglicare's surge workforce was increased to 192 staff in June 2021, including staff from different disciplines and two residential managers who could be deployed to facilities during outbreaks. However, the surge workforce was disbanded in late 2021. Instead, Anglicare now adopts a "risk-based" approach, where the skills and competencies required in an outbreak are identified and deployed as required. There is also increased capacity in the workforce, gained by training drills, experience in real outbreaks, and by a "buddy" system among Residential and Care Managers. An Outbreak Management Team continues to provide leadership and coordination during an outbreak.

29.5 On the topic of communication, a new role of Communications Manager was established to coordinate and supervise communication to residents and primary contacts during an outbreak. Anglicare states it has improved its capacity to manage higher call volumes during an outbreak via its Customer Contact Centre, including by introducing new technology. Anglicare adopted an Open Disclosure Policy in November 2020 which is intended to guide transparent communication, including during outbreaks.

29.6 Anglicare also states it has strengthened its links with LHDs, including services such as VACS.

NSW Health

29.7 On 23 June 2020, the Commonwealth and NSW Governments agreed upon a protocol to support the joint management of a COVID-19 outbreak in a residential aged care facility. This protocol describes the roles and tasks of each of the relevant agencies during an outbreak, including the DOH, ACQSC,

NSW Health and the Local Health District, Clinical Excellence Commission and the facility itself. The latest version was published in March 2022.

29.8 The key principles identified in the protocol include the following:

> All Australians should be able to access healthcare and live with dignity, regardless of their age and where they live
>
> Consumer-centred care
>
> - The clinical and welfare needs of residents are paramount. Decisions on the most appropriate clinical care, including location of the care and whether transfer to hospital is required, are made in consultation with clinical staff and residents (and their representatives). Decisions are regularly reviewed, and made on an individual basis, but also take into account the safety and welfare needs of all residents and staff in the RACF.
>
> - RACF residents continue, as do other people in the community, to have a right to access public health services (including hospital) based on their clinically assessed need.
>
> - Risks to individuals, and the service, take into account, needs and preferences of each resident and their representative (including through advanced care plans), and the circumstances of the RACF at which they reside.
>
> - Communication to residents and their representatives is coordinated by the provider and occurs as frequently as indicated by the changing profile of the outbreak and the communication preferences of the RACF residents and their representatives.

29.9 The protocol states that the Local Health District has responsibility to determine transfers to hospital:

> Determine escalation pathways for the response to clinical deterioration, including care in RACF and/or support transfer to hospital as clinically determined and consistent with the wishes of the resident.

29.10 Guidance provided by NSW Health to residential aged care facilities has been updated throughout the pandemic. Current guidance comprises several online resources related to COVID-19 outbreaks in aged care facilities.

29.11 The current model of care delivered during an outbreak continues to include services such as Hospital in the Home. In August 2021, NSW Health prepared a sample agreement between residential aged care facilities and the LHD. The HITH policy requires such an agreement to be adopted. The agreement sets out the roles and responsibilities of the COVID-19 service and the facility itself, including an outline of what care will and will not be provided.

29.12 Notably, the sample agreement includes the following statement regarding transfer to hospital:

> The COVID-19 Service will make a decision on the most appropriate clinical care for the positive residents, including whether to treat them in the facility or at one of our hospitals, on an individual

basis and in consultation with the resident and their family or their Person Responsible and the General Practitioner. The decision will consider the resident's wishes, any advance care directive, the circumstances of the facility and the safety and welfare needs of all residents and staff in the facility. At all times the clinical and welfare needs of residents is paramount. The COVID-19 Service model of clinical care for positive residents at the facility is known as Hospital in the Home (HITH). Under the HITH model, each positive resident is admitted under the care of one of our admitting clinicians and receives hospital-level care in the facility (added emphasis).

29.13 At a local level, NBMLHD prepared an updated Outbreak Management Plan in July 2021. This sets out in detail the steps that have been taken to prepare for further outbreaks and describes the roles and responsibilities of different parties during an outbreak. The plan is supported by a workforce surge and capacity plan, which identifies the granular detail of staff that would be required to support facilities during an outbreak.

29.14 The outbreak management plan articulates a similar process that was adopted during the outbreak at Newmarch House:

> Clinical oversight of the outbreak will be undertaken by the Infectious Diseases Team under the direction of the Infectious Diseases Consultant. The care of COVID-19 positive residents will be managed by Hospital in the Home (HiTH), and the care of COVID-19 negative residents will remain the responsibility of their General Practitioner.
>
> In order to coordinate the care of all residents in the RACF, a Clinical Care Team, led by the Infectious Diseases Consultant, will be formed and will include Infectious Diseases, the RACF Clinical Coordinator and the PHN as a minimum. Others can be included as deemed appropriate at the time. This Team will ensure that all residents, regardless of COVID-19 status, receive appropriate care while in the Facility, consultation with, and referral to relevant specialties, and timely transfer to hospital if required.

29.15 On the topic of transfers to hospital, these are to be determined by the clinical care team and HITH, but by consultation with Geriatrics, Surgery, Medicine or Intensive Care specialists. The plan identifies that the clinical care team will consider the following factors when determining a transfer to hospital:

- Resident is for active treatment.
- Clinical deterioration, not for palliation.
- Medical or surgical assessment or intervention required (e.g. diabetes, fracture, bowel obstruction) regardless of COVID-19 status.

29.16 Overall management of the outbreak within the LHD, including a determination about what interventions are required, is the responsibility of an Outbreak, Management Team. This comprises the heads of the PHU, Infectious Diseases and Microbiology, Intensive Care, Geriatrics, Palliative Care, and the Clinical Director of Medicine, as well as an Infection Control practitioner, a Disaster Manager, and a person delegated to handle media and communications.

Commonwealth

29.17 On 30 September 2020, the Royal Commission published a Special Report into the response to COVID-19 in Aged Care. The Special Report made six recommendations, in areas of: funding to support family visits; changes to Medicare for allied health services; the establishment of a National Aged Care Plan, to include among other things protocols for decisions about transfers to hospital; introduce an infection control officer as a condition of accreditation; deploy infection control experts to provide training and preparation for RACFs.

29.18 On 30 November 2020, the Federal Government published its Implementation Progress Report. All of the recommendations made in the Special Report had been accepted and were either completed or in progress at that time.

29.19 The DOH augmented its online Infection Prevention and Control training, which had been first made available 15 March 2020, with advice on PPE use.

29.20 The National Medical Stockpile (**NMS**) was replenished and expanded, to include gowns and gloves. A new process was developed for aged care facilities to access PPE from the NMS. The expenditure on PPE during the pandemic was significant – $3.3 billion was invested by the Commonwealth between March and July 2020 to secure essential PPE and medical equipment.

29.21 On 29 June 2020, DOH guidance was issued entitled *First 24 hours – managing Covid-19 in a residential aged Care facility*. On 10 December 2021, a *Being Prepared* checklist was published for Aged Care providers, with links to relevant Federal and State information.

29.22 The ACQSC has also issued guidance, *What we learned from COVID-19 outbreaks in 2021*. RACFs are required to have a comprehensive, up-to-date and well-rehearsed outbreak management plan, and be ready to activate it immediately.

29.23 The CDNA has updated its National Guidelines on *COVID-19 Outbreaks in Residential Care Facilities* on several occasions since the outbreak. The most recent version available at the time of the inquest has since been superseded by a Guideline on Acute Respiratory Infections, published on 22 September 2022. The initial guidance, that providers should plan for 20-30% staffing attrition, was revised in later versions of the Guidelines, recommending instead that staffing contingency should be based on the current nature of the pandemic.

29.24 **Conclusions:** Having regard to the action taken by the institutional parties since the Outbreak, which has resulted in improvement in relevant policies, practices and guidance material, it is neither necessary nor desirable for any recommendation to be made pursuant to section 82(1) of the Act.

29.25 Further, the evidence established that sufficient policy material and guidance existed at the time of the Outbreak to inform a clinical response that was consistent with best practice. However, as has already been described, issues with staff workload, shortages and training, and ineffective communication, in particular between HITH and Newmarch House, resulted in non-adherence with such policy material and guidelines. As noted above, the action undertaken since the Outbreak has resulted in improvements in staffing levels and competencies, more effective and responsive communication frameworks, clearly defined leadership and management roles, and establishment of escalation, review and intervention pathways.

29.26 Finally, the demands of responding to another COVID-19 outbreak would be different in many respects to those that existed in early 2020. New strains of the virus and a widespread vaccination program, together with the broader community experience of having lived through the pandemic, are all matters which will necessarily impact upon any future response to a similar event.

PART TWO

30. Raymond Jennings

HEALTH

Co-morbidities

30.1 Raymond Jennings was 93 years of age when he passed away at Newmarch House on 18 April 2020 during the COVID-19 outbreak. He had a number of existing comorbidities at the time, namely, Parkinson's disease associated with hypotension, benign prostatic hypertrophy, peripheral arterial disease, dementia, depression, anxiety, osteoarthritis, double incontinence, cerebrovascular accident (CVA) and ischemic heart disease (IHD) with syncopal episodes, chronic obstructive pulmonary disease (COPD), an ex-smoker, and had chronic pain of a possible neuropathic cause. Mr Jennings also had hearing loss and visual impairment.

Background and events leading up to COVID-19 diagnosis

30.2 Mr Jennings required assistance for most activities of daily living and could not stand or walk unaided, requiring assistance with dressing and toileting. He sought assistance from staff at Newmarch House by clapping and buzzing.

30.3 A review by geriatrician Dr Amit Gupta on 26 March 2020 found that Mr Jennings was progressively frail with cognitive decline and likely moderate vascular/Parkinson's dementia. Mr Jennings developed pressure sores during 2019 and 2020, as he was unable to reposition himself and he refused to be repositioned by staff. A bruise was discovered on his right arm on 6 April 2020. These wounds required ongoing treatment. In early April 2020, Mr Jennings developed urinary tract infections. He became unsettled and resistive to care. He was prescribed antibiotics.

RELEVANT MEDICATIONS

30.4 Mr Jennings' regular medications included madopar (Parkinson's disease), fludrocortisone (CVA/IHD), Ventolin (COPD) and norspan (buprenorphine) patch, oxycodone, Lyrica (pregabalin) and paracetamol for pain management.

PRN Medication - Midazolam and morphine

30.5 Following Mr Jennings' Covid-19 positive results, Dr Kakkat prescribed morphine 2.5mg and midazolam 5mg/mL on 17 April 2020. Mr Jennings was also prescribed Maxalon 10mg/2mL and glycopyrrolate 200mcg/ml. None of these medications appear to have been administered. Dr Kakkat gave evidence that prior to the outbreak at Newmarch House, his usual practice when prescribing anticipatory medications was to have a discussion with family members in relation to that decision. That did not occur in this case.

COVID DIAGNOSIS

30.6 Mr Jennings took a combined nose/throat PCR test on 14 April 2020 at 3.45pm. It was found to be positive for SARS-CoV-2 on that day. At an unknown time on 15 April 2020, the facility manager Melinda Burns was advised that Mr Jennings' PCR test was positive. Ms Susan O'Neill, Mr Jennings' next of kin (NOK), was informed of the positive result by a nurse at 8.15am on 16 April 2022. The result was first recorded in Newmarch House progress notes at 8.22am on 16 April 2022, namely close to two days after testing.

30.7 It is unclear on the evidence precisely when infection control measures were introduced in Mr Jennings care, (for example the donning and doffing of PPE or strict isolation with only a dedicated COVID nurse/carer attending to him), in the period between testing and the formal notification of the result in the clinical records. He resided in the Blaxland wing, which until his diagnosis, had no positive cases.

ADVANCE CARE PLAN

30.8 Raymond Jennings' daughter, Susan O'Neill, completed an Advance Care Plan (ACP) with Mr Jennings' GP, Dr Dharmaratnam on 27 August 2018. It stated Mr Jennings did not want cardiopulmonary resuscitation (CPR) and did not want to be kept alive by being fed artificially. Antibiotics were to be administered "*on a case-by-case basis in consultation with the family.*" Mr Jennings did not want to be transferred to hospital, except to maintain comfort, and preferred to remain at his place of residence following palliative care, the priority being his comfort and dignity. The ACP was revised on 19 November 2019, recording that antibiotics were not to be administered except to promote comfort. The ACP was further reviewed in February 2020 but was not amended.

30.9 Ms O'Neill gave evidence at the inquest that when the ACP was filled out by herself there was no discussion with Anglicare staff about what various expressions in the ACP meant, including the statement that Mr Jennings' preference was not to be administered antibiotics except to "*promote comfort*", to not be transferred to hospital except to "*maintain comfort*" and his preference to remain in his place of residence following a palliative care plan, the priority being his dignity and comfort.

Discussions around ACP

30.10 On 16 April 2020, Ms O'Neill received a call from an RN at Newmarch House advising that Mr Jennings had tested positive for COVID-19. At 12.00 pm, there was a case conference call between Ms O'Neill, Dr Dharmaratnam and Dr Kakkat. During the conference call Ms O'Neill was asked by Dr Kakkat about Mr Jennings' End-of-Life Plan and what the family wanted to do in the worst-case scenario. Ms O'Neill confirmed that she did not want Mr Jennings to be taken to hospital and advised that she and her family wanted Mr Jennings to be treated at Newmarch House under palliative care. Ms O'Neill confirmed that Mr Jennings should remain in the nursing home in the event of a deterioration. The note of that conference records:

> He is to be managed at the nursing home. In the event of deterioration, he is not for intubation, CPR or ICU admission. He is to be managed by hospital in the home treatment. Any changes the family to be contacted and kept in the loop. He will be given low flow oxygen. Also, if he has any infection, they will manage him in NH with antibiotics. He will be managed palliatively at the NMH. Susie has

the following questions:- What symptoms does he have? - Are they mild or severe? - - What is the usual time line of the virus?- What is the time line of the illness?- Does dad know about his situation that he is positive?- What is the supportive measures in place at the nursing home for him?- Is he conscious?- In worst case scenario, will they be allowed to come and see their father?- Does he understand what is going on?- Will there be a point of contact at the NH for her to enquire about her father. In regards to the above questions as they pertain to his current situation, the Nursing home is requested to give her a call and answer them. We have explained to Susie the symptoms this illness shows, management forward and the supportive measures in place in the event of worsening symptoms.

30.11 Mr Jennings was not involved in this conference call. In her oral evidence, Ms O'Neill stated that she believed that her father did have the cognitive capacity to make decisions on his own treatment at the time of the discussion on 16 April 2020. During this conference call Dr Dharmaratnam noted that "*He [Mr Jennings] is to be managed at the nursing home in the event of deterioration, he is not for intubation, CPR or ICU admission*", being intensive care procedures administered in a hospital setting. Dr Dharmaratnam further noted that Mr Jennings "*is to be managed by Hospital in the Home treatment*".

30.12 Ms O'Neill gave evidence that she was <u>not</u> provided with any information during that conference call as to what Hospital in the Home (HITH) treatment comprised of, including the level of care that Mr Jennings would receive in HITH. She gave evidence that "*there was certainly no discussion about what it* [HITH] *was or did (sic) I agree to it or anything*" or whether she had a choice in relation to what model of care her father would receive. Despite the progress note recording that "*we have explained to Suzie* t*he symptoms this illness shows, management forward, and the supportive measures in place in the event of worsening symptoms,*" Susan O'Neill gave evidence that she <u>never</u> received a call about such matters from Newmarch House staff. Her understanding was the key priorities at the time in relation to Mr Jennings' treatment were that "*He would be kept comfortable in his familiar surroundings. Dad always hated hospital, and I thought if he had COVID and <u>he was not going to recover</u>, I wanted him to stay where he was*". Ms O'Neill was later informed that if Mr Jennings deteriorated, two family members could visit in PPE. This did not eventuate.

30.13 Dr Kakkat gave evidence that he understood the words "*I do not wish to be transferred to hospital except to maintain comfort*" to mean that *comfort* related to a "*fracture or pain or something fixable*" and only then would transfer to hospital be required. Further, Dr Kakkat's opinion was that it was 'better' to keep Raymond Jennings at the nursing home given his comorbidities.

30.14 On 16 April 2020 at 3.58pm, a copy of Mr Jennings' 21 November 2019 ACP was faxed to Nepean Hospital for placement on the HITH admission forms.

30.15 On Friday 17 April 2020, Ms O'Neill received a call from the Head of Infectious Diseases at Nepean Hospital, Dr Branley. Ms O'Neill gave evidence that during the call with Dr Branley he referred to HITH but he did not explain to her what HITH meant, whether she had a choice on Mr Jennings' behalf regarding what treatment he would receive, nor was she informed as to the level of care her father would receive under HITH, as compared to treatment following transfer to hospital. Despite this, Ms O'Neill gave evidence that she did not want Mr Jennings to be transferred to hospital.

30.16 Mr Jennings' was provided treatment that was in accordance with his ACP. However, the detail of the care would be provided to him under HITH was not explained to Ms O'Neill. Although she understood he was to be admitted to HITH, she was not in a position to provide informed consent.

PROGRESSION OF ILLNESS

15 April 2020

30.17 On 15 April 2020 Mr Jennings' vitals levels were recorded once at 1.48pm 90% 2L 02 (BP 166/95 Pulse 88 T37.7C), and at 4.45pm Temp at 38.1C. The nurse was informed. At 1.48pm, Mr Jennings had an unwitnessed fall from his bed. No injuries were recorded. Ms O'Neill spoke with Mr Jennings twice during the day, he sounded well and did not complain of any health issues. Ms O'Neil was not informed of her father's fall.

16 April 2020

30.18 On 16 April 2020, Mr Jennings' observations were recorded three times at 4.31am SPO2 92% RA (BP 148/97, Pulse 100, RR 18, Temp 38.2C), 6.41am SpO2 90% on 2L (BP 166/95, Pulse 88, Temp 37.7C), and then some 12 hours later at 6.30pm SpO2 94% (BP 165/100, RR 22, Pulse 72) and Temp at 1.00pm (38.7C). At 4.31am Mr Jennings was awake, alert and coughing, but not in pain or distress. At 6.41am, Mr Jennings was found lying on his back naked in the toilet. He said he had lost balance getting up from the toilet. He denied hitting his head but complained of pain on his right hip. An accident and incident form was completed. Mr Jennings was receiving oxygen at 6.41am, although subsequent notes do not record whether this continued.

30.19 At 8.22am Mr Jennings' COVID positive status was recorded for the first time in the Newmarch House clinical records. At 10.50am, Mr Jennings was admitted to HITH. At 12.00pm, there was a case conference call between Ms O'Neill, Dr Dharmaratnam and Dr Kakkat as outlined above. At 3.03pm, an entry in HITH progress notes recorded Mr Jennings positive COVID result, his background history and medication and his admission "*as per New Protocol for HITH COVID-19 NH residents.*" The plan was to enrol Mr Jennings for HITH and await an *up-to-date* Advance Care Plan from Newmarch House. No up-to-date care plan was created or sent.

30.20 At 6.30pm, Clinical Educator Leslie Dominguez noted that Mr Jennings had shown signs of weakness that day, required lots of prompting to take his medication and was not eating well. He had a productive cough.

17 April 2020

30.21 On 17 April 2020 Mr Jennings' observations were recorded three times at 12:00 SpO2 97% (BP 173/84, RR 30, Pulse 148, Temp 39.0C), at 14:00 SpO2 85% (BP 181/100, RR 27, Pulse 127, Temp 36.9C), and at 17:35 SaO2 97%, (BP 173/84, Pulse 148, Temp 39.0C). His increased respiratory rate (RR) at 30 and 27 breaths per minute is suggestive of fast breathing (tachypnoea), yet there is no recorded nursing or medical response to this presenting symptom. At 4.05pm, Mr Jennings was reviewed by the VACS team, including Dr Kakkat. The note was limited to a record that Mr Jennings was "*93 yrs old male*

not for transfer with hospital with COVID +ve", a list of his comorbidities, and observations identical to those recorded at midday by a care worker. Anticipatory medications were charted by Dr Kakkat, including morphine, but there is no record that these were clinically indicated, discussed with family, or in fact administered.

30.22 Counsel Assisting submitted that the limited nature of Dr Kakkat's notes and the recording of observations identical to those recorded earlier on the same day suggests that Dr Kakkat performed a remote review rather than a face-to-face consultation. It was submitted on behalf of Dr Kakkat that a progress note entry by Ms Burns at 4.05pm on 17 April 2020 records Mr Jennings being, "*[s]seen by VACS team*", and that Dr Kakkat's own entry refers to, "*[a]t Newmarch House*". It was further submitted the recording of identical observations might simply represent the observations being utilised by Dr Kakkat rather than recording his own observations, noting Dr Kakkat's evidence that he did not take observations himself unless they had not already been taken by nursing staff.

30.23 As noted already, the making of progress note entries does not necessarily mean that Dr Kakkat conducted face-to-face consultations with a resident. This is particularly so having regard to Dr Kakkat's own evidence that he did not always see patients when he attended Newmarch House. The limited nature of Dr Kakkat's entry and the absence of documentation which would ordinarily be expected with the charting of anticipatory medications suggest that it is most likely that no face-to-face consultation was conducted by Dr Kakkat.

30.24 In the afternoon of Friday 17 April 2020, Ms O'Neill received a call from Dr Branley, who told her that he had visited Mr Jennings earlier that morning and that he would be treated in the HITH arrangement. Dr Branley advised that Mr Jennings was not experiencing breathing difficulties, however he was not getting enough oxygen into his body and that he had a fever. Dr Branley said to Ms O'Neill that if Mr Jennings survived the weekend, then he would have a chance of "*getting over it*" but that his medical opinion was he did not think Mr Jennings would recover.

30.25 A message was relayed to Mr Jennings that his family loved him. Ms O'Neill was informed that Mr Jennings said he "*loved [them] too*". That was the final time that Ms O'Neill heard from Mr Jennings prior to his death.

30.26 At 7.53pm, an unknown agency nurse recorded that Mr Jennings was "*not feeling well today, very shaky and unable to communicate in full sentences*". He had not eaten lunch or dinner but had water from a cup. Ms O'Neill was updated and she asked to be regularly updated about what was happening. At 8.05pm, RN Tegan Dean noted that Mr Jennings' blood pressure was outside the normal range. Chaplain Melanie Walker spent some time with Mr Jennings during the day. During the night of 17 to 18 April 2020, RN Emma Cardwell attended upon Mr Jennings.

18 April 2020

30.27 On 18 April 2020 Mr Jennings' observations were recorded three times at 2.00am SpO2 90% (BP 103/59, RR 14, Pulse 86, Temp 36.2C), 3.00am SpO2 90% (BP 103/59, Pulse 86, Temp 36.2C, RR 14), and at 9.10am FiO2 96% (BP 100/70, Pulse 69). At 3.00am, RN Cardwell recorded that Mr Jennings was asleep in bed. He was woken by a voice and was communicative. He denied pain. RN Cardwell

noted “no respiratory symptoms or increased WOB [work of breathing]”, but Mr Jennings’ oxygen saturation had been low on the previous shift. RN Cardwell performed deep breathing exercises with Mr Jennings and repositioned him to optimise respiratory function. At 9.56am, Mr Jennings was administered his usual medications and was assisted with breakfast.

30.28 Roughly half an hour later, at approximately 10.30am, care staff attended Mr Jennings and he was found not breathing, with no vitals, no pulse, cold skin and his face had turned blue. An agency nurse attended and confirmed he was deceased. A staff member then called Mr Jennings’ son, Glenn Jennings, to inform him of his father’s death, despite Ms O’Neill being recorded as Mr Jennings’ primary contact and responsible person. Glenn Jennings then called his sister to inform her of Mr Jennings’ death.

30.29 All other aspects of Mr Jennings’ treatment and the circumstances of his death were discovered by the family through a chance encounter with Dr Branley after his death. Prior to this chance encounter, Susan O’Neill was not given any information on the last days of Mr Jennings’ life, apart from a brief phone call from the RN on the afternoon of 17 April 2020. On that call, the RN provided an update that Mr Jennings had not been eating but that he had managed to drink a small amount of water, and in her view, he was doing slightly better.

MANNER AND CAUSE OF DEATH

30.30 **Cause of Death**: Associate Professor Kotsimbos, Professor Kurrle and Professor French considered that Mr Jennings’ cause of death was COVID-19 lower respiratory tract infection, with contributing factors being ischaemic heart disease, frailty, and Parkinson’s disease.

30.31 **Manner of Death**: The three experts agreed that as Mr Jennings was one of the earliest residents to be diagnosed with COVID-19, and his death was quite sudden, no other outcome was likely in the circumstances. There was no suggestion that his symptom management at end of life was unsatisfactory.

30.32 **Impact of any significant co-morbidities**: Mr Jennings had chronic lung disease which may have had an impact, but ischaemic heart disease, frailty and Parkinson’s disease all played a more significant role, because in combination, they resulted in a reduced capacity to fight an infection. Associate Professor Kotsimbos opined that as Parkinson’s disease has an impact on blood pressure, it particularly played a role.

30.33 **Issues with care received**: The experts opined that Mr Jennings had appropriate oxygen support and nothing extra could have been done. Associate Professor Kotsimbos noted that there were no clinical records suggesting that he was desaturating or dyspnoeic prior to his death. He was using nebulised Ventolin which may have created a risk of aerosol spread of COVID to staff and other residents, but this did not have an effect on his own care.

30.34 **Whether different action may have affected the outcome**: No

30.35 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Raymond Jennings.

Date of death

Mr Jennings died on 18 April 2020.

Place of death

Mr Jennings died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Jennings' death was COVID-19 lower respiratory tract infection, with ischaemic heart disease, frailty, and Parkinson's disease being significant conditions which contributed to death.

Manner of death

Mr Jennings died of natural causes following diagnosis of COVID-19 infection. Mr Jennings' symptoms were appropriately managed and he was provided with adequate oxygen support. No other steps in Mr Jennings' clinical management could have been instituted which would have materially altered the eventual outcome.

31. Ronald Farrell

HEALTH

Co-morbidities

31.1 Ronald Farrell was 94 years of age when he passed away at Newmarch House on 19 April 2020 during the COVID-19 outbreak. Registered Nurse (RN) Emma Cardwell was with him when he passed.

31.2 He had a number of comorbidities at the time of his death including cerebral vascular accident (CVA), cognitive impairment, ischemic heart disease (IHD), chronic obstructive pulmonary disease (COPD), emphysema, osteoarthritis, chronic pain, depression, recurrent falls, poor mobility, hypertension and cataracts. Mr Farrell also had a history of subdural hematoma as a result of a fall (2012/2013), stroke (2014), lower respiratory tract infection, chronic lower respiratory disease, skin cancers, arthritis and gait abnormality.

Background and events leading up to COVID-19 diagnosis

31.3 Mr Farrell was normally independent in self-care, and walked to meals and activities, but had medications given to him and was on oxygen 2L/min via a concentrator when he was in his room. Virginia Clarke, Mr Farrell's daughter, said that if her father went without oxygen for too long or did not know where the machine was, he would panic.

31.4 Ronald Farrell had several falls in the months prior to contracting COVID-19, including one on 16 and one on 17 April 2020. He was screened for delirium (acute confusion) and injury.

RELEVANT MEDICATIONS

31.5 Mr Farrell was prescribed regular medications including: Alepam (anxiety), axit, cardiprin, nordip, paracetamol, Salpraz, targin (chronic pain), vitamin D3, alvesco (COPD/emphysema), oxygen (COPD/emphysema), salbutamol (COPD/emphysema), ultibro breezhaler (COPD/emphysema), amlodipine (IHD), mirtazapine (depression). Mr Farrell was prescribed (prn) a number of medications to be taken as required including Endone (chronic pain), gastrogel, hypnovel, macrovic power, nitrolingual 400, salbatumol, sodium bicarbonate mouthwash and Systane eye drops.

PRN Medication - Midazolam and morphine

31.6 On 17 April 2020, Mr Farrell was prescribed morphine 2.5mg and midazolam 2.5 – 5mg by Nurse Practitioner (NP) Hailey Carpen from the Nepean Hospital Virtual Aged Care Service (VACS). Whilst the electronic progress notes record morphine being administered on 19 April 2020, there is no corresponding entry in Mr Farrell's medication charts.

COVID DIAGNOSIS

31.7 Mr Farrell took a PCR test for COVID-19 on 14 April 2020 at 3.45pm. The results returned a positive test at 5.10pm on 14 April 2020. He was admitted to Nepean Hospital on the Hospital in the Home (HITH) two days later on 16 April 2020 at 10.50am. On 17 April 2020 at 11.46am, Newmarch House manager Melinda Burns called Mr Farrell's daughter Virginia Clarke to see how she was coping with the knowledge of her father's COVID-19 positive status, believing that Ms Clarke was aware as the clinical records noted she had been notified. Ms Clarke was taken by surprise, as she had not in fact been notified about her father's COVID-19 diagnosis prior to speaking with Ms Burns. The following day, Ms Clarke was told by unknown staff member that her father only had a '*mild*' case of COVID-19 as his temperature was never higher than 37.5 degrees.

31.8 It is unclear on the evidence when Newmarch House first became aware of Mr Farrell's COVID positive result. A note recorded on 15 April at 7.03pm indicates that Newmarch House was unaware at that time as to the swab results, despite the swab returning a positive result 24 hours earlier. He resided in the Lawson wing.

31.9 It is unclear on the evidence as to whether Ronald Farrell was aware he had COVID-19 as Ms Clarke gave evidence that she did not inform him as she was concerned he "*might go into panic mode*" and she did not wish to upset him. Ms Clarke never received any answer from Newmarch staff as to whether they had informed him and he passed away on the Sunday prior to any anticipated return call by a doctor on the Monday in this regard.

31.10 Mr Farrell's Newmarch House Admission records contain a signed copy of the Charter of Aged Care Rights, dated 1 May 2019. Point Five of the Charter states "*I have the right to be informed about my care and services in a way I understand."* Point 7 of the Charter states*, "I have a right to have control over and make choices about my care and personal social life including where the choices involve personal risk.*"

31.11 At the time of the Covid outbreak in April 2020, his daughter's belief was that her father was cognitively able to understand what type of care was being delivered to him and was capable of exercising control over choices made in relation to his care and treatment. It was only after her father passed away that she was informed that NSW Health had decided to implement HITH and <u>not</u> transfer any residents to the local hospital. There was never a conversation between Ms Clarke and any staff member at Newmarch House or Nepean regarding the HITH model of care or what it meant. Ms Clarke was never informed by a doctor what treatment was to be administered to Mr Farrell following his COVID-19 diagnosis as he passed before being called by any doctor. She believes the HITH approach adopted by Newmarch House was not equivalent to a hospital setting.

ADVANCE CARE PLAN

31.12 On 21 August 2018 Ms Clarke completed an Advance Care Plan (ACP) on behalf of her father. It stated that Mr Farrell did not want cardiopulmonary resuscitation (CPR) or to be kept alive by being fed artificially. It stated that he *did* want to receive oral antibiotics and that he understood that intravenous administration of antibiotics may require transfer to hospital. It also stated that Mr Farrell did not want to be transferred to hospital except to maintain comfort and a handwritten note

stated "*Ronald does not wish to go to hospital unless it is deemed necessary*". The ACP was updated on 18 April 2020, the only tick box variation being that he *did not* wish to receive oral antibiotics except to promote his comfort. There was a handwritten note that stated "*We would like everything that can be done to help Dad when the need arises*."

Discussions around ACP

31.13 On 18 April 2020, in the context of Mr Farrell's known Covid positive status, Ms Clarke was asked to complete an End-of-Life Plan. An updated ACP, as outlined above, was signed. Ms Clarke raised questions with Newmarch House about why a further ACP was being created. Ms Clarke was fearful her father's condition was deteriorating, but she was reassured by Newmarch House staff that his condition was not deteriorating.

31.14 In relation to the ACP, Ms Clarke recalls simply being called by somebody indicating that, "*Every family is getting this documentation to complete so we can update all our records."* Ms Clarke did discuss the ACP form with her father, although he had a sore throat and couldn't really talk and simply replied yes or no to the questions. Mr Farrell expressed to Ms Clarke that he wanted his updated ACP to be in the same terms as his previous ACP and although he was not keen on going to hospital he would if he had to. Ms Clarke gave evidence that she updated the ACP without input from any medical practitioner, and she did not have any information at all in relation to what was to be expected in terms of being COVID positive.

31.15 Ms Clarke's updated the ACP with the words "*we would like everything that can be done to help dad when the need arises."* Her expectation was that if hospital transfer was required, it would occur. She held this expectation despite knowing that her father did not like hospitals and did not like to be out of his comfort zone. Her belief was that there was better treatment in hospital than in a nursing home, in particular in the context of an outbreak.

31.16 Ms Clarke felt that the decision not to send Mr Farrell to hospital was taken out of her hands once NSW Health subsequently informed her that no Newmarch House residents would be transferred to a hospital.

PROGRESSION OF ILLNESS

14 April 2020

31.17 On 14 April 2020, Mr Farrell had symptoms of upper respiratory tract infection, namely a productive cough and fever. No further observations were recorded on 14 April 2020.

15 April 2020

31.18 On 15 April 2020 Mr Farrell's saturation levels were recorded twice at 2.30pm 96%, (BP 126/65), and 7.03pm SpO2 96% 2LO2 (BP 126/65, P73, RR20, Temp 37.6C).

16 April 2020

31.19 On 16 April 2020, Mr Farrell's observations were recorded five times at 11.15am SpO2 94% 2LO2 (BP148/70 pulse 87 temp 37.1C), 12.00pm SpO2 91% (86 bpm, Temp 37.2C, 133/75), 4.16pm SpO2 93% O2NP (69 bpm 124/62, 36.4C), 7.53pm SpO2 92% O2RA (RR 23, BP 149/99 Temp 37.5 P83) and at 8.50pm SpO2 96% 2LNP (BP 156/86, P88). Mr Farrell had difficulty talking on the phone as his voice was hoarse and he could not speak properly. RN Emma Cardwell noted that she encouraged Mr Farrell to use the O2 concentrator, but he removed it on several occasions. At 3.45am, RN Cardwell found Ronald Farrell on the floor after sliding off his chair. He was able to move his arms and legs and denied hitting his head. He was hoisted back to bed and there were no apparent injuries.

17 April 2020

31.20 On 17 April 2020 Mr Farrell's observations were recorded four times at 04:00 SpO2 92% RA (BP149/99 Temp 37.5 P83), 8.19am SpO2 89%02RA (36.9 Temp, 135/61, 89 bpm, 21 resp) 5.07pm 84% w/o O2 (BP139/68 P 97 Temp 37.2C RR22), and at 6.19pm 89%RA (Temp 36.9C, 135/61. 89 bpm, 21 resp). At 6.30am RN Cardwell found Mr Farrell sitting next to his bed on the floor. He said his legs gave way and he lowered himself onto the floor. He did not buzz for staff assistance. He was hoisted back to bed and was assisted by staff to walk to the toilet.

31.21 Dr Kakkat made an entry into the Nepean Progress notes at 5.41pm recording in part "*COPD on 2L O2*" and a few of Mr Farrell's comorbidities followed by an entry that anticipatory medication was charted.

31.22 Dr Kakkat was questioned in relation to his clinical thinking for prescribing anticipatory medications for Ronald Farrell in circumstances where the Nepean clinical record entry records no vital signs. He gave evidence that if he wrote anticipatory medication there would be a [clinical] 'indication' and that "*it is not a blanket thing*." Dr Kakkat was unable to give any clinical justification for prescribing anticipatory medications. He said that the medications were prescribed as anticipatory of any symptoms, namely pain, shortness of breath, agitation, irritability, for vomiting, for nausea, and 'these types of symptoms.' Of note is that Ronald Farrell had none of these symptoms at the time of the prescribing of the anticipatory medication.

31.23 At around 11.00pm on 17 April 2020 Mr Farrell was found in front of his chair, denying hitting his head but some pain on his right flank region. He denied hitting his head but complained of some pain on his right-hand side. He was able to move his limbs and there was no evidence of trauma or bruising and he was hoisted into bed. RN Cardwell noted that he had an audible gurgle and yellow secretions. She administered oxygen which improved his oxygen concentrations.

31.24 RN Cardwell called Ms Clarke to discuss the ACP as she was concerned regarding the number of falls [three] in the last 24 hrs. The note as to that call records "*We agreed that if Ron had uncontrolled pain I would transfer him to hospital but we would seek to manage him here. Virginia states that Ron does not want to go to hospital and Ron reiterated this. 1 x care staff now sitting outside his room where able*."

18 April 2020

31.25 On 18 April 2020 Mr Farrell's observations were recorded four times at 1.00am SpO2 84% w/o 02 (BP139/68 P 97 T37.2C RR 22), 5 hours later at 6.40am SpO2 90%2L (P94), 8 hours later at 2.11pm 85% w/o (BP 142/65 P78 RR 35 Temp 37.1C), and lastly at 10.15pm SpO2 91% 02 (23 resp, temp 36.7C, 118/64). There is no record that Mr Farrell's abnormal saturation levels were escalated for review by a medical practitioner.

31.26 Progress notes from Nepean Hospital indicate that RN Sidney from the Nepean HITH unit contacted Newmarch House requesting updates on all COVID-19 positive cases, including observations, status and current condition but at the time of recording the entry at 3.38pm no information or contact had been received.

31.27 On the evening of 18 April 2020, Ms Clarke received a call from Mr Farrell. He was upset and could not breath because his oxygen machine wasn't working. He also reported that he was hungry and he had not eaten and that he had been continuously pressing the buzzer but no one had attended upon him. Ms Clarke felt that her father was in panic mode, and so was unclear whether in fact he had been pressing his buzzer. Ms Clarke called Newmarch House and was told that someone would call her back. Subsequently, a female staff member called and advised her that her father had taken his oxygen mask off but that it had been put back on. Staff reassured Ms Clarke that a meal would be arranged.

19 April 2020

31.28 On 19 April 2020 Mr Farrell's observations were recorded twice at 3.00am SpO2 85% w/o 02 (142/65, P 78, RR 35, Temp 37.1C), and at 2.15pm SpO2 ~70% (RR33). Mr Farrell had deteriorated overnight with oxygen saturation at 70% despite oxygen, with laboured breathing and cough. Oxygen had been increased to 6L/min via O2 concentrator. RN Cardwell noted that she had attended to Mr Farrell at 4.15am and he appeared to be sleeping comfortably. She noted secretion build up which she attempted to help him clear and he was repositioned in high fowlers. RN Cardwell called Dr Graydon at 4.55am to discuss commencing end of life medications.

31.29 RN Cardwell called Ms Clarke stating that Mr Farrell was in great distress and had trouble breathing. Ms Clarke gave evidence that she understood this to mean that they were going to make him comfortable to die peacefully. Up until that point she was unaware that morphine had been prescribed for her father.

31.30 At approximately 5.30am, RN Cardwell called Ms Clarke and put her on loudspeaker so she could speak with Mr Farrell. Ms Clarke went through all their family members' names and told him they all loved him. He did not respond. RN Cardwell told Ms Clarke she would stay with him so he was not alone. Morphine was commenced at approximately 05.00am.

31.31 At 6.00am Mr Farrell passed away in his room. RN Cardwell stayed in Mr Farrell's room with him until he passed away. RN Cardwell called Ms Clarke at 06.15am to advise of Mr Farrell's death.

31.32 RN Cardwell gave evidence that her role during the COVID-19 outbreak required her to constantly balance providing clinical care and communicating with families, which took up considerable time and energy. She described the difficult work conditions, and in particular the dynamic situation, and stated she attempted to provide the best care she could in the circumstances she was working in.

31.33 Ms Clarke did not believe there was enough communication from Newmarch House during the COVID-19 outbreak. Information that she received in relation to Mr Farrell's condition was limited to her communications with RN Cardwell only.

MANNER AND CAUSE OF DEATH

31.34 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agreed that Mr Farrell's cause of death was COVID-19 lower respiratory tract infection with pneumonia. Significant contributing factors included his chronic lung disease and emphysema.

31.35 **Manner of Death**: Professor Kurrle explained that Mr Farrell's lung disease put him at a very high risk of dying from a lung infection, and considered he probably had delirium prior to his death, noting he had a number of falls, and that would fit with the increasing infection he was experiencing prior to death.

31.36 **Impact of any significant co-morbidities**: The experts opined that severe lung disease placed Mr Farrell at a very high risk of dying from a lung infection, and he may have had a secondary bacterial infection.

31.37 **Issues with care received**: In terms of the circumstances in which Mr Farrell's death took place, Associate Professor Kotsimbos opined that Mr Farrell's chronic obstructive lung disease was a significant contributor to his death. Therefore, the use of oxygen in this setting was particularly relevant because it was not just a function of treating the infection involving the lungs but was also treating the underlying lung problem. Associate Professor Kotsimbos noted that Mr Farrell's use of oxygen was difficult and the effectiveness of the use of oxygen was also difficult to assess as he kept removing his mask following his COVID-19 diagnosis. Associate Professor Kotsimbos considered that the use of nebulising Ventolin had particular implications for Mr Farrell in terms of the need for bronchodilation, but also in terms of aerosol spreading to anyone that was in his room, and staff, if appropriate infection control measures were not undertaken. Associate Professor Kotsimbos also considered that there was a possibility that there may have been a secondary bacterial infection because of his underlying lung disease, so empirical antibiotics to cover that would have been a reasonable treatment option. Associate Professor Kotsimbos could not confirm whether antibiotics had been administered to Mr Farrell following his COVID-19 diagnosis because the progress notes were difficult to follow.

31.38 **Whether different action may have affected the outcome**: No

31.39 Associate Professor Kotsimbos noted that Mr Farrell was diagnosed with COVID-19 after the first wave of testing on 14 April 2020, therefore his diagnosis occurred early, and he may have already been symptomatic before testing. Despite his comments on the use of antibiotics and more effective

oxygen administration, Associate Professor Kotsimbos did not consider, on the balance of probabilities, that different treatment would have affected Mr Farrells outcome.

31.40 Professor Kurrle agreed with Associate Professor Kotsimbos that antibiotics could have been administered and if Mr Farrell was transferred to hospital, he would have likely had more consistent monitoring of his oxygen saturations and better treatment. However, given his significant comorbidities, transfer to a hospital would probably not have changed his outcome as his likelihood of survival was "*quite low*".

31.41 Professor French agreed with both Associate Professor Kotsimbos and Professor Kurrle in relation to their views on Mr Farrell's comorbidities contributing to his death, the adequacy of care provided to him up until his time of death and whether or not different management would have changed his outcome. That is, on the balance of probabilities, different treatment would not have changed Mr Farrell's outcome.

31.42 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Ronald Farrell.

Date of death

Mr Farrell died on 19 April 2020.

Place of death

Mr Jennings died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Farrell's death was COVID-19 lower respiratory tract infection and pneumonia, with chronic lung disease and emphysema being significant conditions which contributed to death.

Manner of death

Mr Farrell died of natural causes following diagnosis of COVID-19 infection. Whilst transfer to hospital would have allowed for the possibility of antibiotic therapy and monitoring of oxygen saturations, no effective treatment could have been instituted which would have materially altered the eventual outcome.

32. Edith Brownlee

HEALTH

Co-morbidities

32.1 Edith Brownlee was 92 years of age when she passed away whilst sitting in her chair at Newmarch House on 21 April 2020 during the COVID-19 outbreak. She had a number of existing comorbidities at the time, including dementia (mixed Alzheimer's/vascular), ischemic heart disease (IHD) (coronary artery bypass grafts (CABGs) in 2004) with syncopal episodes, longstanding shortness of breath with frequent episodes of productive cough/wheeze, hypothyroidism, a history of breast cancer, hypertension, gastric reflux and high cholesterol. Mrs Brownlee also had trachea stenosis and left vocal cord paralysis from an operation to remove her thyroid in her twenties, a large hiatal hernia in her stomach (2004) and glaucoma.

Background and events leading up to COVID-19 diagnosis

32.2 Mrs Brownlee was cognitively intact, and independent with toileting and eating. She had no respiratory symptoms other than a longstanding wheeze. She was able to talk with her family regularly on the phone.

32.3 Mrs Brownlee suffered loss of consciousness numerous times at Newmarch House. In 2019, Mrs Brownlee lost consciousness and was transferred from Newmarch House to Nepean Hospital where her family was advised that a stent was required, but due to her age and frailty, a decision was made not to perform the procedure. Mrs Brownlee was found unconscious at Newmarch House on three occasions between 9 March 2020 and 18 March 2020.

RELEVANT MEDICATIONS

32.4 Mrs Brownlee's regular medications included metoprolol, lercanidipine and candesartan (IDH and CABGs) and thyroxine for hyperthyroidism. Mrs Brownlee was also prescribed Acimax, Adesan, calcium, Cardasa, Eutoxsig, Genox, Lorstat, Minax, vitamin D3, Zircol, hydroxo-B12, lantanoprost, molaxole powder, Novasone, paracetamol, Salbutamol and sorbolene cream.

PRN Medication - Midazolam and morphine

32.5 On 17 April 2020, at 5.26pm Mrs Brownlee was prescribed a number of medications by Nepean Hospital Virtual Aged Care Service (VACS) Nurse Practitioner (NP) Hailey Carpen. The medications were termed 'crisis medications,' namely morphine 2.5mg subcutaneous to a maximum of 40mg per day and midazolam 2.5 – 5mg subcutaneous to a maximum of 60mg per day.

32.6 There is no record to indicate that Edith Brownlee was seen by *any* Hospital in the Home (HITH) or VACS team member (medical or nursing) between 17 April 2020, and the time of her death on 21 April 2020. The only entries between those dates involved a remote review of the Newmarch House

progress notes. There is likewise no evidence in the Newmarch House clinical records that Mrs Brownlee was seen by a GP after 8 April 2020.

COVID DIAGNOSIS

32.7 Mrs Brownlee took a combined nose/throat PCR test on 14 April 2020 at 3.52pm and the test result returned a positive finding for SARS-CoV-2 that same day. The result was first recorded in Newmarch House progress notes two days later at 5.00pm on 16 April 2020. At 5:30pm on 16 April 2020, Mrs Brownlee's Next of Kin (NOK), Ms Karen Brownlee, was informed of Mrs Brownlee's positive COVID-19 test result.

ADVANCE CARE PLAN

32.8 On 14 August 2019, Mrs Brownlee's daughter-in-law Karen Brownlee, discussed with Dr Sharma Mrs Brownlee's End-of-Life Plan. The plan outlines that she did not want to be resuscitated, tube fed or transferred to hospital. Karen Brownlee completed an Advance Care Plan (ACP) with Dr Richardson on 11 September 2019. The ACP stated that Mrs Brownlee did not want cardiopulmonary resuscitation (CPR) and did not want to be kept alive by being fed artificially. Antibiotics were to be administered "*to promote comfort.*" Mrs Brownlee did not want to be transferred to hospital, except to maintain comfort, and preferred to remain at her place of residence following a palliative care plan, the priority being her comfort and dignity.

Discussions around ACP

32.9 Mrs Brownlee was admitted into HITH on 16 April 2020. Following admission into HITH, a notation was recorded in Mrs Brownlee's progress notes that stated "*await aged care facility to send us up to date care planning*".

32.10 Dr El Jamaly gave evidence that in mid-April he was notified that the geriatrics medicine department was "*looking at the system where they will do telehealth and … discuss with the nursing home at Newmarch and look at finalising and liaising with then about advance care planning.*" Dr El Jamaly also gave evidence that he did not know how that aspect of the HITH process involving the provision of advance care planning became a requirement.

32.11 On 17 April 2020, Dr Sharma contacted Karen Brownlee to discuss Mrs Brownlee's care and to inform her that Dr Branley would be looking after Newmarch House residents. No changes were made to Mrs Brownlee's ACP. Karen Brownlee believed that no change was needed as "*it all sounded and felt like it was under control.*"

PROGRESSION OF ILLNESS

15 April 2020

32.12 On 15 April 2020, Mrs Brownlee's observations were taken twice at 11:30 (Temp 37.4, Blood glucose 4-10mmol/L, Systolic blood pressure 110-160 mm Hg, Diastolic blood pressure 60-90 mm Hg), and at 15:45 (Temp 36.9, Blood glucose 4-10mmol/L, Systolic blood pressure 110-160 mm Hg, Diastolic

blood pressure 60-90 mm Hg). At 7.00am, Mrs Brownlee received personal care and assistance to toilet. At 6.26pm, Mrs Brownlee refused Molaxole powder for oral liquid.

16 April 2020

32.13 On 16 April 2020, Mrs Brownlee's observations were recorded twice at 09:00 (Temp 35.6, Blood glucose 4-10mmol/L, BP 128/66)), and at 5.00pm when saturation levels were also recorded SpO2 99% (Temp 36.5C BP 127/6).

32.14 At 10.30am, Mrs Brownlee was admitted into HITH.

32.15 At 3.46pm, Newmarch House Care Manager, Ms Leann Hinton, recorded in the notes "*I have spoken to Dr Richardson and he has given verbal consent and will send written consent for Edith to access/support and gain virtual consultation from VACs team and Infection Control and my Emergency Doctor.*"

32.16 At 5.00pm, a Clinical Educator noted that Mrs Brownlee was lying in bed. A Registered Nurse noticed Mrs Brownlee had a wheeze. Mrs Brownlee advised that she always had a wheeze and that she felt fine and did not have a cough. At 6.53pm, Newmarch House Manager Melinda Burns called Karen Brownlee, and noted that the family was distressed but still happy with care.

17 April 2020

32.17 On 17 April 2020, Mrs Brownlee's observations were recorded once at 20:06 SpO2 97 % (Temp 36.4, BP 147/61, BPM 62). At 10.47am, Mrs Brownlee refused molaxole powder and Novasone.

32.18 An entry at 4.02pm by RN Catherine Sidney records, "*patient reviewed by VACS today at nursing home. for HITH call tomorrow*". There is no further information about this review.

32.19 At 5.26pm RN Carpen from VACS recorded that observations were not recorded and yet "*anticipatory end of life medications ordered today.*" Whether there was a remote review of the notes, or an in-person review, is unclear. RN Carpen also completed the medication chart.

32.20 At 8.06pm, Mrs Brownlee was seen laying in her bed, reporting she had eaten breakfast and no lunch and stating she had no cough but was sneezing at times. At 6.45pm, Dr Sharma from VACs spoke with Karen Brownlee about her mother's ACP, noting that she is not for resuscitation, intubation or ventilation and not for transfer to the hospital if she deteriorates. At 6.48pm, Mrs Brownlee "*missed*" being administered Acimax, Genox, Lorstat, Minax, Novasone, paracetamol and latanoprost.

18 April 2020

32.21 On 18 April 2020, Mrs Brownlee's observations were recorded three times at 1.00am SpO2 96% (Temp 37, BP 127/58, P 58, RR 21), 4.00pm SpO2 92% (Temp 36.4, BP 147/60, P 78, RR 17), and at 8.35pm SpO2 95% (Temp 35.6, BP 156/69, 23 Resp). At 1.00am, Mrs Brownlee was alert and interactive.

32.22 At 3.40am, Mrs Brownlee was administered Latanoprost eye drops. At 4.00am, Mrs Brownlee was not administered a nebuliser due to being COVID-19 positive.

32.23 Progress notes from Nepean Hospital indicate that RN Sidney contacted Newmarch House requesting updates on all COVID-19 positive cases, including observations, status and current condition, but had at the time of recording the entry at 15.28pm, received no information.

32.24 At 4.00pm, Mrs Brownlee denied any dry cough or sore throat, and reported nil pain or discomfort. An RN noted that Mrs Brownlee had noisy breathing, to which Mrs Brownlee stated she was perfectly fine.

32.25 At 8.35pm, Mrs Brownlee verbalised that she was feeling well with no cough, no runny nose but was sneezing at times. Mrs Brownlee was not showing any signs of weakness.

32.26 On 18 April 2020, Karen Brownlee received two calls from Newmarch House with updates on Mrs Brownlee's condition following her COVID-19 diagnosis.

19 April 2020

32.27 On 19 April 2020, Mrs Brownlee's vitals were recorded three times at 9.45am SpO2 92% (Temp 36.2, BP 149/59, P 60, RR 18), 2.30pm SpO2 94% (Temp 36.1, BP 150/67, P 66, RR 20), and at 10.00pm SpO2 99% (Temp 36.6, BP 128/66, P 56, RR 18). At 2.30am Mrs Brownlee reported that she was feeling well. She had no increased work of breathing, wheeze was normal, and she had no other respiratory symptoms. At 6.02am, Mrs Brownlee was not able to use a nebuliser due to being COVID-19 positive.

32.28 At 11.00am Mrs Brownlee informed her daughter-in-law during a phone call that she felt "*fine so far,*" with no symptoms. At 2.20pm, Karen Brownlee received a call from Newmarch House and was informed of Mrs Brownlee's status. Mrs Brownlee was reported to have no temperature, no sore throat, no runny nose and no breathing problems. At 5.45pm, Karen Brownlee received another call from Newmarch House updating her on Mrs Brownlee's condition.

32.29 At 3.28pm progress notes from Nepean Hospital indicated that RN Sidney attempted to call Newmarch House on three occasions with no success. There was subsequent contact with the VACS team who advised they would contact Nepean Hospital if there was anything significant to report. RN Sidney requested a system to facilitate a daily update from Newmarch House to Nepean Hospital.

20 April 2020

32.30 On 20 April 2020, Mrs Brownlee's observations were recorded four times at 8.30am (Temp 36.2, BP 122/62, RR 17), at 5.30pm SpO2 95% (BP 104/50), 9.34pm SpO2 95% (Temp 36, BP 104/50, P 73, Resp 28), and at 10.00pm SpO2 92% (Temp 36.5, BP 144/74, P 55, RR 18). At 12.30am, Mrs Brownlee was asymptomatic and afebrile. Eye drops were attended to. Mrs Brownlee had no respiratory symptoms and stated that she would like her bed changed. No observations were recorded at this time.

32.31 At 4.57am and 9.39am, Mrs Brownlee was not administered her nebuliser due to being COVID-19 positive.

32.32 At 5.38pm, VACS nurse remotely reviewed Mrs Brownlee clinical records and recorded "*Edith remains asymptomatic, noted Ventolin not given, maybe consider using MDI with spacer. Unfortunately, no observations recorded today. Please perform a set of observations*." Observations were in fact taken at 8.30am and 5.30pm that day. These were recorded in the vital signs chart, and not recorded in the body of the progress notes.

32.33 At 7.34pm, Cameron Elliot from Newmarch House advised Karen Brownlee that her mother-in-law was "*doing really good and her oxygen and mood was good*". At 9.34pm, Mrs Brownlee was encouraged to drink fluids and again was not administered her Salbutamol due to having COVID-19.

21 April 2020

32.34 At 4.00am, RN Tegan Dean noted that Mrs Brownlee was "*afebrile obs stable asymptomatic meds given as ordered*". Observations were not recorded. At 5.14am, Mrs Brownlee was not administered a nebuliser due to being COVID-19 positive. At 10.17am, Mrs Brownlee was administered her usual medications, except her inhaled medication.

32.35 On 21 April 2020, Karen Brownlee attempted to call her mother-in-law at Newmarch House at 10.59am and 11.14am without success. At 11.50am, Newmarch House staff located Mrs Brownlee sitting in a chair unresponsive. Dr Kakkat assessed Mrs Brownlee at 12.00pm and declared her deceased. Her death was noted as "*sudden.*" At 12:15pm the family were informed of her passing and told it was from a cardiac arrest.

MANNER AND CAUSE OF DEATH

32.36 **Cause of Death**: Associate Professor Kotsimbos considered that the cause of death was COVID-19 infection with underlying ischaemic heart disease being a significant comorbidity. Professor French and Professor Kurrle considered that the primary cause of death was ischaemic heart disease, with COVID-19 infection being a contributing factor. Associate Professor Kotsimbos explained further that he did not think that "COVID-19 infection is the big thing here" but that it had precipitated the event, and that the "biggest underlying problem" was Ms Brownlee's cardiac disease. The experts noted that she had no symptoms indicative of COVID-19 or lower respiratory tract infection/pneumonia despite testing positive to COVID-19.

32.37 **Manner of Death**: Mrs Brownlee had a sudden cardiac arrest caused by her underlying ischaemic heart disease.

32.38 **Impact of any significant co-morbidities**: Mrs Brownlee's underlying ischemic heart disease was a significant comorbidity.

32.39 **Issues with care received**: In terms of the circumstances in which Mrs Brownlee's death took place, Associate Professor Kotsimbos noted that Mrs Brownlee's oxygen saturation levels were not recorded very often which made it difficult to determine the trajectory of her condition following her COVID-19 diagnosis. As her death was very sudden it is unlikely more could have been done.

32.40 **Whether different action may have affected the outcome**: No

32.41 All three experts agreed that transferring Mrs Brownlee to hospital would not have changed her outcome.

32.42 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Edith Brownlee.

Date of death

Mrs Brownlee died on 21 April 2020.

Place of death

Mrs Brownlee died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Brownlee's death was ischemic heart disease with COVID-19 infection being a significant condition which contributed to death.

Manner of death

Mrs Brownlee died of natural causes following diagnosis of COVID-19 infection. No other steps in Mrs Brownlee's clinical management could have been instituted which would have materially altered the eventual outcome.

33. Maria James

HEALTH

Co-morbidities

33.1 Maria James was 78 years of age when she passed away at Newmarch House on 22 April 2020 during the COVID-19 outbreak. She had a number of existing comorbidities including dementia of mixed aetiology, chronic obstructive pulmonary disease (COPD), asthma, obstructive sleep apnoea (OSA), ischemic heart disease (IDH) with a history of five coronary artery bypass graft surgeries (CABGs) in 2008, aortic valve replacement (AVR) in 2010, congestive cardiac failure (CCF), atrial fibrillation (AF), metastatic adenocarcinoma with bone metastases and lung lesions, back pain, spinal fusion with chronic pain and a history of breast cancer (1973). Mrs James also had a history of hypertension, osteoarthritis and possible delirium. She had a history of anxiety and depression. She smoked cigarettes until she was in her fifties. She required assistance with activities of daily living (ADLs).

Background and events leading up to COVID-19 diagnosis

33.2 Mrs James was admitted to Newmarch House on 31 March 2020 for respite following an admission to Nepean Hospital with pain from metastatic bone disease, with primary cancer unknown. She had previously lived alone in her own home and was relatively independent with self-care. She had been declining prior to her last admission to Nepean Hospital. Mrs James had a brief admission to Nepean Hospital on 3 April 2020 after developing a high temperature, sore throat, and a cough. She returned a negative COVID-19 test result at that time.

33.3 When Mrs James returned to Newmarch House on 6 April 2020 she did not report any signs of headache, runny nose, or cough and was under strict direction to isolate in her room given her return from hospital.

MEDICATIONS

33.4 Mrs James was prescribed a number of regular medications including dexmethesone 500mcg once daily (chronic pain), Duride 60mg once daily, Eutroxsig 50mcg once daily, Jurnista 8mg once daily, laxative & senna 50mg/8mg twice daily, paracetamol 500mg four times daily (chronic pain), Salpraz 20mg once daily, Syquet 25mg once daily, Vasocardol 180mg once daily, Zactin 20mg once daily, Breo Elipta powder twice daily, Denpax 25mcg/hour patch, once every three days, Dilaudid 1mg/ml liquid 4 times daily, Molaxole power for oral liquid twice daily, morphine sulphate 10mg/ml injection, 6 times daily (chronic pain) and TwoCal NH Liquid 237mL, four times daily.

33.5 Mrs James was also prescribed diltiazem/nitrates and Apixaban (IHD / CABGs / AVR /CCF and AF) and bronchodilator inhaler medication (COPD/Asthma). Her as required medications included Abstral 100mcg, Asmol CFCFree 100mcg/actuation inhalation, Ativan 1mg, dilaudid 1mg/mL oral liquid, Gastrogel antacid oral liquid, sodium bicarbonate mouthwash 1% and Systane eye drops.

PRN Medication - Midazolam and morphine

33.6 On 17 April 2020, Mrs James was prescribed a number of medications by Dr Kakkat including morphine 2.5mg subcutaneous hourly for "pain and SOB", midazolam 2.5 – 5mg subcutaneous hourly, glycopyrrolate 0.2 – 0.4mg and metoclopramide 19mg.

33.7 Morphine was administered on 21 April 2020 at 5.50pm and 10.18pm; and 22 April 2020 at 5.38pm. It is noted that she was administered hydromorphone hydrochloride until 20 April 2020, which was prescribed in the context of her metastatic bone cancer and predated her known COVID-19 diagnosis.

COVID DIAGNOSIS

33.8 Mrs James took a PCR COVID-19 test at 3.58pm on 14 April 2020 and returned a positive result on the same day. Mrs James' family were informed by Dr Dharmaratnam that she had been diagnosed with COVID-19.

ADVANCE CARE PLAN

33.9 On 18 April 2020, Mrs James' daughter, Ms Patricia Jensen, completed an Advance Care Plan (ACP) on behalf of Mrs James, outlining that Ms James did not want CPR, she did not want artificial nutrition through a tube in nose or stomach, she did not want antibiotics to be administered, and she did not want to be transferred to hospital except to maintain comfort. This was completed in the context of Mrs Jensen's knowledge that her mother was COVID-19 positive. A resuscitation plan completed on 17 February 2020 indicated that in the event of cardiopulmonary arrest, Mrs James did not want CPR, intensive care or intubation.

Discussions around ACP

33.10 At 10:46am on 17 April 2020, a phone call took place between Patricia Jensen, and GP Dr Dharmaratnam. They discussed Mrs James' End-of-Life Plan, including obtaining consent for Dr Dharmaratnam to order end of life medication. The call went for 24 minutes and 55 seconds. Ms Jensen states that after this phone call she realised that "*Mum was not going to live long or make a recovery from contracting COVID-19.*"

33.11 On 21 April 2020, Ms Jensen received a second call from Dr Dharmaratnam. The call went for 4 minutes and 33 seconds. Dr Dharmaratnam informed Patricia Jensen that her mother had an arm fracture and asked if Ms Jensen wanted her transferred to hospital to have her arm fracture medically assessed. Dr Dharmaratnam raised that Mrs James was deteriorating quickly from COVID-19. Comfort measures and pain medication to relieve symptoms were discussed. Ms Jensen confirmed that she did not want her mother to be transferred to hospital because she thought she would pass away soon.

PROGRESSION OF ILLNESS

15 April 2020

33.12 No observations were recorded on 15 April 2020, although an entry was made in the pain chart.

16 April 2020

33.13 On 16 April 2020, Mrs James' saturation levels were recorded at 4.01am SpO2 97% RA (BP 130/95, temp 37.1) and at 6.30pm SpO2 91% (147/73, temp 36.3C, bpm 72). At 12.22pm Mrs James was admitted into Hospital in the Home (HITH) by Dr El Jamaly (Registrar) as per "*new protocol for HITH COVID-19 NH residents*" and they were awaiting her Advance Care Planning. Ms Jensen received a message from her sister Michelle following a video call with her mother and call Michelle reported that she "*just spoke to mum and she is in a lot of pain. Can you call to check she is getting her extra doses. She is in terrible pain.*" At 3.00pm Mrs James complained of pain in her left arm and was seen guarding it. A cough was noted but she was recorded to not be in distress.

17 April 2020

33.14 On 17 April 2020, Mrs James' observations were recorded twice at 4.00am SpO2 94% (Temp 36.7, P79, RR 17) and at 5.00pm SpO2 99% (Temp 36.5, resp 23 bp 12/82). Dr Kakkat made an entry in the Nepean Hospital records at 5.28pm recording the exact same observations that are recorded in the Newmarch House notes at 4.00am.

33.15 Counsel Assisting submitted that from the above, it appears that no face-to-face consultation or assessment in fact took place, but rather Dr Kakkat conducted a remote review of the notes and ordered anticipatory medications. It was submitted on behalf of Dr Kakkat that a nursing entry made at 4.00pm on 17 April 2020 records: "*Client had a VACS review today at the nursing home and is for a HITH call tomorrow*", that Dr Kakkat's own entry records: "*At Newmarch House*" and "*Patient reports asthma*", and that Dr Kakkat may have only recorded the earlier observations taken of Mrs James rather than taken his own observations. Similar to what has already been noted above regarding Dr Kakkat's progress note entries for 17 April 2020, the limited nature of the entry for Mrs James, and the absence of any entry which could not have been drawn from Mrs James' previous history suggests that it is most likely that no face-to-face consultation was conducted by Dr Kakkat. The reference to "*At Newmarch House*" is equally consistent with Dr Kakkat's own evidence that he did not always see patients when he attended Newmarch House, and that most of the time in the first two weeks he was focussing on the drawing up of medication charts.

18 April 2020

33.16 On 18 April 2020, Mrs James' observations were recorded three times at 1.00am SpO2 96% (131/84, 86bpm, 36.1 Temp, RR 21), 10.30pm SpO2 97% 02 (131/84, 86bpm, 36.1 Temp, RR 21), and at 11.18pm SpO2 97% 02 (131/84, 86bpm, 36.1 Temp, RR 21). Mrs James complained of pain on her abdomen. She was given PRN Gastrogel. Mrs James was not displaying any respiratory symptoms, cough or running nose.

33.17 Progress notes from Nepean Hospital indicate that RN Sidney contacted Newmarch House requesting updates on all COVID-19 positive cases, including observations, status and current condition but had at the time of recording the entry at 3.28pm not received any information from Newmarch House.

19 April 2020

33.18 On 19 April 2020, Mrs James' observations were recorded twice at 01:50 SpO2 97% (BP 99/64 P56 RR17 Temp 35.3), and at 11:30am SpO2 97%RA (BP 122/81, P92, RR18). Staff noticed Mrs James had an open wound on her left buttock and by lunch time she had a chesty cough and shortness of breath. Mrs James told her daughter she was in pain.

20 April 2020

33.19 On 20 April 2020, Mrs James' observations were recorded twice at 2.57pm SpO2 97% (BP152/88, HR 100, RR18, Temp 36.2C) and at 8.30p SpO2 95% (Temp 36.8, BP 100/70 110/min). Newmarch House staff contacted Nepean Hospital at 7.46am noting new symptoms but indicated they were happy to "*keep an eye on it*" with VACS to follow up. Mrs James and her daughter had a video call where Ms Jensen noticed that Mrs James was in pain, she was only responding with grunts and sighs. Ms Jensen said her goodbyes, knowing her mother would die soon.

33.20 Prior to 2.58pm, NP Carpen accessed Newmarch House progress notes remotely and noted a new wound on Mrs James' buttocks, recording "*no cough, settled night*". A further remote review by VACS recorded at 5.23pm stated that Maria James remained asymptomatic but had mild tachycardia, and that she might benefit from increased fluids, and to perform a set of observations which did occur some three hours later. Mrs James was reviewed at 8.30pm when it was noted that she seemed to be "*deteriorating from COVID infection*" and was "*very chesty.*"

33.21 There is no record of fluids being administered subcutaneously, intravenously or by observing Mrs James drinking more as per RN Carpen's recommendation.

21 April 2020

33.22 No observations were recorded on 21 April 2020.

33.23 During a VACS round on 21 April 2020, it was recorded at 11.45am that Dr Kakkat noted pain on the left arm upon movement. He suggested that there may be a fracture of the left humerus and prescribed pain analgesia ("*extra s/c morphine for pain relief* +++ *and ongoing dexamethasone plus arm sling*"). The suggested fracture was thought to be caused by a fall that Mrs James sustained on either 16 or 17 April 2020. That prescription was faxed to a pharmacy and an arm sling was ordered. Dr Kakkat informed Dr Sharma of VACS. Nepean Hospital Progress notes record that "*Dr Sharma contacted Dr Branley who had suggested immobilising the arm and arranging analgesia. Not for hospital transfer. Dr Kakkat informed. Asked to contact family.*" Ms Jensen called Newmarch House as she was informed her mother was deteriorating and was not having any oral intake. The progress notes record that Mrs James was administered Morphine for pain relief and restlessness.

33.24 In relation to Mrs James' fractured humerus, Dr Kakkat gave evidence that he had no memory as to whether he examined the fracture; whether he immobilised the arm or whether he had a view in relation to whether she should be transferred to hospital; or any discussion with Dr Sharma. When Dr Kakkat was questioned in relation to the rationale behind not transferring Maria James he said that "*I don't have any specific recall but this patient had metastatic fracture. So metastatic fracture if she receives adequate pain control we can manage conservatively*".

33.25 Dr Sharma gave evidence that she discussed Mrs James' presentation with an orthopaedic surgeon for advice. Dr Sharma's own clinical records at Nepean Hospital make no mention of seeking a second opinion from an orthopaedic surgeon. What the Nepean Hospital VACS notes do record is: "*Dr Sharma contacted Dr Branley who had suggested immobilising the arm and arranging analgesia. Not for hospital transfer*." She gave evidence that she informed Dr Branley because the residents in question were COVID-19 positive.

33.26 Due to the limitations with the contemporaneous clinical records and the fact that this issue was not explored with Dr Branley in evidence, it is not possible to reach any conclusion as to whether Dr Branley indicated that Mrs James was not for transfer to hospital, and whether (if such an indication were given) the basis for this was due to Mrs James' COVID-19 positive status or advice provided by an orthopaedic surgeon. It is noted that on the same day Mrs James' daughter informed Dr Dharmaratnam that she did not want her mother transferred to hospital.

22 April 2020

33.27 On 22 April 2020, Mrs James' observations were recorded twice 5.49am SpO2 96% 2LNP (BP 99/73, Temp 36.7), and at 11.00pm SpO2 89% 3LNP (Temp 37.1, pulse 137). At 5.49am RN Cenizal noted that Mrs James appeared to be settled and was noted to have some pain on movement only. Progress notes some 18 hours later at 11.00pm indicate that Mrs James spent the day in bed, and that she was not alert enough to take oral medications, but she did not appear to be in pain or distress. It is unclear what observations were taken, if any, between the last two recorded entries of 1.40pm and 11pm, a period of 9 hours.

33.28 At 4.45pm Mrs James had a video call with her daughter Michelle where she was unable to speak. Michelle said her final goodbyes, and thought that Mrs James might have had a fall as she saw bruising around Mrs James' eyes, and a wound on the tip of her nose.

23 April 2020

33.29 Mrs James died at 12.20am on 23 April 2020. Ms Jensen was informed of Mrs James' death shortly thereafter.

MANNER AND CAUSE OF DEATH

33.30 **Cause of Death**: Associate Professor Kotsimbos considered the cause of death was acute respiratory distress syndrome associated with COVID-19 infection, and metastatic cancer as a significant contributor. Professor Kurrle agreed with Associate Professor Kotsimbos, but also considered that chronic lung disease and heart disease were significant contributing factors to Mrs James' cause of

death. Professor French considered that the cause of death was more likely to be related to Mrs James' underlying metastatic malignancy with COVID-19 being a contributing factor but he did not disagree with the conclusions of Associate Professor Kotsimbos and Professor Kurrle. Professor French explained that it was more a matter of where you placed the emphasis. That is, COVID-19 being the primary factor and metastatic disease as the contributing factor or metastatic disease as the primary factor and COVID-19 as the contributing factor. Given Mrs James highest temperature recorded was 37.1C (22 April 2020) and she had significant pain symptoms, Associate Professor Kotsimbos considered that it is complicated to determine the cause of Mrs James' death and this was further complicated by the limited detail in the progress notes.

33.31 **Manner of Death**: Mrs James returned a negative swab when she returned from her admission to Nepean Hospital from 3 April 2020 to 6 April 2020. Although she was in isolation from 3 April, there was evidence that other residents walked into her room. The day before she died her oxygen saturations dropped to 89% on three litres of oxygen and she had tachycardia and shortness of breath. In the hours before she died, she deteriorated and was described as chesty, tired, and less alert but was not febrile. Her major symptoms were pain in her abdomen and arm, and she was not eating or drinking which Professor Kurrle opined was because she was in significant pain.

33.32 **Impact of any significant co-morbidities**: Mrs James had been admitted to Nepean Hospital on 2 April with a chest infection, and her symptoms from this seemed to progress after her return from Nepean Hospital on 6 April. Despite experiencing similar symptoms from her chest infection, the evidence does not support a finding that Mrs James contracted COVID-19 at Nepean Hospital. She had significant metastatic bone disease. She also had chronic lung disease and cardiovascular disease both of which had an impact.

33.33 **Issues with care received**: Associate Professor Kotsimbos considered that the palliative care issue in terms of her pain from her metastatic disease, and the pain in her arm from the fracture, was suboptimal. The basis for Associate Professor Kotsimbos' opinion was that in the days prior to Mrs James' death, the records and her daughter's statements clearly indicate that Mrs James was in a significant amount of pain and given that the "*whole point*" of palliative care is to reduce symptoms of pain and discomfort, palliative care was not adequately delivered during the last days of Mrs James' life. The clinical records disclose that observations were taken on an irregular basis.

33.34 **Whether different action may have affected the outcome**: No.

33.35 Professor Kurrle noted that Mrs James complained of pain often to her family and she was prescribed a significant amount of hydromorphone, but she did not always receive it. Although she did not receive hydromorphone and noting that her pain could have been managed better in the last days of her life, Professor Kurrle did not consider that the suboptimal pain management contributed to Mrs James' death. Associate Professor Kotsimbos also did not consider that anything further could have been done in terms of treating Mrs James' chest infection.

33.36 Counsel Assisting notes that Mrs James' pain medication, in the form of hydromorphone for her metastatic bone cancer, appears to have been given in an irregular manner and not at all in the last few days of her life. For example, on 13 April 2020, according to the administered medication charts she received hydromorphone 2mg at 0903, 8mg at 9.17am, 1mg at 11.03am, 2mg at 1.14pm, 2mg at

4.04pm, and 2mg at 20.51. On many other days, in particular from 20 April 2020 onwards, the medication charts records 'missed' or 'absent' or 'admin later.' On 19 April 2020, when Mrs James' daughter noted her mother's complaint of pain, her Jurnista (hydromorphone) dose was not administered until 2.28pm and then not again until 5.08pm for 'left arm pain', despite a script which permitted hourly administration.

33.37 Counsel Assisting submitted that the suboptimal care regarding pain management was likely the result of the 'chaos' described by all nursing staff who did their best in circumstances where there were limited or insufficiently qualified staff to care for the number of residents who required care and management. Had Dr Branley or Dr Sharma directed Mrs James' transfer to hospital with a suspected fracture, in accordance with what the usual protocol is under the VACS and/or HITH policies, although it would not have prevented her death, it is likely would have resulted in far better pain management and less suffering in the last few days of Mrs James' life.

33.38 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Maria James.

Date of death

Mrs James died on 23 April 2020.

Place of death

Mrs James died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs James' death was the combined effects of COVID-19 infection and metastatic bone cancer of unknown primary, with chronic obstructive pulmonary disease and ischaemic heart disease being significant conditions which contributed to death.

Manner of death

Mrs James died of natural causes following diagnosis of COVID-19 infection. Mrs James received suboptimal pain management regarding her fractured left humerus, particularly in the period between 20 and 23 April 2020, which, regrettably, most likely adversely affected the quality of Mrs James' remaining life during the terminal phase. However, this did not contribute to the cause of Mrs James' death, and no other management steps could have been instituted which would have materially altered the eventual outcome.

34. Margaret Brocklehurst

HEALTH

Co-morbidities

34.1 Margaret Brocklehurst was 96 years of age when she passed away on 24 April 2020 at Newmarch House during the COVID-19 Outbreak. She had a number of existing comorbidities at the time including cerebral vascular accident (CVA), ischemic heart disease (IHD), hypertension, Type 2 diabetes mellitus (T2DM), arthritis, gout, gastroesophageal reflux disease (GORD) and tremors. Mrs Brocklehurst had a new onset of atrial fibrillation (AF) in 2017 with a possible small stroke. Mrs Brocklehurst also had a history of leg swelling secondary to chronic venous stasis, hypercholesterolaemia, urinary incontinence and decreased with increased risk of falls. She required assistance with activities of daily living (ADLs).

Background and events leading up to COVID-19 diagnosis

34.2 Mrs Brocklehurst was admitted to Newmarch House on 8 August 2017 as she was no longer able to cope alone in her own home, against a backdrop of suffering from acute confusion and dysphasia. She had been able to walk with a walking frame to meals and around her room. Upon entering Newmarch House she required assistance from staff for personal care due to decreased mobility. On 31 March 2020, she was noted to have cellulitis requiring antibiotics. On 22 April 2020, a deep tissue 'stage 1' pressure injury located on Mrs Brocklehurst's buttocks was discovered and dressed by a Registered Nurse.

RELEVANT MEDICATIONS

34.3 Mrs Brocklehurst was prescribed a number of medications including Alzene, Eliquis, laxative and senna, paracetamol, Progout, propranolol (CVA/IHD), Tryzan, vitamin D3, Zimist, Zimstat, Hyonovel, Maxolon, morphine, Pramin, Robinul, sodium bicarbonate, Systane eye drops, Tricortone, metaclopramide, idazolam, glycopyrolate, Roxithromycin and ramipril (CVA/IHD) and Apixaban (CVA/IHD).

PRN Medication - Midazolam and morphine

34.4 The medication charts show that Dr Kakkat prescribed midazolam and morphine on 17 April 2020 but subsequently crossed both out, for reasons unknown.

34.5 On 21 April 2020, Dr Kakkat prescribed again morphine 2.5mg hourly to a maximum dose of 40mg/day subcutaneously and midazolam 2.5mg to 5mg hourly to a maximum dose of 60mg/day subcutaneously. The PBS patient summary records morphine being prescribed by Dr Richardson (GP) on 22 April 2020 with quantity recorded as 5.

34.6 On 23 April 2020 morphine sulphate 2.5 mg was administered at 11.38/43am, 2.21pm, 3.30pm and 6.50/7.15pm.

COVID DIAGNOSIS

34.7 Mrs Brocklehurst had two combined nose/throat PCR COVID-19 tests on 14 April 2020 and 17 April 2020. The first test was found to be negative on 15 April 2020. The second test was found to be positive for SARS-CoV-2 on 18 April 2020.

ADVANCE CARE PLAN

34.8 No Advance Care Plan (ACP) or Advance Care Directive was prepared for Mrs Brocklehurst.

Discussions around ACP

34.9 In the context of the COVID-19 outbreak, Mrs Brocklehurst's son John Brocklehurst found that communication was poor, and his mother's phone was disconnected. He first became aware that his mother was unwell when he spoke to her on 17 April 2020 and she said she had flu like symptoms. Mr Brocklehurst eventually spoke to a Newmarch House staff member who informed him that Mrs Brocklehurst had tested positive to COVID-19 "*two days prior.*"

34.10 John Brocklehurst does not remember ever filing out an End-of-Life Plan or ACP, or any paperwork for his mother. Newmarch House did not contact John Brocklehurst to request any information after she was diagnosed with COVID-19. John Brocklehurst recalls that Newmarch House implemented Hospital in the Home (HITH), and therefore he considered he did not have the option to send his mother to a hospital. John Brocklehurst believes he should have been given the opportunity to transfer his mother to hospital as he considered that Newmarch House was not providing the best care and treatment for her.

34.11 The Newmarch House progress notes record on 22 April that there was "*no record of an ACP.*" Dr Kakkat said he would ring Mrs Brocklehurst's son to discuss, however there is no evidence to corroborate that a phone call ever took place.

34.12 There were no discussions between treating staff and Mrs Brocklehurst's family regarding her treatment or end of life planning. Dr Kakkat gave evidence that he did not have any particular memory of Mrs Brocklehurst and said that if somebody needed to be spoken to, Dr Sharma would talk to the patient and the relatives. However, if a relative was at Newmarch House at the time Dr Kakkat was there, he might talk to them. Dr Sharma gave evidence that the GPs involved in the residents' care would complete the ACPs and notify her when they were done. Dr Sharma gave further evidence that based on her conversation with the GP Dr Dharmaratnam, Mrs Brocklehurst's ACP was completed by him. There is no evidence to support this assertion by Dr Sharma, and it is noted that general practitioners were not attending Newmarch House in the first two to three weeks of the outbreak. It is also noted that when Dr Dharmaratnam did have conversations with residents or their families about their ACP, he would record this in the clinical records.

34.13 On 22 April 2020 a progress recorded at 3.39am by RN Cenizal records that *'Margaret has no ACP. Refusing hospital transfer when asked.'*

34.14 On 3 May 2020, a Death Screening Tool was completed by Christine Giles. It stated that an Advance Care Plan was in place. Given this is the only entry to that effect, it is likely that this was an error and that no ACP was completed for Mrs Brocklehurst.

PROGRESSION OF ILLNESS

16 April 2020

34.15 At 2.30pm, Mrs Brocklehurst's SpO2 was 91%. At 7.11pm, Mrs Brocklehurst complained of being hot and had a sniffly nose. She had no cough or sore throat. Mrs Brocklehurst's first temperature check was 37.7C and the second was 37.8C. Mrs Brocklehurst's SpO2 was 88% on RA. Mrs Brocklehurst was placed in isolation and PPE was put in place. At 7.33pm, Mrs Brocklehurst's temperature was 37.7C.

17 April 2020

34.16 At 3.00am, Mrs Brocklehurst sat in her recliner chair. She looked alert and comfortable, with no increased shortness of breath. Mrs Brocklehurst denied pain. Her observations were recorded, and regular paracetamol was given (BP 150/81, P 88, Temp 37.8C, RR 19, SpO2 92%). Mrs Brocklehurst was educated on the importance of isolating.

34.17 At 7.50pm, Mrs Brocklehurst sat on the edge of her chair and required assistance to mobilise. Mrs Brocklehurst verbalised that she felt tired and sick. She had been sneezing throughout the day but did not have a dry cough. Her son John was updated on Mrs Brocklehurst's condition. At 9.25pm, Leann Hinton called John Brocklehurst and explained that Public Health tested residents and that Mrs Brocklehurst was being closely monitored. On 17 April 2020, Mrs Brocklehurst was recorded to have "*flu-like*" symptoms.

18 April 2020

34.18 On 18 April 2020, Mrs Brocklehurst's observations were recorded twice at 1.00am SpO2 91% (BP159/73, P 86, Temp 36.7, RR 20), and then roughly 12 hours later at 1.30pm SpO2 87% (Temp 37.8C, 73 BPM, BP 150/70, 21 RR).

34.19 At 1.00am, Mrs Brocklehurst sat in her chair and requested to sleep in the chair. She had no respiratory symptoms or increased work of breathing. Mrs Brocklehurst advised that she had no cough but felt nauseous. It was noted that Mrs Brocklehurst's bed was not working. Mrs Brocklehurst's SpO2 was re-checked at this time and had increased to 93%. At 1.40pm, moisturising lotion was applied to Mrs Brocklehurst's pressure injury, and she was transferred to her bed to relieve pressure on the area. Mrs Brocklehurst was no longer able to mobilise with her walker. At 4.36pm, Leann Hinton called John Brocklehurst and provided him with an update on Mrs Brocklehurst's condition. At 7.45pm, Mrs Brocklehurst was admitted as a patient to HITH with news of her COVID-19 status.

19 April 2020

34.20 On 19 April 2020, Mrs Brocklehurst's observations were recorded three times at 2.20am SpO2 90% NP2L RA (Temp 36.0C, BP 160/71, P 84, RR 22), almost 8 hours later at 10.15am SpO2 88% 2LNP (BP 128/60, P 108, RR 21, Tachycardia P108 bpm), and then almost 12 hours later at 10.00pm SpO2 94% (BP 121/72, P77, RR 18).

34.21 At 2.20am, Mrs Brocklehurst was transferred from her chair to her bed. She did not report symptoms of cough and denied feeling unwell. Staff noted that Mrs Brocklehurst's mobility had deteriorated in the past 24 hours. At 10.15am, Mrs Brocklehurst's SpO2 levels were checked after lunch and had improved to SpO2 92% and O2 therapy was discontinued.

34.22 At 3.27pm, Nepean Hospital RN Sidney recorded the following in the progress notes:

> [H]ave attempted to call nursing home on three different numbers with no answer. one of the people called was the case manager Leanne Hinton who also didn't answer the phone so a message was left for her to contact outreach when possible. no return call ATOR. have also called the VACS on call to find out if there is anyway of getting information on the residents and she advised that If there was anything major with any of them she would advise us. if possible could we get a system in place where the RN from each ward where the residents are located call outreach and just give a quick update on each patient when that RN has time to do so. or even one person from the nursing home give outreach a call with an update on each patient

34.23 At 5.30pm, John Brocklehurst was updated with Mrs Brocklehurst's condition. John was informed that Mrs Brocklehurst had returned a positive COVID-19 test and required some oxygen as she was a little short of breath but was otherwise stable. John advised staff that he spoke with his mother daily.

20 April 2020

34.24 Mrs Brocklehurst's observations were recorded four times at 6.00am SpO2 91% 4L (BP 122/86, P 63, RR 20, SpO2 91% on 4L), over three hours later at 9.30am SpO2 88% 2L (BP 100/54, P 60, RR 15), then over five hours later at 2.46pm. SpO2 was not taken (RR 20, P 63, BP 122/86, Temp 36.5). Three hours later at 5.58pm SpO2 91% 4LPM 02 (BP 122/86, P63, T36.5C RR20), and lastly at 10.00pm SpO2 93% 4L (BP 166/70, P 77, RR 18).

34.25 At 12.30am, Mrs Brocklehurst was observed to be asymptomatic and afebrile. Her observations were stable (but not recorded) and she was administered medications.

34.26 At 12.11pm, Dr El Jamaly recorded that he updated Newmarch house of the positive COVID-19 result and '*Informed of the need for single room and strict PPE and isolation facility aware of the protocol for covid-19 +ve patients.'*

34.27 At 2.47pm, Nepean Hospital RN Malaihollo, following a review of the observations and comments obtained from Newmarch House progress notes through the VACS team, recorded that Mrs Brocklehurst was asymptomatic, "*SpO2 was 91% - team aware*".

34.28 At 5.58pm, Mrs Brocklehurst's clinical records at Newmarch House were accessed and reviewed remotely by Nepean Hospital Virtual Aged Care Service (VACS) Nurse Practitioner (NP) Hailey Carpen, who recorded the following notes: *"Margaret Brocklehurst, 96 year old lady with a new diagnosis of COVID19 under the care of HITH Unable to contact facility today Remote review of the notes Remains asymptomatic this morning BP 122/86, P63, T36.5, SpO2 91% on 4LPM O2, RR 20 Please perform a set of observations Will review again tomorrow."*

34.29 At 7.15pm, John Brocklehurst was updated on Mrs Brocklehurst's progress. John was informed that Mrs Brocklehurst's oxygen saturation had dropped from 91% to 88% and that she was receiving oxygen therapy of 2L/min. At 9.07pm, Leann Hinton recorded, "*Margaret, was reviewed by Dr James Branley, and he stating to continue to monitor her bowel motions and I have informed her son. The above was written in error*". It is unclear whether this relates to Mrs Brocklehurst. At 9.29pm, Mrs Brocklehurst was encouraged to consume fluids.

21 April 2020

34.30 At 12.52am, Mrs Brocklehurst was given "*Asymptomatic meds*". At 4.00am an unknown RN recorded that Mrs Brocklehurst remained on oxygen therapy, was afebrile and had stable observations. At 4.15pm, Lifestyle team leader Lisa Courtney noted that staff called John Brocklehurst to organise regular calls with Mrs Brocklehurst. John advised that he already called Mrs Brocklehurst daily and did not need staff to facilitate calls. At 6.00pm Mrs Brocklehurst were recorded as - SpO2 86%2L (BP 128/68, RR 15). At 7.50pm, Mrs Christine Giles called John Brocklehurst and provided an update on Mrs Brocklehurst's condition. At that stage Mrs Brocklehurst was short of breath, her oxygen saturation was low, but oxygen therapy had changed to 4L. Her temperature was 37.8C.

22 April 2020

34.31 On 22 April 2020, Mrs Brocklehurst's observations were recorded six times at 3:30am SpO2 80% 4L (BP 159/72, P 98, temp 37.9C), at 3.39am SpO2 73%5L, at 6.00am SpO2 88%5L, at 8.09am SpO2 85%5L (BP 164/85, RR 25), at 8.27am *desaturating* 75% NP5L, and at 11.25am SpO2 77% Hudson Mask (BP 127/86, P 59, Temp 36.6C).

34.32 At 2.30am, Mrs Brocklehurst's temperature was 36.7C. At 3.30am, Mrs Brocklehurst was given medication. No cyanosis was present, but her nose prong was noted to not be properly fitted and her oxygen was increased to 5 litres. Mrs Brocklehurst advised that she was "*fine*". At 3.39am, RN Cenizal recorded the following note "*Margaret has no ACP. Refusing hospital transfer when asked. 73% saturation on 5L via NP. Rang VACS – Dr Kakkat advised to keep oxygen on highest setting, position comfortably. Crises meds not charted for Margaret. Denies feeling distress."*

34.33 At 6.00am, Mrs Brocklehurst's SpO2 was 88% on 5L. RN Cenizal noted that she had placed tape on Mrs Brocklehurst's face to keep her nose prong in place and asked whether she could call her son. At 8.27am, and unknown RN recorded that Mrs Brocklehurst was "*desaturating 75% NP5L (mouth breathing), lips slightly purple tinge, P/C Rinata re actions, instructed to phone Covid Dr Kakkat. Dr instructed for HM 5L, morphine is charted PRN. Now saturating 85%".*

34.34 At 10.10am, Dr Kakkat wrote the following progress note after what appears to be a face-to-face consultation with Mrs Brocklehurst: "*SOB it showed scattered crackles Plan Ruide 150mg bd Charted Continue crisis medications… Son John Brocklehurst contacted and informed about Margaret's deteriorating condition and about Dr Kakkat's review. John was informed that end of life medications have been charted*."

34.35 At 3.42pm, RN Smith contacted the VACS team and they advised they were reviewing COVID-19 patients at Newmarch House. They would fax details of patients and their condition when finalised to HITH. At 5.45pm, RN Dean acknowledged an alert that Mrs Brocklehurst's blood pressure was out of the normal range and she administered regular medications to stabilise blood pressure. At 11.25pm, Mrs Brocklehurst was alert in bed and stated she was "*fine*," with no pain or distress. Her pressure wound was dressed. An air mattress was to be provided to her.

23 April 2020

34.36 On 23 April 2020, Mrs Brocklehurst's observations were recorded six times at 5:45am SpO2 85% 5L oxygen via face mask (Temp 36.5C), at 8:08am SpO2 85% 6L (BP 141/61, P 78, RR 26), at 11:38am SpO2 84% via HM 5L, at 2:21pm SpO2 88%, at 6:30pm SpO2 ~88% on NP 2L, and at 6:55 SpO2 76% 4L (BP 118/70, P90, RR 16).

34.37 At 2.34am, Mrs Brocklehurst was diagnosed with a urinary tract infection. At 5.45am, Mrs Brocklehurst denied pain and stated she was fine. At 8.15am, RN Cardwell recorded that Mrs Brocklehurst was resting in bed and recorded "W*OB increased. Tachypnoea and SpO2 in 86% on 6L via Hudson mask. Call to son, update given. Agreeable to commence morphine if required. Will call with an update later today."*

34.38 At 10.35am, Mrs Brocklehurst was not administered her medications due to not being alert enough to swallow safely. At 11.38am, Mrs Brocklehurst was administered morphine for respiratory distress. RN Cardwell noted the family was aware and "*Dr Kakkat aware to review.*" At 11.43am, Mrs Brocklehurst was administered 2.5mg of morphine when her saturation levels were at 88% and this improved her tachypnoea. At 2.21pm, Mrs Brocklehurst was administered 2.5mg of morphine. At 3.30pm, Mrs Brocklehurst was administered 2.5mg morphine. It was noted that Mrs Brocklehurst was for comfort care due to HITH and that her family had been updated by Dr James Branley.

34.39 At 3.50pm, Nepean Hospital RN Sidney attached to HITH conducted a remote review of the notes and noted that Mrs Brocklehurst was unwell and recorded previous observations taken. At 3.51pm, Nepean Hospital NP Hailey Carpen likewise conducted a remote review of the clinical records at Newmarch, noting her deteriorating state and records that she has been commenced on Morphine.

34.40 At 6.50pm, Mrs Brocklehurst was administered 2.5mg of Morphine as she was in respiratory distress. At 7.15pm, RN Cardwell recorded that Mrs Brocklehurst was minimally responsive and is for comfort measures per HITH. Mrs Brocklehurst's SpO2 was 78%. John Brocklehurst was contacted and wished to be called if Mrs Brocklehurst passed away overnight. At 7.50pm, RN Cardwell recorded that Mrs Brocklehurst's medications were withheld, as oral intake was not appropriate at the time.

34.41 At 8pm, John Brocklehurst attended Newmarch House to say goodbye to his mother, despite this being contrary to the direction. He was wearing full PPE. Mrs Brocklehurst was unconscious at the time.

24 April 2020

34.42 At approximately 11am, staff attended Mrs Brocklehurst and found she was not breathing. John Brocklehurst was advised of Mrs Brocklehurst's passing. At 11.30am, Ms Christine Giles entered the following progress notes "Dr *James Braden* [Branley] *had reviewed Peg this morning and felt that she had no or minimal respiratory effort."* Mrs Brocklehurst's GP, Dr Richardson, was contacted and informed Newmarch House that he was willing to do the cremation certificate, but that he would like HITH to complete the death certificate.

MANNER AND CAUSE OF DEATH

34.43 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agreed that Mrs Brocklehurst's cause of death was COVID-19 infection. Significant contributing factors included her cardiovascular disease including IHD, hypertension, atrial fibrillation and diabetes.

34.44 **Manner of Death**: Associate Professor Kotsimbos considered that following Mrs Brocklehurst's infection with COVID-19, her oxygen support was relatively good and empirical antibiotics were used. Associate Professor Kotsimbos opined that Mrs Brocklehurst died comfortably and fairly suddenly.

34.45 **Impact of any significant co-morbidities**: The following conditions were significant: lung disease, atrial fibrillation, ischaemic heart disease, hypertension, and diabetes. Professor Kurrle opined that Mrs Brocklehurst's frailty would have contributed to her reduced ability to respond to the infection.

34.46 **Issues with care received**: The experts felt her care was good as she had oxygen support, which was well given and documented, and had been given empirical antibiotics. They felt that her multiple co-morbidities were reasonably well managed.

34.47 **Whether different action may have affected the outcome**: No.

34.48 All three experts agreed that there was nothing further that could have been done for Mrs Brocklehurst following her infection with COVID-19 given her multiple comorbidities and considering that she was managed reasonably well at Newmarch House. Mrs Brocklehurst was infected towards the end of the first wave in Newmarch House and Associate Professor Kotsimbos noted that the infection control measures could have been significantly better. However, in his opinion, Mrs Brocklehurst was very frail and therefore it did not take much for an infection to cause problems.

34.49 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Margaret Brocklehurst.

Date of death

Mrs Brocklehurst died on 24 April 2020.

Place of death

Mrs Brocklehurst died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Brocklehurst's death was COVID-19 infection, with ischaemic heart disease, hypertension and type II diabetes mellitus being significant conditions which contributed to death.

Manner of death

Mrs Brocklehurst died of natural causes following diagnosis of COVID-19 infection. Mrs Brocklehurst's symptoms were appropriately managed, and no other management steps could have been instituted which would have materially altered the eventual outcome.

35. Keith Smith

HEALTH

Co-morbidities

35.1 Keith Smith was 82 years of age when he passed away on 26 April 2020 at Newmarch House during the COVID-19 outbreak. He was the only resident who died at Newmarch House with a family member present and by his side when he passed.

35.2 He had a number of existing comorbidities at the time of his death including mild dementia (since 2015), hypertension, type 2 diabetes mellitus and hyperthyroidism. Mr Smith was also becoming incontinent, sedentary, forgetful, and unsteady on his feet which was resulting in a number of falls. He required assistance with activities of daily living (ADLs).

Background and events leading up to COVID-19 diagnosis

35.3 Mr Smith was admitted to Newmarch House on 17 August 2016 after residing in two other facilities. Mr Smith was chairfast and moved around in a wheelchair, requiring assistance with most activities of daily living, but was able to feed himself. As his condition declined and he needed further assistance, Mr Smith was moved from the Lawson wing for low care residents to the Wentworth wing for high care residents. Mr Smith became wheelchair bound as a result of at least nine falls that occurred within the Wentworth wing.

RELEVANT MEDICATIONS

35.4 Mr Smith was prescribed a number of regular medications including Abisart 75mg tab, Cardol 80mg tab, celepram 80mg tab, diaformin 1g tab, Eutroxsig 100mcg tab, Januvia 100mg tab, Noxicid 40mg cap, Osteomol 665mg MR tab, vitamin D3 25mcg tab, anti-inflammatory pain relief (Apohealth) 1% gel cream, and Cortic-DS 1% cream.

35.5 Mr Smith was prescribed a number of medications on an as needs basis including Actrapid flexpen 100 units/mL, glucagen hypokit 1mg power for injection, Hynovel 5mg/mL, Maxolon 10mg/mL, morphine sulphate 10mg/mL, Robinul 100mcg/mL, sodium bicarbonate mouthwash 1% and Systane 1.4% eye drops.

35.6 Mr Smith was also prescribed Sotalol, Irbesartan, Metformin and Sitagliptin (Hypertension/Type 2 diabetes mellitus) and Thyroxine (Hypothyroidism).

PRN Medication - Midazolam and morphine

35.7 On 17 April 2020, Dr Kakkat prescribed PRN morphine at 2.5mg hourly to a maximum dose of 40mg/day subcutaneous route, and midazolam 2.5mg to 5mg hourly to a maximum dose of 60mg/day subcutaneously.

35.8 Mr Smith was administered 2.5mg morphine via subcutaneous injection as per 'LMO orders on 24 April at 10.06pm'. On 25 April 2020 he was administered 2.5mg morphine at 12.05am; at 2.30am for 'pain'; and at 4:25am for agitation with increased work of breathing with tachypnoea. An RN noted that "*subcut butterfly inserted in rt (right) upper arm for morphine administration. Resident for ongoing comfort care*."

COVID DIAGNOSIS

35.9 Mr Smith took a PCR COVID-19 test at 5.09am on 14 April 2020 and returned a positive result. His COVID-19 positive status was known to Newmarch House by the morning of 16 April 2020.

ADVANCE CARE PLAN

35.10 Prior to Mr Smith's infection with COVID-19, there was no Advance Care Plan (ACP) in place. From 12 April 2020 to 17 April 2020, Ms Tracey Reeves, Mr Smith's daughter, received a few phone calls from nurses and management of Newmarch House informing her that Mr Smith's condition was satisfactory.

35.11 Between 16 April 2020 and 18 April 2020, Ms Reeves received an email from RN Lorena Bestrin of Newmarch House requesting an Advance Care Plan (ACP) for Mr Smith. On 19 April 2020, Ms Reeves completed an ACP on behalf of Mr Smith outlining that he did not want CPR, artificial nutrition through a tube in nose or stomach, antibiotics, nor to be transferred to hospital except to maintain comfort. Ms Reeves states that she returned the ACP to Newmarch House on 19 April 2020 via email to Anglicare.

Discussions around ACP

35.12 Between 23 March 2020 when the lockdown at Newmarch House commenced, and 12 April 2020, the day after the outbreak was declared, Ms Reeves had little to no direct contact with Mr Smith. Ms Reeves was receiving updates from Anglicare via email on the COVID-19 situation at Newmarch House.

35.13 On 22 April 2020, Ms Reeves was spoken to by Dr Fox, geriatrician at Nepean Hospital, to confirm that Mr Smith was for comfort measures at Newmarch House. During this telephone call, Ms Reeves informed Dr Fox that she had sent the ACP to Newmarch House via email to Anglicare.

35.14 On 22 and 23 April Ms Reeves made a number of calls from Newmarch House in her efforts to receive an update from Newmarch about her father's wellbeing. She was contacted on 24 April 2020 at about 11.00pm and was advised that Mr Smith's condition was deteriorating. Ms Reeves immediately attended Newmarch House to be with Mr Smith and was provided with PPE and was permitted to hold his hand. She left at 3.30am on 25 April 2020. At 7am, Ms Reeves returned to Newmarch House, and she stayed with Mr Smith until he passed away.

PROGRESSION OF ILLNESS

16 April 2020

35.15 Mr Smith's saturation levels were not recorded on 16 April 2020. Observations were recorded once at 4:24am (BP was 148/78 and Temp 37.2C).

35.16 Mr Smith vomited at 1.00am but denied any further vomiting or nausea. Some coughing was noted. Mr Smith's bed was placed at the lowest height and had a crash mat for safety. Dr Bassa gave verbal consent to Leanne Hinton, care manager at Newmarch House, for Mr Smith to have support from the Virtual Aged Care Service (VACS) team and infection control team from Nepean Hospital. When staff attended to Mr Smith at 4.30pm and 6.00pm he did not have any complaints of nausea and was not displaying respiratory symptoms.

35.17 Mr Smith was enrolled in the Hospital in the Home (HITH) at Nepean Hospital 'as per New Protocol' with a record stating that '*HITH await the aged care facility sending an up-to-date ACP*.'

17 April 2020

35.18 On 17 April 2020, observations were recorded three times. SpO2 levels were not recorded. At 3.00am his temperature was recorded (Temp 36.6C), at 4.00am some vitals were recorded (T 36.6, P 69, BP 151/67), at 4.30pm SpO2 was not recorded but other vitals were recorded (Temp 36.5C, Pulse 73, resp 25 BP 125/82).

35.19 At 4.00am, Mr Smith was found on a roll mat, with his legs half on the bed. He was hoisted back into bed. No respiratory symptoms were observed.

35.20 VACS Nurse Practitioner (NP) Carpen made an entry in the Nepean Hospital clinical records, based on what appears to be a remote review of the progress notes at Newmarch House, as the observations recorded are identical to those recorded at 4am. The note recorded that Mr Smith was under the care of HITH and ordered 'anticipatory end of life medications.' Namely, the medications were ordered in the absence of any face to face consultation or review by any VACS medical practitioner and without an existing clinical indication.

18 April 2020

35.21 On 18 April 2020, observations were recorded five times. At 1.00am SpO2 93% (BP 119/53, Temp 36.4C, P64), at 7.00am Temp 38.5C, at 10:00am SpO2 38.50% (BP 100/78, P 17), five hours later at 3.00pm SpO2 97% (BP 110/69, P 65, RR 17, Temp 37.0C); at 5.00pm (BP 110/70, P 68, RR 17, Temp 37.6C), and over five hours later at 10.45pm SpO2 96% (176/84, P 76, RR 19, Temp 36.7C).

35.22 At 1.00am, Mr Smith was noted to be asleep but interactive and appropriate when woken and appeared comfortable. Mr Smith's medications were administered at 7.00am and he had breakfast. It was noted that he preferred to be laying down and resting, but he responded to instructions and was orientated. He ate his dinner and tolerated fluids well. He rolled out of bed at 10.30pm and was

assisted back into bed by two staff members. Ms Reeves received a call from Newmarch House informing her that Mr Smith had a temperature but was otherwise well.

35.23 RN Hayes from HITH recorded that Newmarch House was contacted, and a request was made for an update on all COVID-19 positive cases, including observations, status and current condition but at the time of recording the entry at 3.35pm, no information had been received from Newmarch House.

19 April 2020

35.24 On 19 April 2020, Mr Smith's observations were recorded twice. Once at 3.30pm SpO2 97% (BP 110/72, P 70, RR 17) being 16 hours after his last observations were recorded at 10.45pm on 18 April 2020 and once against at 8.30pm (five hours later) SpO297% (BP 141/65, P 80, RR 17, Temp 36.6C).

35.25 Mr Smith was found kneeling twice during the day with a wet pad of faeces and urine. Both times he was cleaned up, put back to bed, had zinc cream applied to the groin area as it was slightly red, his pull up pad was changed, and his bed sheets and pillows were changed. Mr Smith was fed and administered his medications in the afternoon.

35.26 At 3.37pm progress notes from Nepean Hospital indicate that RN Sidney attempted to call Newmarch House on three occasions with no response. Subsequent contact with the VACS team was made and the VACS team advised they would soon contact Nepean Hospital if there was anything major to advise. RN Sidney requested a system to facilitate daily updates from Newmarch House to Nepean Hospital.

20 April 2020

35.27 On 20 April 2020, Mr Smith's observations were recorded twice. Once at 11am, although oxygen saturation was not recorded (BP 135/80, P 96, Temp36.6C), and 11 hours later at 10:00pm SpO2 93% (BP 180/80, P78, RR18, Temp 36.2C).

35.28 According to the progress notes, Mr Smith was asymptomatic for COVID-19 and stated to a nurse that he did not have a runny nose, sore throat, or a cough. RN Husar recorded in the Nepean Hospital records "*Nil Obs, settled overnight, asymptomatic*" based on VACS NP Carpen's remote review of the Newmarch House progress notes.

21 April 2020

35.29 On 21 April 2020, no observations were recorded.

35.30 Mr Smith was moved to the Lawson Wing. He was noted to be asymptomatic and told staff of Newmarch House that he was feeling fine. NP Carpen (VACS) conducted a remote review of the Newmarch House progress notes but there is no evidence that any medical or nursing staff attached to VACS reviewed Mr Smith in person.

22 April 2020

35.31 On 23 April 2020, Mr Smith's observations were recorded on four occasions. First at 12.06am SpO2 96% (BP 122/66, P 72, RR 15), then again at 3.18am SpO2 93% RA (BP 136/67, Pulse 78, Temp 36.7C), again at 6.00am SpO2 95% (Temp 36.1C, Pulse 72), and 17 hours later at 11.00pm SpO2 94% RA (BP 110/67, Pulse 66, Temp 36.4C).

35.32 At midnight, Mr Smith was found face down on the crash mat. No injury was observed, and he was moving his limbs as normal. He was transferred back to bed via full lifter. RN Mikaela Cenizal made a note to contact Mr Smith's GP and physiotherapist in the morning. At 11.00pm, Mr Smith was observed to be in no pain or distress.

23 April 2020

35.33 On 23 April 2020, Mr Smith's observations were recorded three times. Once at 8.25am, SpO2 96% (BP 187/76, P 67, Temp 36.4C), nine hours later at 5.25pm, SpO2 92% (BP 123/65, P 69, RR 19, Temp 37.0C), and over four hours later at 10.00pm (Temp 37.2C).

35.34 At 8.30am, Mr Smith was observed to be resting comfortably in bed and denied respiratory symptoms. At 5.30pm, Mr Smith was alert and responding and was assisted to have a drink. It appears VACS conducted a remote review again of Mr Smith's Newmarch House notes and recorded, in part incorrectly, the observations taken 8 hours earlier at 8.25am.

24 April 2020

35.35 On 24 April 2020, Mr Smith's observations were recorded four times. First at 6.00am, SpO2 95% (P 85, Temp 36.5C), eight hours later at 2.12pm, SpO2 90% (BP 122/66, P 73, RR 18, Temp 37.0C), then over nine hours later 10.45pm, SpO2 85% (BP 144/77, P 88, RR 40, Temp 38.2C), and again at 11.05pm (BP 144/77, P 88, RR 40, Temp 38.2C).

35.36 At 2.20pm it was noted that Mr Smith was not as bright or responsive as the day before, yet he appeared to be comfortable and was not presenting with signs of respiratory distress. At 7.50pm an oxygen concentrator was applied via Nasal Prongs as per local medical officer (LMO) phone order. Mr Smith was noted to be very lethargic and unresponsive to conversation. His pad was changed, and his bottom was very red. It was noted that he needed to be repositioned overnight with regular pressure checks. His BGL was checked and was 10.4 at 6.20pm.

35.37 At 10.06pm, Mr Smith was administered 2.5mg morphine via subcutaneous injection as per "*LMO orders*". At 11.00pm, Mr Smith vomited after taking his tablets. He was changed by nurses and was observed to have a productive cough. It was noted that his doctor was to review, and his family was to be contacted.

35.38 At 11.54pm, an unknown RN spoke to Mr Smith's daughter Ms Reeves, who stated she wanted to come and see her father. The RN explained the risks of attending the facility and that she would be required to isolate for two weeks. Ms Reeves understood the risks and was happy to isolate after

visiting. She came to visit him that night, with a nurse present at all times, and was able to hold his hand. Ms Reeves left at approximately 3.30am on 25 April 2020.

25 April 2020

35.39 At 12.05am, the progress notes record that Mr Smith was administered morphine 10mg/mL injection at a dose of 2.5mg and Maxalon 10mg/2mL injection. At 2.30am, Mr Smith was administered 2.5mg morphine for "*pain.*" At 3.30am Mr Smith's temperature was 37.6C and he was on oxygen via Nasal Prongs. At 4.25am the Newmarch House progress notes record that Mr Smith was noted to be agitated with increased work of breathing with tachypnoea. He was on oxygen 3L/min via Nasal Prongs. His temperature was 37.3C. Mr Smith was given PRN morphine 2.5mg. An RN noted that "*subcut butterfly inserted in rt upper arm for morphine administration. Resident for ongoing comfort care*." There is no corresponding record of this administration in the medication charts. No further observations were recorded after 4.28am, which appears to be consistent with the cessation of full observations given that Mr Smith had entered the terminal phase of his care.

35.40 Mr Smith died at 9.00am on 25 April 2020. Ms Reeves returned to Newmarch House at around 8am and was with her father when he died.

35.41 Dr Kakkat agreed in oral evidence that there is nothing in the clinical records that indicated a face-to-face or video conference occurred between any member of the VACS team and Keith Smith during the period he had COVID-19.

MANNER AND CAUSE OF DEATH

35.42 **Cause of Death**: All three experts, Associate Professor Kotsimbos, Professor Kurrle and Professor French, agreed that Mr Smith's cause of death was COVID-19 infection. Significant contributing factors were his underlying cardiovascular disease, diabetes, frailty, dementia, hypertension, and the fact that he was chair-fast.

35.43 **Manner of Death**: Keith Smith's deterioration was quite slow, so a secondary bacterial infection may have developed, but on the balance of probabilities this did not change the outcome. He had a high level of frailty and dependency. There was no suggestion that his symptom management at end of life was unsatisfactory.

35.44 **Impact of any significant co-morbidities**: Dementia, diabetes and cardiovascular disease.

35.45 **Issues with care received**: Associate Professor Kotsimbos considered that following Mr Smith's infection with COVID-19, his oxygen use was appropriate. Associate Professor Kotsimbos noted that no antibiotics were given, and it would not have been unreasonable to have given Mr Smith some antibiotics, however opined that this would not have changed his outcome, noting further that he was diagnosed with COVID-19 in the first wave of infections.

35.46 Professor Kurrle commented that Mr Smith was moved from one wing to another after his COVID-19 diagnosis, and that this would have likely upset him and resulted in falls. Professor Kurrle noted that on 17 April 2020, anticipatory end of life medications were ordered, despite Mr Smith not receiving

those medications until 24 April 2020, which appeared to assume that he was going to be palliative. Communication about the provision of end-of-life medications was lacking.

35.47 **Whether different action may have affected the outcome**: No.

35.48 Professor Kurrle considered whether moving Mr Smith to hospital would have allowed him to be more closely monitored, but ultimately concluded that taking Mr Smith to hospital would not have necessarily improved his outcome given his frailty and his status as chair-fast. Professor French considered that once Mr Smith was diagnosed with COVID-19 there was no effective treatment available to him, and that transfer to an acute care hospital would not have altered his outcome.

35.49 All experts agreed that there was a lack and/or frustration in communication between Newmarch House and Mr Smith's family following the pre-emptive prescription of end-of-life medications on 17 April 2020. Professor French opined that once end-of-life medications are ordered there needs to be a signalling of an intent that treatment is moving towards palliative care and this should be communicated to all staff and the resident's family members, so that they understand the trajectory of care.

35.50 All experts agreed that communication between Newmarch House and Nepean Hospital was frustrated, which would have made the assessment of when to administer end-of-life medications difficult. Associate Professor Kotsimbos emphasised the importance of the chain of command in terms of who makes decisions to either titrate up or down the end-of-life medications. In Mr Smith's case, this should have been under the assessment and management of the HITH clinical leader.

35.51 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Keith Smith.

Date of death

Mr Smith died on 25 April 2020.

Place of death

Mr Smith died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Smith's death was COVID-19 infection with hypertension, type II diabetes mellitus and dementia being significant conditions which contributed to death.

Manner of death

Mr Smith died of natural causes following diagnosis of COVID-19 infection. Mr Smith's symptoms were appropriately managed. Anticipatory end-of-life medications were ordered for Mr Smith on 17 April 2020 but they were not provided until 24 April 2020, although this delay did not contribute to death. No other management steps could have been instituted which would have materially altered the eventual outcome.

36. Leone Corrigan

HEALTH

Co-morbidities

36.1 Leone Corrigan was 89 years of age when she passed away on 27 April 2020 at Newmarch House during the COVID-19 Outbreak. She had a number of existing comorbidities including dementia, congestive cardiac failure (CCF), hypertension (HG), type 2 diabetes mellitus, diverticular disease, history of breast cancer (2019), gastroesophageal reflux disease (GORD), macular degeneration, and mild renal impairment. Mrs Corrigan also had a history of left corneal transplant, left Funch's corneal dystrophy, hyperchloremia, faecal Incontinence and cholecystectomy. Mrs Corrigan was at high risk of falls and required hearing aids.

Background and events leading up to COVID-19 diagnosis

36.2 Mrs Corrigan was admitted to Newmarch House in 2014 and was at that time classified as low care. She was mobile with a walking frame on admission to Newmarch House but after a number of falls in late 2019 she was confined to a wheelchair by Christmas 2019. Mrs Corrigan spent the majority of her time in her room.

36.3 In the six months prior to her death, Mrs Corrigan's health deteriorated. In November 2019, staff noted that Mrs Corrigan would attend the communal dining room with faecal smearing on her clothes and hands; would become agitated when requested to wash herself and requested staff to attend upon her in the dining room immediately. Otherwise, Mrs Corrigan would tear up paper and place them on the floor, creating a risk of falls. She suffered two more falls on 16 April 2020 and 24 April 2020. She required assistance with activities of daily living (ADL).

RELEVANT MEDICATIONS

36.4 Mrs Corrigan was prescribed a number of regular medications including Abisart, calcium, Cardiprin, Ferro-Grad C MR, Janumet (diabetes), Nordip, Noxicid, paracetamol, Uremide, Zimstat, Eleuphrat ointment, Hydroxo-B12 injection, Lantus Solostar injection (diabetes), Tricortone, Ativan, Glucagen hypokit, Hyponovel, Maxolon, Ordine, Robinul, sodium bicarbonate mouthwash and Systane eye drops.

36.5 For her CCF/HT, Mrs Corrigan was prescribed Irbesartan, Amlodipine and Frusemide.

PRN Medication - Midazolam and morphine

36.6 On 17 April 2020, Nurse Practitioner (NP) Carpen, of the Nepean Hospital Virtual Aged Care Service (VACS) prescribed an as required dose of morphine at 2mg hourly to maximum dose of 16 doses per day subcutaneous route and midazolam 2.5mg to 5mg hourly to a maximum dose of 60mg per day subcutaneously. Dr Kakkat charted 'crisis medication.' Morphine was administered on 26 April at 12.47pm for pain and dyspnoea and 7.52pm for dyspnoea and 27 April 2020 at 12.32am and/or 1:30am for dyspnoea.

COVID DIAGNOSIS

36.7 Mrs Corrigan took a combined nose/throat PCR test on 14 April 2020 at 3.51pm. The test result was positive for SARS-CoV-2. Dr Branley advised Newmarch House staff the following day, and Mrs Corrigan was admitted to Hospital in the Home (HITH) for daily follow up. On 15 April at 5.33pm, Newmarch House manager Melinda Burns contacted Mrs Corrigan's son John and informed him of the positive test result.

ADVANCE CARE PLAN

36.8 John Corrigan completed an Advance Care Plan (ACP) with Dr Sheehan on 18 September 2018. The ACP stated that Mrs Corrigan did not want cardiopulmonary resuscitation (CPR) and did not want to be kept alive by being fed artificially. Antibiotics were to be administered to "*promote comfort.*" Mrs Corrigan did not want to be transferred to hospital, except to maintain comfort, and preferred to remain at her place of residence following a palliative care plan, the priority being her comfort and dignity. She wished for a Catholic priest to provide her Last Rites. Mrs Corrigan's ACP was updated every 12 months. However, there does not appear to have been any changes to the ACP at the time of the outbreak in 2020.

Discussions around ACP

36.9 On 15 April 2020, John Corrigan received a call from Newmarch House and was advised that his mother, Mrs Corrigan, had tested positive to COVID-19. During this call, staff at Newmarch House suggested to John Corrigan that Mrs Corrigan be left at Newmarch House for treatment, as transfer to a hospital may be traumatic for her. John Corrigan was given the option to send Mrs Corrigan to hospital. On the same day, John Corrigan received an email from Newmarch House outlining their plan for how they were to "*deal with the residents.*" John was advised that Mrs Corrigan would receive specialist care, which would be no different to the care she would receive if she was sent to hospital. John was informed that if Mrs Corrigan's condition escalated, she could be transferred to hospital and placed on a ventilator. John was nominated as his mother's family contact.

36.10 Over the next few days, John Corrigan received calls from Newmarch House updating him on Mrs Corrigan's condition. He did not receive a call on 19 April 2020 from Newmarch House and he attempted to call Newmarch House however no one answered the phone. Further phone calls from Newmarch House to John Corrigan occurred between 20 and 24 April 2020, updating John on his mother's condition.

36.11 On 24 April 2020 at 7.37pm, John Corrigan received a call from a nurse at Newmarch House advising that Mrs Corrigan's oxygen had dropped and that she was struggling to breath and that Morphine and palliative care was being considered. On 25 April 2020, John Corrigan attempted to call Newmarch House for an update on his mother's wellbeing, but was unsuccessful. On 26 April 2020 and 27 April 2020, John received calls from Newmarch House advising that his mother was deteriorating and was very weak. John Corrigan tried to call Newmarch House on the morning of 27 April 2020 but was unsuccessful. Mrs Corrigan passed away in the afternoon of 27 April 2020.

36.12 Mrs Corrigan was one of only a few residents whose clinical records contained a completed End of Life Pathway form.

PROGRESSION OF ILLNESS

15 April 2020

36.13 On 15 April 2020, Mrs Corrigan's temperature was recorded three times. However, her other vital signs were not recorded.

36.14 At 11.30am, Mrs Corrigan's temperature was 36.1C. At 3.50pm, Mrs Corrigan was automatically admitted as a patient to HITH prior to any consultation or review of her records. There does not appear to have been any family consultation prior to her admittance. At 3.45pm, Mrs Corrigan's temperature was 36.7C. At 5.33pm, John Corrigan received a phone call from Newmarch House informing him that Mrs Corrigan had tested positive to COVID-19, as outlined above, that she had a slight cough, and her temperature was 36.4C.

16 April 2020

36.15 On 16 April 2020, Mrs Corrigan's observations were recorded four times. First at 3.52am, SpO2 96% RA (BP 132/72, P 88, Temp 36.5C, RR 17), before breakfast SpO2 88% (Temp 36.7C, P 89, BSL 9.9, RR 21, BP 189/109), at lunchtime SpO2 93% w/o O2, and approximately eight hours later at 9.00pm SpO2 96% on Nasal Prongs (BP 136/88, Hr 87, Temp 36.2C, RR 21).

36.16 At 3.52am, Mrs Corrigan was recorded to be coughing but not in distress. At 11.52pm, Dr El Jamaly (HITH Registrar) recorded that Mrs Corrigan was enrolled in HITH as per "*New protocol for HITH COVID-19 residents*" and they were awaiting the Advance Care Plan. At 12.34pm, Melinda Burns contacted John Corrigan and provided him with an update of Mrs Corrigan's condition. Mrs Burns noted that Mrs Corrigan's temperature was stable. At 3.22pm, Leann Hinton recorded that she had spoken to Dr Rezk (Mrs Corrigan's GP) and he "*has given verbal consent and will send written consent for Leone to have access/support/consultation with the VACS team and infection control team at Nepean Hospital and have access to my emergency doctor*". At 4.22pm, Melinda Burns provided an update of Mrs Corrigan's condition to John Corrigan. At 6.22pm, the following note was recorded by Clinical Educator Dominguez:

> Leone was seen lying in bed this morning. She was attended by Staff and RN straight away and was given a sponge. Staff used a stand up lifter for Leone in order to transfer her from bed to chair. Leones O2 sat was low and was 88 %. She was immediately given a O2 2L via nasal prong. Leone was alert and verbally responsive, Obs 36.7 temp., 89 bpm, BSL 9.9 prior to breakfast, 21 resp., 189/109. O2 sat re-checked again at lunch time and was 93 % without O2. Leone was seen with some soiled washer that indicated that she had vomited but feels well as verbalised. Leonne has removed her O2 and has no shortness of breath.

36.17 At 7.00pm, RN Cardwell noted that Mrs Corrigan was found on the floor. Mrs Corrigan stated that she had slid from her recliner and denied pain. RN Cardwell noted that Mrs Corrigan had a red mark on her buttock, but no other injuries were sighted. She had no increased work of breathing.

17 April 2020

36.18 On 17 April 2020, Mrs Corrigan's observations were recorded twice. Once at 6.30am, SpO2 not recorded (BP 131/75 P 65 Temp 36.6C, BSL 9.9), and over twelve hours later at 7.21pm, SpO2 91% RA, (RR 23, BP 138/67, P 51).

36.19 At 6.30am RN Cardwell noted that Mrs Corrigan had slept well overnight, and observations remained stable. Mrs Corrigan was alert and verbally responsive before breakfast. She had a dry cough but had no nasal congestion; her observations were taken, and she was given 2L of oxygen for comfort via nasal prong. When staff checked on Mrs Corrigan again, she had removed her nasal prong. At 12.48pm, Melinda Burns updated John Corrigan on Mrs Corrigan's condition. John requested that staff check Mrs Corrigan's phone to make sure it was on the hook.

36.20 Counsel Assisting submitted that VACS appears to have only conducted a remote review of Mrs Corrigan's records, rather than a face-to-face consultation, noting yet again that the observations recorded by Dr Kakkat in the Nepean Clinical at 17:12 were almost identical to the observations recorded by nursing staff 12 hours earlier at 6:30am. Dr Kakkat ordered 'crisis medications'. It was submitted on behalf of Dr Kakkat that a nursing entry made at 4.05pm on 17 April 2020 records: "*patient recviewed by VACS today at nursing home. For HITH call tomorrow*", that Dr Kakkat's own entry records: "*At Newmarch House*", and that Dr Kakkat may have only recorded the earlier observations taken of Mrs James rather than taken his own observations. Similar to what has already been noted above regarding Dr Kakkat's progress note entries for 17 April 2020 for other residents, the limited nature of the entry for Mrs Corrigan, and the absence of any entry which could not have been drawn from Mrs Corrigan's known previous history suggests that it is most likely that no face-to-face consultation was conducted by Dr Kakkat. The reference to "*At Newmarch House*" is equally consistent with Dr Kakkat's own evidence that he did not always see patients when he attended Newmarch House and that most of the time in the first two weeks he was focussing on the drawing up of medication charts.

18 April 2020

36.21 On 18 April 2020, Mrs Corrigan's observations were recorded twice. Once at 1.00am, SpO2 92% 2LNP RA (BP 132/80, P 80, Temp 36.8C, RR 21) and over 21 hours later at 9.30pm, SpO2 92% BP 136/79, P 59, Temp 35.2C).

36.22 At 1.00am, Mrs Corrigan was attended to by RN Cardwell. RN Cardwell noted that Mrs Corrigan was comfortable in her bed, she had a moist cough, but no increased work of breathing. RN Cardwell did not administer Mrs Corrigan with Tricortone cream due to there being no stock. Prior to breakfast, Mrs Corrigan's blood sugar level was 5.1mmol/L. She ate her breakfast, and no cough or nasal congestion was noted.

36.23 Progress notes from Nepean Hospital indicate that RN Hayes (HITH) contacted Newmarch House requesting updated on all COVID-19 positive cases, including observations, status and current condition, but at the time of recording the entry at 3.30pm, no information from Newmarch House had been received.

36.24 At 9.30pm, RN Cardwell assisted Mrs Corrigan to call her son John. RN Cardwell noted that Mrs Corrigan's respiratory rate was 24, but she was not in distress. Her rate improved with deep breathing exercises. RN Cardwell further noted at 9.30pm that Mrs Corrigan was feeling well with no cough or shortness of breath, her pad was changed, and her observations were taken. At 10.10pm, Clinical Educator Dominguez noted that Mrs Corrigan required oxygen therapy throughout the day.

19 April 2020

36.25 On 19 April 2020, Mrs Corrigan's observations were recorded three times. First at 7:30am, SpO2 not recorded (BP 132/76, P 78, RR 17, Temp 36.4C), at 9.00am, SpO2 96% (BP 132/76, P 78, RR 17, Temp 35.2C), and then again, 11 hours later at 8.00pm, SpO2 97% (BP 160/90, P 72, RR 18, Temp 36.2C).

36.26 At 7.30am, Mrs Corrigan's blood sugar levels were checked, and insulin was administered. At 9.00am, Mrs Corrigan's blood glucose was 5.1mmol/L and insulin was administered.

36.27 At 3.28pm, progress notes from Nepean Hospital indicate that RN Sidney attempted to call Newmarch House on three occasions with no response. Subsequent contact with the VACS team was made who advised they would contact Nepean Hospital if there was anything major to advise. RN Sidney requested a system to facilitate a daily update from Newmarch House to Nepean Hospital. At 4.15pm, Mrs Corrigan was administered regular insulin.

20 April 2020

36.28 On 20 April 2020, Mrs Corrigan's observations were recorded four times. First at 6.00am, SpO2 94% (BP 120/70, P 80, RR 18, Temp 35.6C), at 9:00am, SpO2 92% (BP 160/82, P 72, RR 16, Temp 36.5C), at 4.57pm, SpO2 94% (BP 120/70, P 80, Temp 35.6C, RR 18), at again at 10.00pm, SpO2 35.70% (BP 122/75, P 87, RR 18, Temp 35.7C).

36.29 At 12.30am, an unknown RN noted that Mrs Corrigan was "*afebrile obs stable Asymptomatic meds given as ordered creams applied personal care attended settled well*." At 6.00am, RN Cardwell noted "*Loose BM* [bowel movements] *today had had episode two days ago. Referral to GP. Staff to please monitor and document*." At 4.57pm, VACS Aged Care Nurse Practitioner Carpen conducted a remote review of the clinical notes and recorded "*Please recheck observations Will review again tomorrow*:"

36.30 At 7.15pm, Melinda Burns called John Corrigan and provided an update on Mrs Corrigan's condition. Ms Burns noted that "*family happy with care and appreciated phone call*." At 8.00pm, Mrs Corrigan's SpO2 was incorrectly recorded as 35.7%. At 9.12pm, Mrs Corrigan was reviewed by Dr Branley, and it was recorded that "*he is happy with her progress and her temp was 37. FM called family to keep them informed*." It is noted that this is one of the very few clinical records which records a bedside review by Dr Branley.

36.31 At 9.31pm, RN Dean acknowledged an alert and noted "*an action of systolic out of Leone normal range, regular BP medications were administered with good effect"*.

21 April 2020

36.32 On 21 April 2020, Mrs Corrigan's vital signs were not recorded.

36.33 At 3.00am, an unknown RN noted that Mrs Corrigan had loose bowels overnight and was provided with a sponge bath. She remained asymptomatic and denied any sore throat, runny nose, or lethargy.

36.34 At 3.00pm, Leann Hinton noted that Mrs Corrigan was "*Reviewed by Dr Kakkat he has written up Rulide 150mg BD*" and that she left a message for John Corrigan. At 4.37pm, VACS Aged Care Nurse Practitioner Carpen noted a remote *Review of line listing from facility Report of a cough and diarrhea today Will review again tomorrow* and that Mrs Corrigan was under the care of HITH. Counsel Assisting noted that this entry makes plain the confusion as to whose care the COVID-19 positive residents were under, HITH or VACS and as a result, who were the lead clinicians.

36.35 At 7.28pm, Manager Zdziebko left a message for John Corrigan providing him with an update. On 21 April 2020, Mrs Corrigan was given antibiotics for a cough. It was also noted that she has "*cough and diarrhoea +++".*

22 April 2020

36.36 On 22 April 2020, Mrs Corrigan's observations were recorded three times. First at 2:00am, SpO2 93% on RA (BP 114/76, Temp 36.9C, P 110), at 6:00am SpO2 90% RA, at 8:30am SpO2 88% (BP 122/72, P 78, RR 18, Temp 36.5C). Mrs Corrigan's oxygen saturation dropped, and she was given oxygen.

36.37 At 2.00am, RN Cenizal attended upon Mrs Corrigan, who was awake and alert. She noted that Mrs Corrigan was coughing. Twelve hours later at 2.14pm, Melinda Burns called John Corrigan, who asked if Mrs Corrigan would be given a mobile phone as soon as possible.

36.38 At 4.01pm, VACS Aged Care Nurse Practitioner Carpen reviewed the Newmarch clinical records remotely and simply recorded the vitals charted 8 hours earlier at 6.00am and notes '*Now on Oxygen via Hudson mask @5LPM.'* No independent clinical assessment or review is brought to bare at all by VACS.

36.39 At 4.57pm, an unknown nurse did not administer Janumet 50/850 tablet (Type 2 diabetic medication) to Mrs Corrigan.

23 April 2020

36.40 On 23 April 2020, Mrs Corrigan's observations were recorded four times. At 2.00am SpO2 89% RA (BP 136/65, P 98, Temp 36.6C), at 5.45am SpO2 96%, at 10:15am SpO2 92%RA (BP 118/75, P 68, RR 18, Temp 36.1C), and at 3.55pm SpO2 91% (BP 115/81, P 87, RR 22, Temp 36.5C), [corresponding entry Sats 92% (BP 118/75, T 36.1, RR 18, HR 68)].

36.41 At 2.00am Mrs Corrigan was awake, alert and coughing. No distress, shortness of breath or pain was noted. RN Cenizal asked Mrs Corrigan to put on the oxygen and Mrs Corrigan refused, stating that

she cannot sleep with it. At 10.25am, RN Cardwell noted that Mrs Corrigan was alert and interactive with no respiratory concerns. She refused oxygen and her SpO2 was 92%. RN Cardwell called John Corrigan who asked questions regarding "*cleaning residents*".

36.42 At 3.55pm, VACS Aged Care Nurse Practitioner Carpen reviewed the notes remotely and recorded *"Refusing oxygen at this stage Hemodynamically stable"*. Again, no independent clinical assessment or review is brought to bare at all by VACS.

36.43 The corresponding entry in the Nepean Progress notes at 3.54pm by RN Sidney attached to HITH states "*taken from nursing home notes, no symptoms on notes with BP 118.75, T 36.1, sats 92% RR 18, HR 68*." At 4.00pm, RN Cardwell noted that Mrs Corrigan was resting in bed and did not voice any concerns. Mrs Corrigan was on room air. John Corrigan was provided with an update of her condition. At 7.30pm, Christine Giles recorded the following note:

> Contacted John and apologised for the delay in the Medications this afternoon, Medications were administered by manager and Leone is settled and appreciative. Reassured that medications will be on time from now on and John expressed his thanks for the work that staff are doing and said he understood the pressures. Leone seemed in brighter spirits later this afternoon.

24 April 2020

36.44 On 24 April 2020, Mrs Corrigan's observations were recorded three times. First at 6.00am SpO2 80% (BP 121/736, P 83, Temp 34.8C), then again over eight hours later at 2.20pm SpO2 96% 2LNP (BP 136/88, 2l P 87, RR 21, Temp 36.2C), and almost five hours later at 7.00pm SpO2 82% 5L (BP 110/78, P 78, RR 22, Temp 36.6C).

36.45 At 11.30am, Mrs Corrigan was repositioned. At approximately 2.15pm, Mrs Corrigan sustained an unwitnessed fall. Her oxygen was low, and oxygen was administered at 6L via Hudson mask after she had increasing shortness of breath and hypoxia. Her saturation was 90% and respiratory rate was 22. Mrs Corrigan did not appear lethargic but had two episodes of loose bowels. At 3.42pm, RN Dean noted "*an action of systolic BP slightly out of range to continue with daily vital signs monitoring and report to LMO if any concerns".* At 4.25pm, RN Malaihollo recorded in the Nepean Hospital Progress notes that "*Pt d/c from HITH. VACS aware. Follow up 2nd daily per NUM*".

25 April 2020

36.46 On 25 April 2020, Mrs Corrigan's observations were recorded three times. Once at 1.00am, SpO2 not taken (BP 107/63, P 77, RR 24, Temp 36.5C), two hours later at 3.00am, SpO2 99%, and then 15 hours later at 6.00pm, SpO2 98% (P 65, Temp 36.4C).

36.47 At 4.02am, an unknown RN attended to Mrs Corrigan, who had a loose bowel movement and resulting red rash. She remained on 6L oxygen via Hudson mask. At 12.35pm, Mrs Corrigan was noted to be "*RIB, alert but intermittently drowsy*". She was assisted to sit up and drink some water. The RN contacted John Corrigan and sent him pictures as requested. At 1.04pm, Newmarch House Manager Melinda Burns noted that as of 25 April 2020 until further notice staff were to document on paper-based notes. At 8.43pm an unknown RN attended to Mrs Corrigan and provided her family with an update her of condition, namely:

> I have explained that she is not well at present that she seems better than yesterday but is having constant loose black/green stool – sample taken. Groins looks like they have a rash/breaking due to contact with faecal matter. Sacrum and insides of buttocks have the same, there may be a grade 1 to the left buttock. 2 hourly [turns]. Informed GP over the phone about her condition. She stated that if she was in pain or distress she could have sub-cut morphine.

26 April 2020

36.48 On 26 April 2020, Mrs Corrigan's observations were recorded three times. First at 5.00am, SpO2 not recorded (Temp 36.3C, P 83, RR 28, BP 138/69), at 7.50am, SpO2 88% (Temp 36.8C, P 105, RR 24, BP 120/73), and then approximately 12 hours later at 8.40pm, SpO2 96%, (Temp 36.2C, P 69, RR 22, BP 100/54). On 26 April 2020, Mrs Corrigan became increasingly weak and distressed with decreased fluid intake.

36.49 At 2.15am, an unknown nurse attended to Mrs Corrigan and noted "*medications given as charted, observations remain with normal limits, Pressure care attended 2nd hourly, patient asleep at time of report.*" At 2.30am, Carer Adhikari noted that "*Leone is having problem to drink water and juice, staff tries to give her water and juice by spoon. 2 hourly pressure care for her, staff applied sudocream on her sore bottom. She said she is comfortable and she go back to sleep".*

36.50 At 12.47am, Mrs Corrigan was administered 2mg of morphine for pain and dyspnoea.

36.51 At 1.03pm, it was noted that "*until further notice staff are to document on paper-based notes*." At 1.09pm, Mrs Corrigan was administered morphine 2mg/ml oral liquid, due to pain and dyspnoea. At 3.45pm Mrs Corrigan had increased work of breathing and was tachypnoeic. At 7.52pm, she was administered morphine 2mg/mL oral liquid due to dyspnoea.

27 April 2020

36.52 At 12.20am, Mrs Corrigan's pulse was 60 and respiratory rate was 18 BPM. At 12.32am, Mrs Corrigan was administered morphine 2mg/mL oral liquid due to dyspnoea. At 1.30am, Mrs Corrigan's pulse was 56 and respiratory rate was 18 BPM. At 4.38am, Mrs Corrigan was administered morphine 2mg/mL oral liquid due to dyspnoea. At 5.00am, Mrs Corrigan's pulse was 50 and respiratory rate was 16 BPM. Observations were recorded at 9:30am (Temp 36C, P 56, RR 20, BP 76/60).At 10.30am, physiotherapy attended to Mrs Corrigan and noted the plan was not for further physiotherapy until requested. From 12.44pm onwards, Mrs Corrigan was not administered any medications.

36.53 At 3.00pm, RN Cardwell noted that Mrs Corrigan had reduced consciousness over the course of her shift and was not responsive. Mrs Corrigan had her eyes open and was pain free with no respiratory distress. RN Cardwell noted that she had called Dr Rezk, the VACS team and John Corrigan to notify them of Mrs Corrigan's deterioration. At 3.30pm, Mrs Corrigan's temperature was 35.9C and her respiratory rate was 18 BPM.

36.54 At approximately 3.46pm, staff attended Mrs Corrigan and found she had passed away. A staff member called Mrs Corrigan's daughter, Bernadette, to inform her of her mother's death. However, John Corrigan was recorded as Mrs Corrigan's primary contact and responsible person. Bernadette

then called John to inform him of Mrs Corrigan's death. An End-of-Life Pathway form was completed on 27 April 2020.

MANNER AND CAUSE OF DEATH

36.55 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree that Mrs Corrigan's cause of death was COVID-19 infection with some contribution from her underlying comorbidities, particularly her cardiovascular comorbidities. Professor Kurrle emphasised her frailty, diabetes and renal impairment being significant contributors. Professor French emphasised her diabetes as a significant contributor.

36.56 **Manner of Death**: The experts note that Ms Corrigan's decline was progressive, and her deterioration was prolonged, yet there was no end-of-life pathway determined until the day she died, and she only received morphine for the first time the day before.

36.57 **Impact of any significant co-morbidities**: Frailty, diabetes, renal impairment, and cardiovascular disease all had an impact.

36.58 **Issues with care received**: Yes; see below.

36.59 **Whether different action may have affected the outcome:** Possibly.

36.60 As Mrs Corrigan was infected in the first wave of COVID-19 infections at Newmarch House, Associate Professor Kotsimbos did not consider there was anything that could have been done to prevent her infection. Associate Professor Kotsimbos considered that oxygen therapy was reasonable but fluid management could have been improved considering her comorbidities. Associate Professor Kotsimbos noted that because of Mrs Corrigan's significant cardiovascular comorbidities, particularly diabetes, she was on medication that lowered blood pressure and also diuretics. She also had diarrhoea after her infection with COVID-19 which would have contributed to further fluid losses.

36.61 Associate Professor Kotsimbos noted that Mrs Corrigan's End-of-Life pathway was not determined until the day of her death (27 April 2020), and she only received Morphine the day prior to her death. In the context of a prolonged deterioration, Associate Professor Kotsimbos considered that Mrs Corrigan may have been better managed if she was transferred to a hospital in circumstances where palliative care was not provided until the last day of her life.

36.62 Professor Kurrle was somewhat critical of the suboptimal management of Leone Corrigan's fluids over the course of her prolonged deterioration from the date of her COVID-19 positive test result to her death. Professor Kurrle also noted that Mrs Corrigan had pressure areas on her buttocks following her infection with COVID-19. Given the circumstances, Professor Kurrle considered that the degree of care provided in Newmarch House did not amount to a degree of ideal care. Professor Kurrle was not sure how Mrs Corrigan would have progressed if she was transferred to hospital but did consider that her outcome may have been different if that did occur.

36.63 Professor French did not consider that any treatment was available to prevent Mrs Corrigan's death, but accepted the comments made by Professor Kurrle and Associate Professor Kotsimbos in terms of Mrs Corrigan's sub-optimal management at Newmarch House.

36.64 It is noted that the care and treatment of Mrs Corrigan is a clear example of where the suggestion that equivalent care to hospital care was being delivered at Newmarch House was simply incorrect. This can be said upon limiting the analysis simply to the administration of fluids. There is no evidence that Ms Corrigan was ever placed on subcutaneous fluids, or IV fluids, which the experts have noted this as a deficiency in the care she received. Given observations were often taken 12 to 16 hours apart, its likely there were many hours between visits from carers and this would have also hampered the ability of carers to encourage fluid intake by Mrs Corrigan, or assist with fluid intake such as tea or juices.

36.65 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Leone Corrigan.

Date of death

Mrs Corrigan died on 27 April 2020.

Place of death

Mrs Corrigan died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Corrigan's death was COVID-19 infection with hypertension, congestive cardiac failure and type II diabetes mellitus and dementia being significant conditions which contributed to death.

Manner of death

Mrs Corrigan died of natural causes following diagnosis of COVID-19 infection. Mrs Corrigan received suboptimal fluids management between the time of her COVID-19 diagnosis and death, and her end-of-life pathway was not determined until the day of her death on 27 April 2020. Transfer to hospital would have allowed for improved clinical management which may have made a material difference to the eventual outcome.

37. Barry Jehan

HEALTH

Co-morbidities

37.1 Barry Jehan was 93 years of age when he passed away on 28 April 2020 at Newmarch House during the COVID-19 Outbreak. He had a number of existing comorbidities including dementia (mixed Alzheimer's/vascular), hypertension, type 2 diabetes mellitus, right nephrectomy, osteoarthritis and previous spinal surgery. Mr Jehan had a hearing impairment requiring hearing aids.

Background and events leading up to COVID-19 diagnosis

37.2 In 2015, Mr Jehan's daughter, Mary Van Put, noticed that Mr Jehan was becoming forgetful. In 2016, he was diagnosed with early onset Vascular Dementia and Mixed Alzheimer's. Mr Jehan was admitted to Newmarch House on 23 October 2018. He had previously lived with his daughter Mary but moved into residential care once he required assistance with personal care. Mr Jehan was able to mobilise reasonably well with a walking frame and was able to walk to the lounge area with assistance. He did so even after residents were required to isolate to their rooms.

RELEVANT MEDICATIONS

37.3 Mr Jehan was prescribed a number of regular medications including Gilclazido MR (Adrix) 60mg, Mizart 80mg, Plax 75mg, Odaplix 75mg, Trejenta 5mg, Kelfex 500mg for 5 days, Ear clear 6.5% ear drops and Semeglee 100 units/mL injections.

37.4 Mr Jehan was also prescribed a number of medications on an as needed basis including Actrapid penfill 100 units/mL injection, Foss 0.704% nasal spray, paracetamol 500mg, Poly-tears 0.1/0/3% eye drops, Eleuphrat 0.05% cream and GTN patch 25mg. For his hypertension and type 2 diabetes mellitus, Mr Jehan was prescribed Micardis, Natrilix SR and Diabex XR.

PRN Medication - Midazolam and morphine

37.5 Dr Kakkat wrote three scripts on the 25 April 2020 and one script on 26 April 2020, for morphine 2.5mg s/c to a max of 20mg (for agitation) and midazolam 2.5mg. maximum of 10 mg for SOB. It is unclear why three scripts bearing the same date were written.

37.6 Nepean Clinical records of 26 April 2020 at 3.21pm record that:

> a call was received from ADON (Assistant Director of nursing) requesting crisis medications and the following was recorded
> RN Howse and RN Fenech took pack to Newmarch House Lawson ward…
> Morphine 5mg ampules x 10 and Midazolam 5mg 10 ampoules were also given to RN from Newmarch House but not signed in as they do not have an S4 register. RN House and RN Fenech witnessed same. Pts name written on all medication.

37.7 On 27 and 28 April the records indicate that phone orders were made for crisis medication to be charted. Ms Van Put gave evidence that subsequent to her father's death, she read that her father had been commenced on EOL (end of life) medications, however, she did not know what they were and they were never mentioned to her.

37.8 The medication charts do not disclose any administration of either morphine or midazolam.

COVID DIAGNOSIS

37.9 Mr Jehan took a PCR COVID-19 test on both 14 April 2020 and 17 April 2020 and returned a negative result on those dates.

37.10 On 20 April 2020, Mr Jehan took a PCR test with a preliminary report returning a positive result for COVID-19 (with the final report only being available on 29 April 2020). At 3.31pm on 23 April 2020, Mr Jehan took a further PCR COVID-19 test and returned a positive result. On 24 April 2020, Ms Van Put was notified of the positive test result.

ADVANCE CARE PLAN

37.11 On 16 June 2019, Ms Van Put signed an Advance Care Plan (ACP) on behalf of her father. The plan stated that he did not want CPR or to be kept alive by artificial feeding, but that he did want to receive oral antibiotics and did want to be transferred to hospital if medically indicated.

37.12 Ms Van Put gave evidence that Mr Jehan's 16 June 2019 ACP "*absolutely reflected*" both her and her father's wishes as at the time of contracting COVID-19 on 23 April 2020, namely that he be transferred to hospital if medically indicated.

Discussions around ACP

37.13 On 19 April 2020, (before Mr Jehan's COVID-19 diagnosis), Ms Van Put sent an email to Newmarch House asking a number of questions on behalf of the family. One of the questions posed by the family was whether Newmarch House had the infrastructure and capacity to intubate the residents should ventilators be required. Ms Van Put gave evidence at the inquest that they specifically asked this question based on the knowledge of a paramedic in the family. They noted that HITH was the proposed treatment model, but questioned whether equipment such as ventilators and x-ray machines were available, so that the family could ascertain whether HITH at Newmarch House would be equivalent to treatment at a hospital.

37.14 On 22 April 2020, Newmarch House Manager Melinda Burns informed the family that it was not advisable to take their father home, as he could potentially have the virus and they could all become unwell.

37.15 On 24 April 2020 a phone call took place between Ms Van Put and Mr Jehan's GP Dr Dharmaratnam, regarding her father's COVID-19 positive diagnosis, and the care to be delivered. There was no discussion about an ACP, only a discussion about a "*do not resuscitate*" plan; a discussion about keeping Mr Jehan comfortable at Newmarch House; and Ms Van Put's request that Mr Jehan be

taken to hospital if required. She raised in that conversation two earlier times when that had occurred. Ms Van Put states that she communicated that if Mr Jehan ended up with symptoms, and he was unwell, the family wanted him to be provided comfort measures in the home until the need for hospital care was required. She specifically used the expression "*as per his Advance Care Plan.*" She stated that although her contemporaneous notes of the 12.30pm 25 April 2020 conversation with Dr Dharmaratnam do not record Mr Jehan's ACP or discussion about transfer to hospital, the conversation did entail these two issues. Her evidence on that point was "*I know for certain that we weren't asked about* [the terms] *of his advanced care plan, we wanted him comfortable at home being Newmarch until hospital treatment* [was] *required and then we wanted him to go to hospital as per his plans*".

37.16 Dr Dharmaratnam's note records the following:

> Currently he is non febrile 36.8 degs, CSats 96%, R/ABP 137/70RR 17/min HR 66/min. He is communicating well and in good spirits, I did speak about comfort care and oxygen therapy – if required Mary has indicated that her father is not for resuscitation, ionotropes, ICU admission or intubation. He is for comfort care... she did ask about his UTI for which he has been started on antibiotics (Keflex) I said we would continue that as that would treat his UTI but not COVID. Did let her know that currently we have no curative medications for COVID-19 and thus symptomatic treatment is the approach. Plan: isolation, Symptomatic treatment, Panamax 500mgs, QID/PRN02 PRN @ 2 Lts/min, continue regular medications as per chart incl Keflex.

37.17 Dr Dharmaratnam stated in evidence that he could not recall Ms Van Put stating that she wanted her father to be transferred to hospital, as per his Advance Care Plan, if needed. He stated that at that stage a person who had COVID was not being transferred to hospital.

37.18 Ms Van Put said in evidence that there was a second call on 25 April 2020 which involved herself, Dr Dharmaratnam, Dr Sharma and her sister, Kate. She gave evidence that Dr Dharmaratnam was talking about "*hospital comfort of HITH*" and that Ms Van Put and her husband's response was that they would want Mr Jehan to be made as comfortable as possible, but that he should be transferred to hospital as per his ACP if required. The term "*Advance Care Plan*" was not mentioned. It was just about comfort.

37.19 Ms Van Put gave evidence that she did not have a clear recollection about the subsequent phone call with Dr Sharma on 25 April 2020, and the contents as recorded in the iCare notes. Those notes record in part:

> "Discussed about the Advance Care Plan….."
> She is concerned about ADL's on a daily basis…"
> John Behan wants to know how isolation is. He is questioning- he has been in his room for a month, even with this he has contracted the virus. Is this the best place for him to be. Is this the safest place for him to be..
> Dr Sharma advised that she will request PH (Public Health) to speak to the family….In regards to the care, Anglicare is the people who will need to answer that question….. Medical staff are in contact with the nursing staff and there is telehealth in place to check on the patient. The nurses are updating the medical staff of the progress of the patient…

> Dr Sharma has explained to the family that there is infectious disease specialist and palliative care team in place. Have explained that we have given phone advice to the nursing staff and the instructions are being followed up.
> John [son in law] agrees that the medical issues are new to all of us. All he is wanting os for his father in law to be cared and medical services initiated when required.
> They are wanting to know the frequency of the care provided to their father. We are unable to give exact details of the frequency of care.

37.20 Ms Van Put maintained in her oral evidence that her understanding after the two phone conversations with Dr Dharmaratnam and Dr Sharma was that, "*If he* [Mr Jehan] *got symptoms and it progressed, that he would be made as comfortable as possible until the time* [was] *needed for him to go to hospital for ventilators or whatever*." Further, she gave evidence that it was her understanding that the ACP remained in place unless there was a new signed ACP, which there was not.

37.21 Professor Kurrle opined that Mr Jehan's ACP was not followed.

PROGRESSION OF ILLNESS

22 April 2020

37.22 At 6:22pm, it was noted by Nurse Practitioner (NP) Hailey Carpen, that Mr Jehan had vomited a moderate amount that day. His blood pressure was high, and nursing staff were reporting ongoing hypertension. This was discussed with Dr Sharma who suggested he may have a Urinary Tract Infection (UTI). It was recorded that Mr Jehan "*Needs MSU, and Keflex 500mg and to continue to monitor BP. If BP was >200mmHg please add GTN patch.*" At 10:15pm, vital signs were taken (BP 129/64, P 90, Temp 37.5C, RR 22, O2 93%). Progress notes stated that Mr Jehan was unwell and that a GP had ordered oral antibiotics that day. "*Keflex 500mg. TDS administered @ 2100 hours, febrile of 37.5C given PRN x 2 Paracetamol at 2215 hours*." It was also noted that a coughing episode was observed. Medication records indicate that antibiotics was administered between 23 April 2020 and 27 April 2020.

23 April 2020

37.23 On 23 April 2020, Mr Jehan's observations were recorded eight times. At 6.32am SpO2 96% (BP 115/54), at 12.30pm SpO2 96% (BP 157/79, P 91, RR 20), at 12.50pm SpO2 96% (BP 170/81), at 2.18pm SpO2 95% (BP 143/73), at 3.16pm SpO2 98%, at 5.20pm SpO2 98%, at 6.20pm SpO2 (BP 161/81), and at 8.00pm SpO2 95% (BP 143/75).

37.24 At 4.52am, progress notes indicate that Mr Jehan slept well overnight, had no complaints of pain but was observed to be coughing slightly. Mr Jehan had a fall at 12.15pm. Two staff members were in his room making his bed and found him in the toilet. The staff stated he was trying to get up using his walker and slipped down onto his bottom. Progress notes indicate that he appeared alert and could recall the incident. A head-to-toe assessment was done, and no injury was noted, nor was there any sign of redness or bruising on his bottom. He was assisted by staff using a hoist lifter to get back into bed. Mr Jehan's temperature at 2.49pm was 38.5C. He was given water to drink and was rechecked

at 3.18pm when his temperature was noted to be 37.5C. The Care Manager was informed. At 4.00pm, Mr Jehan's temperature was 36.9C and at 6.26pm it was 36.5C.

24 April 2020

37.25 On 24 April 2020, Mr Jehan's observations were recorded six times. At 5.00am SpO2 95% (BP 143/66), at 10.45am SpO2 96% (BP 129/77), at 5.00pm SpO2 95% (BP 137/70), at 9.00pm SpO2 90% (BP 137/96), at 10.30pm SpO2 96% (R/ABP 137/70RR 17/min HR 66/min), and at 11.00pm SpO2 95% (BP 174/78).

37.26 At 5.00am, Mr Jehan was noted to be asleep with no complaints of pain or discomfort. Progress notes state "*recheck BSL 3.6mmol @0500 given resident a drink and honey monitor for any changes, rechecked BSL in half an hour".* Mr Jehan's blood glucose was rechecked at 6.00am and he was noted to be asymptomatic for COVID-19. Progress notes indicate that he ate less than half of his lunch and his breakfast. At 5.30pm, progress notes record that Mr Jehan was comfortable and was eating well, his vitals were attended to and were stable, all medications were attended to as charted, and activities of daily living (ADLs) were attended to as scheduled.

37.27 Mr Jehan vomited at around 9.00pm. He was cleaned up by the nurses and clothes were changed. He was afebrile at the time. His temperature was rechecked at 11.00pm and was 39.5C. He was given Panadol with good effect. At 10.30pm, Dr Dharmaratnam telephoned Mary Van Put to notify her of Mr Jehan's positive COVID-19 test.

25 April 2020

37.28 On 25 April 2020, Mr Jehan's vitals were in part recorded. Once at 9.28am, SpO2 88%; at 2:45pm where SpO2 was not recorded (P 80, RR 30) and at 4.00pm SpO2 95%.

37.29 At 1.30am, Mr Jehan's temperature was 36.8C. At 12.30pm iCare notes record the conference call with Ms Van Put, Dr Dharmaratnam and Dr Sharma as outlined above, stating that "*we are unable to give exact details of the frequency of care.*" At 2.45pm, Mr Jehan was noted to be alert but lethargic, and cognition was unable to be assessed due to decreased hearing. Progress notes state "*Nil signs of pain. Warm well perfused. HR 80bpm, RR 30, mild SOB, nil cough apparent. Repositioned in bed, sat upright for mediation administered by EEN on duty. Able to swallow adequately. Pad in situ. Nil complaints ATOR.*"

37.30 A progress note recorded later that day at 5.45pm stated that Mr Jehan's observations seemed to have stabilised since the morning, but he was clammy, coughing and lethargic. Mr Jehan needed full assistance with all ADLs. The doctor who reviewed Mr Jehan recommended Rulide to be prescribed due to thick sputum when he coughed. Also noted that oral fluids were to be pushed and he should remain on 2L of oxygen and if he became tachypnoeic and desaturates then he could have morphine.

26 April 2020

37.31 On 26 April 2020 observations were recorded four times. First at 4.35am SpO2 94% (Temp 36.4C, P 84, R 36, BP 175/71), five hours later at 9.35am SpO2 92% (Temp 37.2C, P 88, RR 37.2, BP 121/70), at 12.00pm SpO2 93% (Temp 37.7C, P 90, R 37.7, BP 161/60), then ten hours later at 10.10pm SpO2 84% (Temp 37.2C, P 89, R 38).

37.32 A progress note at 1.27am states "*Alert. Nil signs of SOB or DOB ATOR. With oxygen at 2LPM via nasal prongs. Nil corns ATOR. Pad changed by AINs. Needs assistance with ADLs. Sleeping well sitting ATOR*". At 7.15am it was noted that Mr Jehan had deteriorated overnight, desaturating to 84% and respiratory rate of 36. A doctor directed to increase oxygen and give Morphine. Morphine was not charted, and oxygen was put back on at 3L per minute. Oxygen saturations increased to 94%. At 10.00am, Dr Natalie Fox, a palliative care physician at Nepean Hospital, was contacted by Lorena Bestrin at Newmarch House regarding end-of-life medications for Mr Jehan. Progress notes indicate that Ms Fox would organise the end-of-life medications with a doctor and would provide a fax to Newmarch House.

37.33 Mr Jehan had a Virtual Aged Care Service (VACS) telehealth consultation with Dr Sharma at an unknown time. VACS notes indicate that Mr Jehan had a temperature overnight, but he appeared comfortable at rest. Nil complaints were voiced. Temperature was 35.6C, BP 103/72, O2 sats 93% on RA, RR 18/min. The progress note stated "*Plan oral care, pressure area care, O2 sat if required if O2 sat less than 94%. ACD completed by Dr Manoj Dharmaratnam and crisis medication completed on 25/4 after the medication chart was faxed to ACRC*."

37.34 Ten ampoules of morphine (2.5mg) and midazolam (5mg) were given to an RN from Newmarch House. The midazolam was not signed in as a S4 register was not available, although it is noted that there was no requirement at the time for an aged care facility to sign S4 drugs into a register. At 8.40pm, Mr Jehan had his ADLs attended to as well as PAC. He appeared to be asleep and settled. At 10.00pm, progress notes indicate that Mr Jehan refused staff assistance with dressing into night clothes.

27 April 2020

37.35 On 27 April 2020, observations were recorded seven times. First at 5.15am SpO2 94% (Temp 37.2C, P 92, R 24), at 6.10am SpO2 92% (P 10.8), at 9.30am SpO2 90% on 2L (Temp 36.4C, P 80, R 24, BP 151/68), at 11.30am SpO2 was not taken (P 12.7), over five hours later at 5.00pm SpO2 88% on 3L (Temp 37C, P 95, R 18 P 18.2), then three hours later at 8.10pm SpO2 86% on 3L (Temp 37C, P 94, R 18), and almost four hours later at 12.00am SpO2 90% on 3L (P 90, R 26).

37.36 Mr Jehan was noted to be very breathless, and an RN phoned a doctor for a telephone order of oral Morphine which was noted to be 'effective' although there is no record of morphine being administered. Later in the day, Mr Jehan appeared to be "*quite lethargic*". An air mattress was ordered and "*pressure areas remain intact. Regular replenishing required. Remains with poor response, minimal conversing but pts baseline as per regular staff*". At 2.50pm, Mr Jehan was noted to be alert and cooperative, and medications were given as chartered. He tolerated breakfast, lunch and fluids. It was further noted that "*PAC attended to, resident placed on R and L side throughout the*

day. Sacrum red but blancheable, cream applied. Rang pharmacy regarding oral AB course finished as it was for five days and finished yesterday and needed to be taken off signing sheet. Pharmacy stated they would take it off."

37.37 At 9.00pm, a RN spoke to Ms Van Put, and told her than Mr Jehan was comfortable and well looked after. Mr Jehan was noted to be asleep, but rosary attended to with classical music playing. Ms Van Put gave evidence that a nurse called Ursula told her that her father was eating three meals a day, that he was chatting on about being a signalman and his classical music and that she had "good feelings" about him (alluding to his recovery).

28 April 2020

37.38 At 3.00am, Mr Jehan was noted to be in bed, appeared comfortable but not very alert. Medications were not given at this time. Progress notes request that the morning staff to "*please get crisis medication.*" Mr Jehan died 10 minutes after this entry. The notes record "*Mr Jehan has died just now. I last saw him at 2.40am and he was quite comfortable then, I had prayed with him at around 2.30am and deterioration noted in respiratory effort but he was quite comfortable*."

37.39 At 3.36am, Mary Van Put received a call from a nurse, Ursula, who informed her of her father's passing and that it happened quickly and was unexpected as there were no signs. She informed Ms Van Put that her father had had a disturbed night and she had been checking on him regularly. She stated that she had given Mr Jehan rosary beads during the evening, and they had said a "*decade of the rosary*" together. Soon after this, Ursula was called away from his room and when she returned, he had passed away.

37.40 Ms Van Put gave evidence that one of her concerns in relation to her father was that he was not reviewed by a doctor at any point in time after the COVID positive diagnosis had been made. Clinical records indicate a single telehealth consult took place on 26 April 2020, two days before he died, following a family conference the day before where concerns as outlined above, were raised.

MANNER AND CAUSE OF DEATH

37.41 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree that Mr Jehan's cause of death was COVID-19 infection. The experts agreed that contributing comorbidities included Dementia, Diabetes and his history of cardiovascular disease.

37.42 **Manner of Death**: In terms of the circumstances of his death, Associate Professor Kotsimbos notes that Mr Jehan was diagnosed with COVID-19 in the third wave of testing at Newmarch House. Therefore, if Newmarch House was "*shut down in the first instance,*" there wouldn't have been ongoing infections, including that of Mr Jehan. Secondly, Associate Professor Kotsimbos noted that crisis medications were charted but not given to Mr Jehan, which meant that he was uncomfortable towards the time of his death.

37.43 **Impact of any significant co-morbidities**: Dementia, diabetes and cardiovascular disease were contributing factors.

37.44 **Issues with care received**: The experts agreed that it was very difficult to determine how much supportive care Barry Jehan received in terms of oxygen and they noted that he did not receive the crisis medications charted when he needed them. He had an ACP from 2019 that said he wanted to be transferred to hospital if appropriate, and transfer to hospital may have helped. He may have had a concurrent urinary tract infection and that noted his fall on the day he tested positive.

37.45 **Whether different action may have affected the outcome**: Yes.

37.46 Professor Kurrle noted that before Mr Jehan tested positive for COVID-19, his family wanted to take him out of Newmarch House to care for him. Professor Kurrle considered that if Mr Jehan was allowed to leave Newmarch House, as requested by his family, it is less likely that he would have contracted COVID-19.

37.47 Professor Kurrle, Associate Professor Kotsimbos and Professor French noted that Mr Jehan's ACP stated that he wished to be transferred to hospital if it was appropriate. Professor Kurrle considered that if Mr Jehan was transferred to hospital, it may have helped Mr Jehan's outcome.

37.48 Professor French opined that once Mr Jehan contracted COVID-19 and his condition deteriorated then there was no effective treatment that could have prevented his death. Relevantly, Associate Professor Kotsimbos noted that there was very little evidence of what *effective* infection control measures were in place at the time of Mr Jehan contracting COVID-19.

37.49 Having regard in particular to the evidence of Professor Kurrle, the decision that all residents should remain at Newmarch House during the Outbreak exposed Mr Jehan to a risk of contracting COVID-19. Permitting Mr Jehan to leave the facility after a second negative test, removing other COVID-positive residents from the facility, or better infection control measures, may have prevented infection.

37.50 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Barry Jehan.

Date of death

Mr Jehan died on 28 April 2020.

Place of death

Mr Jehan died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Jehan's death was COVID-19 infection with hypertension, type II diabetes mellitus, and Alzheimer's and vascular dementia being significant conditions which contributed to death.

Manner of death

Mr Jehan died of natural causes following diagnosis of COVID-19 infection. Following Mr Jehan's diagnosis, and when he was on an end-of-life pathway, anticipatory medications were charted but not administered which adversely affected the quality of Mr Jehan's remaining life. In addition, if Mr

Jehan had been permitted to leave Newmarch House as requested by his family when he was negative for COVID-19 it is less likely that he would have contracted COVID-19. Following his COVID-19 diagnosis, if Mr Jehan had been transferred to hospital in accordance with his Advance Care Plan it is not possible to reach a conclusion as to whether this would have made a material difference to the eventual outcome given the difference in opinions in the expert evidence.

38. Shirley Yates

HEALTH

Co-morbidities

38.1 Shirley Yates was 91 years of age when she passed away on 27 April 2020 at Nepean Hospital, after being transferred there on 25 April 2020 from Newmarch House during the COVID-19 Outbreak. She was transferred to Nepean Hospital with a suspected rib fracture following a fall.

38.2 Mrs Yates had a number of existing comorbidities including hypertension, diverticular disease, osteoarthritis, a Bakers cyst, a history of bilateral retinal detachment, cataracts, varicose veins, second toe amputation, shingles, small vein ischemia-CT brain, left supraspinatus tendon tear total, and urinary incontinence. She required assistance with activities of daily living (ADLs).

Background and events leading up to COVID-19 diagnosis

38.3 Mrs Yates was admitted to Newmarch House 3 weeks prior to the outbreak being declared on 18 March 2020 for short term respite care. She had previously lived alone with considerable support from her daughters. She had intended to move permanently to Newmarch House but only a respite bed remained available, a second four-week offer being made on 14 April 2020 which she accepted. Counsel Assisting noted that this second offer of respite care was being made 3 days into the outbreak being declared at Newmarch House.

38.4 Mrs Yates' mobility was hindered due to severe arthritis, and she used a walking frame for short distances and a wheelchair for longer distances. She was independent with grooming and was able to navigate use of her mobile phone. Mrs Yates suffered two falls whilst at Newmarch House, on 5 April 2020 and on 19 April 2020.

RELEVANT MEDICATIONS

38.5 At the time of her death, Mrs Yates was prescribed various medications including amitriptyline (osteoarthritis), Lorstat, Tramadol (osteoarthritis), Vaspcardol, vitamin D3, bio magnesium, Immune Aid, latanoprost, Trusamide, Hypnovel, Maxolon, morphine, Robinul, sodium bicarbonate, Systane eye drops and midazolam. Mrs Yates was also prescribed Diltiazem (hypertension) and Panadol (osteoarthritis).

PRN Medication - Midazolam and morphine

38.6 On 17 April 2020, Dr Kakkat prescribed Mrs Yates morphine 2.5mg, midazolam 2.5mg, glycopyrolate 200mg, Maxolon 2mL, Robinul (unknown quantity) and metaclopramide 10mg.

38.7 On 24 April 2020 following a fall on 19 April 2020 which resulted in ongoing left breast pain, Mrs Yates was administered 0.25mls of morphine for pain.

38.8 After admission to Nepean Hospital on 25 April 2020, the following day Mrs Yates was commenced on 15mgs of morphine and midazolam via subcutaneous infusion (syringe drive) as she was unwell suffering shortness of breath. This continued until 27 April 2020, when the dose appears to have bene doubled to 30mg of morphine and midazolam via subcutaneous infusion.

COVID DIAGNOSIS

38.9 Mrs Yates took a combined nose/throat PCR test on 14 April 2020 at 3.59pm. It was found to be positive for SARS-Cov-2. On 16 April 2020, Dr Boulton (Nepean Hospital) was unable to contact Mrs Yates to advise her of the result and as a result informed her daughter Leonie Bellingham. It was Ms Bellingham who informed Newmarch House of her mother's positive COVID-19 test result and asked that the message be relayed to Mrs Yates. This never occurred, and ultimately it was Shirley Yates' daughter Kay Yates who informed her of her COVID-19 test result.

ADVANCE CARE PLAN

38.10 Mrs Yates did not have a documented Advance Care Plan (ACP). She had an Appointment of Enduring Guardian dated 7 June 2018, which advised that if she reached a terminal phase of an illness, was permanently unconscious or in a persistent vegetative state, she did not wish to receive any medical treatment, other than palliative care, even if the treatment would prolong her life.

38.11 Following Mrs Yates' positive COVID-19 result on 14 April 2020, staff from Newmarch House requested that a discussion occur and an ACP be prepared with Mrs Yates' daughter, Kay Yates. No ACP was prepared.

38.12 On 26 April 2020, a Resuscitation Plan was prepared by Kay, which noted that CPR was to be withheld where such CPR is likely to result in negligible clinical benefit.

Discussions around ACP

38.13 Kay states that Mrs Yates did not have an ACP in place however she did have a Do Not Resuscitate Order in place as she did not want to be in a position where she was intubated. According to Kay, staff at Newmarch House had indicated they would send Kay and her family paperwork in relation to an ACP after Mrs Yates positive COVID-19 test results however this never occurred, despite repeated requests from Kay and her family asking Newmarch House to provide the relevant paperwork.

38.14 Following a fall on 19 April 2020, Shirley Yates suffered pain in her chest which did not abate.

38.15 On 22 April 2020 at 5.51pm, Nepean Hospital Virtual Aged Care Service (VACS) Dr Sharma and nurse practitioner (NP) Carpen recorded observations and 'anticipatory end of life' medications were ordered. At 6.43pm, NP Carpen recorded:

> Advance Care Planning Dr Kakkat VACS Doctor and Dr Sharma at Nepean Hospital have had discussions Shirley Yates daughters regarding advance care planning [Kay] wants her mother to remain in the nursing home if she deteriorates, Mrs Yates is not to be transferred to hospital [Kay] has

> however highlighted that her mother had a fall and this may be a sign of a UTI. Dr Kakkat has requested MSU and commencement of Keflex 500mg tds Same ordered

38.16 On 25 April 2020, Dr Sharma called Kay Yates in relation to Mrs Yates' condition. Kay told Dr Sharma that her mother needed transfer to Nepean Hospital for an X-ray in case she had sustained a fractured rib or had consolidation in her lungs following the fall. Dr Sharma made arrangements for Mrs Yates to be transferred to Nepean Hospital, and once transferred, Kay felt that the communication from nurses and doctors caring for her mother improved, and that she was continuously updated on her mother's condition and care plans.

38.17 On 27 April 2020 Kay was informed by staff at Nepean Hospital that Mrs Yates' condition had deteriorated further, and her mother was "*sedated and comfortable.*"

38.18 Kay was happy with the palliative care her mother received at Nepean Hospital.

PROGRESSION OF ILLNESS

16 April 2020

38.19 On 16 April 2020 at 10.15am, Mrs Yates was admitted to Hospital in the Home (HITH).

17 April 2020

38.20 On 17 April 2020, Mrs Yates' observations were recorded twice. First at 5.44pm, SpO2 94% (BP 113/64, P 60, Temp 37.5C, RR 17), and then at 7.45pm, SpO2 97% (Temp 37.5C, P 89, BP 134/79, RR 17).

38.21 At 5.44pm, RN Hailey Carpen appears to have reviewed Mrs Yates in person, as the observations she recorded at 5:44pm are not found in the Progress notes. RN Carpen ordered anticipatory end of life medications and notes that they were awaiting an ACP .

38.22 Counsel Assisting noted that Mrs Yates appears to have been one of the very few residents who had a face-to-face consultation by a VACS team member upon admission in HITH and prior to the ordering of end of life medications.

38.23 At 7.45pm, Clinical Educator Leslie Dominguez at Newmarch House noted that Mrs Yates had a dry cough, with no nasal congestion. Her daughter Leonie Bellingham was contacted to advise of Mrs Yates' condition and Mrs Bellingham requested that her sister Kay be called for medical issues relating to their mother. At 7.46pm, Newmarch House Care Manger Leann Hinted noted:

> I explained to Kay that Shirley is under the care of her GP and infection control at Nepean hospital and VACs and we are following Public Health recommendations. Shirley is isolated and we are monitoring her temperature daily, Currently she did have a little cough which has improved Shirley and Kay told me, I stated I will keep her informed and she has my mobile number so she can contact me at any time.

18 April 2020

38.24 On 18 April 2020, Mrs Yates' observations were recorded three times. First at 1.00am, SpO2 97% (BP 117/81, Temp 37.5C, P 78, RR 16), over ten hours later at 12.00pm SpO2 not recorded (BP 114/75, P 96), and then seven hours later at 7.00pm SpO2 97% (Temp 36.1C, BP 110/72, P 77, SpO2 97%).

38.25 At 1.00am, RN Cardwell noted that Mrs Yates was moving around in her wheelchair, was transferring positions independently and had contacted her daughter via the phone. No respiratory symptoms were noted. At 6.33am, Mrs Yates was not administered her medications. Clinical Educator Dominguez noted that Mrs Yates ate breakfast in her chair and was scrolling through her tablet looking at baby photos. Mrs Yates washed herself and changed her clothes on her own. She showed no signs of respiratory symptoms.

38.26 At 3.34pm, Nepean Hospital RN Sidney (attached to HITH) noted:

> Have been in contact with care manager Leanne Hinton in regards to updates on all positive covid19 residents. We required their observations, status and current condition but have so far been unable to obtain information. Was informed that the AN from each ward would contact us in regards to their current condition however no contact has been made at time of report have also had a call from public health to see if we had been able to contact nursing home as they are having the same sort of issues trying to obtain information. Will attempt to contact Newmarch House again tomorrow.

19 April 2020

38.27 On 19 April 2020, Mrs Yates' observations were recorded three times. First at 1.00am, SpO2 94% (BP 140/67, Temp 36.3C, P 67, RR 16), over ten hours later at 11.15am, SpO2 96% RA (BP 110/56, Temp 36.6C, RR 16), and over twelve hours later at 11.30pm, SpO2 98% (BP 146/79, P 73).

38.28 At 3.00am, RN Cardwell noted that Mrs Yates felt well and denied pain. No respiratory symptoms were present and Mrs Yates attended to her own activities of daily living (ADLs). At 5:43pm Clinical Educator Uditha Abeyaratne recorded that "S*hirley reported coughing up yellow sputum early this morning however she was not coughing when I was checking her. Shirley stated she is feeling well, well dressed and sitting in the wheelchair".* Mrs Bellingham was contacted and updated as to Mrs Yates' condition.

38.29 At 3.35pm, Nepean Hospital RN Malaihollo noted:

> Have attempted to call nursing home on three different numbers with no answer. one of the people called was the case manager Leanne Hinton who also didn't answer the phone so a message was left for her to contact outreach when possible. no return call ATOR. have also called the VACS on call to find out if there is anyway of getting information on the residents and she advised that if there was anything major with any of them she would advise us. If possible could we get a system in place whore the RN from each ward where the residents are located call outreach and just give a quick update on each patient when that RN has time to do so. or even one person from the nursing home give outreach a call with an update on each patient.

38.30 At approximately 11.30pm, Mrs Yates experienced a fall from her bed. She was able to stand with stand-by assistance. Mrs Yates reported pain in left side/breast and graze to her left knee. No evidence of haematoma or trauma to the head was observed. RN Cardwell contacted Mrs Bellingham and discussed transfer to hospital if Mrs Yates required it, as she had no ACP. Mrs Bellingham stated "*only if she needs it*", but at that time, was happy for her mother to remain at Newmarch House. RN Cardwell noted: *Given CVI9+ status I also advised that I may need to discuss t/f with specialist on call when I do this. Happy for this to happen*.

20 April 2020

38.31 On 20 April 2020, Mrs Yates' observations were recorded six times. At 12.05am, SpO2 92% (BP 125/77, P 80, RR 18, Temp 36.7C), at 1.20am, SpO2 95% (BP 120/76, P 89, RR 17, Temp 36.7C), at 2.00am, SpO2 94% (BP 119/72, P 86,Temp 36.0C), at 6.00am, SpO2 93% (BP 133/87, P 80, RR 17, Temp 36.5C), at 11:30am, SpO2 92% (BP 110/72, P 72, RR 15, Temp 36.6C), and at 10.00pm SpO2 90% (BP 135/88, P 78, RR 19, Temp 36.6C).

38.32 At 2.45pm, Mrs Yates' SpO2 was 86%. RN Cardwell re-checked her saturation and found it to be 94%. Deep breathing was encouraged. At 2.35pm, HITH RN Malaihallo noted that Mrs Yates' observations were obtained remotely by NP Carpen from the Newmarch House Progress notes and that her O2 Stas were 93%, the team was aware and Mrs Yates was asymptomatic." At 5.50pm, NP Carpen conducted a remote review of Mrs Yates and records stated '*Unable to contact facility today, No concerns highlighted in notes' and recorded the earlier observations*:

38.33 At 7.46pm, Manager Renata Zbziebko contacted Mrs Bellingham to update her on Mrs Yates' condition. No symptoms of COVID-19 were noted.

21 April 2020

38.34 On 21 April 2020, Mrs Yates vital signs were not recorded anywhere in either the Newmarch House progress notes or the Nepean Hospital clinical records.

38.35 At 4.00am, an unknown RN attended to Mrs Yates and noted: *Afebrile obs stable meds given as ordered Resident complaining of painful left breast and ribs from fall the previous night. Personal care attended.* At 4.27pm, VACS NP Carpen reviewed Mrs Yates and noted: "*Mrs Shirley Yates, 91-year-old lady with COVID19 under the care of HITH Review of line listing from facility Remains afebrile today, Remains asymptomatic Will review again tomorrow".* At 6.41pm, Manager Zdziebko noted:

> Spoke with LEONIE BELLINGHAM about mums progress. She is concern about mum not having enough clothes to wear and wants to bring clean washing for mum as she is on respite. Mum complaint over the phone to her that she is served cold drinks in a timely manner. I explained that we will commence fluid intake chart as of next shift to ensure she is receiving cold drinks she wants.

38.36 Counsel Assisting noted that no fluid chart was commenced, and 4 days later on 25 April the same notation is made regarding pushing oral fluids and maintaining a fluid balance chart, without follow up.

38.37 Mrs Yates was charted as receiving Paracetamol at 10.53am and 3.23pm. Her next dose of Paracetamol was charted at 12.53am on 22 April 2020. Contrarily, Kay stated that "we became aware that mum had not received Panadol the night before until after 10.30am the next morning". Where she received this information from is unclear.

22 April 2020

38.38 On 22 April 2020, Mrs Yates observations were recorded at four times. At 12.30am, SpO2 97% (BP 96/66, P 102, RR 18, Temp 36.9C), at 3.42am, SpO2 96% RA (BP 128/77, P 73, Temp 36.7C), at 6.00am, SpO2 94% RA (Temp 36.3C, P 76), and over 17 hours later at 11.18pm SpO2 97% RA (BP 121/75, P 65).

38.39 At 3.42am, nil coughing was noted. At 5.45am, Mrs Yates denied shortness of breath. At 10.38am, Newmarch House Manager Melinda Burns noted that she had provided lemonade to Mrs Yates and permission was granted to allow her family to bring her extra clothes. At 6:43pm the Clinical Nurse Consultant (CNC) from Nepean Hospital notes the conversation with Shirley's daughter Kay, NP Carpen, Dr Sharma and Dr Kakkat regarding her mother's ACP as outlined earlier in these submissions.

38.40 At 11.18pm, RN Cenizal noted: *Shirley awake and alert. Urine sample taken, negative pH 6 sG 1.02... Noted OAB is charted. Unable to start, resident asleep now...spoke to daughter...MSU still pending.* Her observations were taken (BP 121/75, P 65, SpO2 97% RA).

23 April 2020

38.41 On 23 April 2020, Mrs Yates' observations were recorded four times. First at 5.45am, SpO2 90% (Temp 36.9C), then at 7.55am, SpO2 88% (BP 112/60, P 75, Temp 36.4C), and almost eight hours later at 4.31pm, SpO2 88% RA (BP 112/60 Temp 36.4C, RR 20, HR 75), and at 5.55pm SpO2 91% (BP 94/64, P 75, RR 22, Temp 36.3C).

38.42 At 7.55am, Mrs Yates "*complained of pain in L breast - on regular paracetamol, will review post administration...Dry cough as per resident".*

38.43 At 1.09pm, Mrs Yates was reviewed by Dr Kakkat who noted: "*Dr Mohammed Faizal Kakkat, Shirley is not having appetite. She prefer hot foods and drinks. She have cough Chest clear Stable Plan continue meds Please give her hot foods and drinks, tea with milk no sugar Update the family".*

38.44 At 6.00pm, RN Cardwell left a message for Mrs Bellingham providing an update on Mrs Yates' condition. Mrs Yates denied pain but asked for laundry. RN Cardwell noted she had escalated this to management.

38.45 At 6.31pm, HITH RN Sidney noted the following: "*taken from nursing home notes with VACS in attendance symptoms: low appetite and cough BP 112/60 temp36.4 sats88% AA RR20 HR 75"*.

38.46 It was put to Dr Kakkat during oral questioning that Shirley Yates' daughter has no memory of Dr Kakkat asking Mrs Yates any questions or examining her mother during this consult, despite a

complaint of pain in the left breast as recorded by RN Cardwell. Dr Kakkat stated that he does not have a memory per se of Mrs Yates but "*if I see the patient then I have to examine the patient*".

38.47 Dr Kakkat gave evidence that pain in the left breast alone is not an indication to take a patient to hospital. If there is a loss of consciousness, a decreased level of consciousness, or any vomiting post a fall, then he would consider hospital admission is indicated. He stated further that he was not being discouraged from taking patients to hospital, but that the protocol was that contact should be made with VACS before sending a person to hospital. He stated that if it was clinically indicated then he would have the patient transferred to hospital.

38.48 It is noted Dr Kakkat's entry in the notes at 1:09pm is one of the very few entries made by Dr Kakkat and one of the very few face-to-face consultations he appears to have conducted on any of the 19 COVID-19 positive residents. A full set of vital signs were not recorded, and any history taken regarded Mrs Yates' pain was also not recorded. This is in contrast to the preceding record written by RN Cardwell.

38.49 Counsel Assisting submitted that there was a clear indication in this case for transfer to hospital during this review, as the history was that Mrs Yates had suffered a fall and had continuously made complaints of pain in her left breast, unresolved at the time of review. This indicated a possible fracture which could only be diagnosed by X-ray.

24 April 2020

38.50 On 24 April 2020, Mrs Yates' observations were recorded five times. At 6.00am, SpO2 95% (P76), at 9.21am, SpO2 82% (BP 112/62, P 79, RR 22, Temp 37C), over five hours later at 2.30pm, SpO2 66% RA 85% on 4LNP, then five hours later at 7.30pm, SpO2 94% (BP 123/69, P 83, RR 21), and then almost four hours later at 11.15pm, 92% (BP 135/78, P 90, RR 24).

38.51 At 9.47am, an unknown RN noted that Mrs Yates said that she felt worse today than yesterday, and that her daughter requested bloods be taken, ECG and Maxalon to be charted for nausea. At 2.30pm, Mrs Yates' observations were taken (SpO2 66% RA, 85% 4L NP, 6L HM applied – maintaining SpO2 94%). She denied shortness of breath or chest pain but complained of left sided breast pain. At 3pm PRN (as required) morphine was given with good effect.

38.52 At 2.41pm, VACS RN Carpen conducted a remote review of Mrs Yates' records rather than a face-to-face review. This is despite the fact that Mrs Yates' daughter had contacted VACS twice that day raising concerns about her mother. NP Carpen noted that Mrs Yates was feeling worse that day, and her breathing was labouring under decreasing oxygen saturations of 89%. RN Carpen response was not to escalate the matter to Dr Kakkat or Dr Sharma, but rather to advise the Newmarch House Care Manager to add oxygen at 2Lpm.

38.53 Following a conversation with her mother, Kay Yates felt that her mother's confusion was increasing. At 4.20pm, Mrs Yates was not administered with her medications. At 4.30pm, Mrs Yates was discharged officially from HITH.

25 April 2020

38.54 On 25 April 2020, Mrs Yates' observations were recorded four times. At 8.30am, SpO2 80% (BP 112/69, P 75, RR 21, Temp 37.1C), over six hours later at 2.59pm, SpO2 75% (BP 114/69, P 82, Temp 37.7C), then over eight hours later at 10.52pm SpO2 82% RA (P 22), and at 11.14pm SpO2 86% 2L NP (BP 119/72, HR 82). She was admitted that evening to Nepean Hospital at 11.30pm.

38.55 At 1.30am, Mrs Yates was assisted into bed from her wheelchair. She complained of not getting enough oxygen and was anxious as the oxygen mask had been removed. The mask was placed back on, and she settled into bed. Despite that concern, the next recorded entry is some 14 hours later, at 3.24pm, an unknown RN noted:

> Shirley was RIB ATOR watching TV. O2 in situ. Denies SOB although tachypnoeic RR24. Productive cough, thick purulent sputum in small amounts. States ongoing L) chest wall pain exacerbated by deep breaths and repositioning. Alert and orientated. States poor appetite however will try and eat dinner. Requesting the return of her laundry. Nil other complaints.
>
> Shirley reported that the L) chest wall pain was from a previous fall in her room. Denies any bruising or wounds to area. I spoke with her daughter Kay who has raised the following concerns for mother Shirley and has requested a medical review:- purulent sputum ?infective process hypoxia following fall and with chest wall pain preventing adequate inspiration.

38.56 At 5.25pm, an unknown RN noted:

> Discussion with the doctor and a video call involving Shirley there is a plan in place as she is desaturating reduced oral intake, and has chest wall pain. We will push oral fluids - maintain a fluid balance chart for this. Continue on Oxygen 2L and use morphine as the resident requires. She is fatigued and complains of having no taste. Updated the family.
>
> Additional conversation with the daughter - informed her of the plan from the Doctor. She Seemed happy and had no issues with the plan. GP advised that she would be sent to hospital. Ambulance called at 20.45. Shirley and family aware.

38.57 At 11.30pm, Mrs Yates arrived at Nepean Hospital. RN Maenzanise noted:

> ...care plan completed. Patient came as a direct admission from Nursing Home after having had a fall. ? FRACTURED Ribs...Pace call called due to low Sats 82%; Airway - Oesats had a Pace call, See medical notes with thanks. Breathing - Breath sounds - Nil adventitious sounds heard. Chest Rise - Equal rise and fall of chest. R/R and SPO2 - 22bpm and saturating @ 82% on RA.
>
> Circulation - Cap refill - Brisk, < 3 seconds. Warmth of extremities- Peripherally warm to touch. BP + HR - BTF as per iView documentation. GCS-15 Limb Strength/Mobility- Ambulating independently. Pain/Discomfort - Denies any chest pain or palpitations during shift, nil complaints of light-headedness Falls Risk Score: FRAMP assessment completed, aware to buzz for nursing assistance. Nurse buzzer within reach of patient at all times.
>
> Temp – Afebrile Wounds/ Skin integrity - Intact. Nil wound dressings. Nil pressure injuries noted or handed over.

38.58 The clinical records described above demonstrate a stark contrast in the detail of the examination and review of Mrs Yates by hospital clinicians compared to the very limited review and examination conducted by Dr Kakkat on 23 April 2020. It illustrates the difference in care between what was received at Newmarch House by the HITH/VACS model of care and their clinicians and hospital care upon admission.

26 April 2020

38.59 On 26 April 2020, now admitted to Nepean Hospital, Mrs Yates' vitals were recorded three times. First at 6.58am, SpO2 84% (BP 115/66, HR 81, Temp 36.5C, RR 24), the at 8.02am, SpO2 82% (RR 40, P8 2), and then over four hours later at 12.32pm, SpO2 87% HFNP (Temp 37C, RR 40, FiO2 50%). A decision was made by treating physicians to treat Mrs Yates for comfort care only, in the setting of palliation and insertion of a syringe drive.

38.60 At 12.26am, Mrs Yates' chest x-ray results were noted:

> There is lung opacification in the mid to lower zones suggesting developing pneumonitis. There is also note made of the upper lobe vascular diversion suggesting a component of underlying cardiac decompensation. There is elevation of the right dome of the diaphragm. Progress evaluation recommended.

38.61 At 2.33am, Dr Hassanwnd-Gandaei noted: "*CXR reviewed: extensive bilateral Patchy opacification noted-?CAP Plan: IDfill_; Xray results DW Med Reg- not for Abx at this stage slow IV fluid charted urle MCS*".

38.62 At 8.02am, RN Aller noted:

> Clinical review initiated (patient not for MET as per ACD). AH JMO called soon after and inquired reason for Clinical review…Requested for patient to breath through her nose rather through mouth for Hi flow machine to take better effect. Unable to do for long periods. Attempted to pass urine on pan with nil success. Underwear replaced with incontinent pad.

38.63 At 8.27am, Dr Rifaath Anver noted:

> *Shirley transferred from Newmarch house 10 days after testing positive for COVID, with history of recent fall and possible clinical rib fractures*
>
> *Underwent investigation with bloods and CXR (mobile CXR performed on the ward due to COVID positivity) - CXR reviewed by night radiologist - within limitations of the erect CXR no obvious fractures noted - Widespread pulmonary infiltrates bilaterally, air bronchograms on CXR - Clinically there were widespread fine inspiralory crackles on examination. Clinically dry - Bloods showed normal wee with significantly elevated crp 257, lymphopenia 0.4 - Clinical picture appeared consistent with COVID pneumonia - Overnight Shirley appeared comfortable from a pain perspective, and did not use any PAN endone charted - Main issue since admission was significant hypoxia, desaturating to 70% on RA - Commenced on NAB 15L achieving sat 86% - Changed to HiFlow Flow 45% with 1 SL 02 achieving sats of up to 93% - Initially only mildly tachypnoeic to 22 breaths per minute, speaking in full sentences and not distressed - Shirley remained stable overnight, Saturating 91-93% on HiFlow until -6.43am when*

she was noted to desaturate to 84% on 15L via HiFlow inspite of checking sats probe and repositioning her - At Sam became increasingly tachypnoeic to 40 bpm with increased work of breathing

Discussed with Dr. Archana Sud.
Dr. Sud noted that Dr. Anita Sharma had been in contact with Shirley's daughter Kay, who is a retired nurse - Confirmed that goals of care have been discussed with Kay - Given deterioration goals of care would now be directed towards comfort care. Can cease obs but continue to provide maximal oxygen support - Dr. Sud advised to chart crisis meds and request pal care consult. Dr. Sud will be reviewing patient this morning - Discussed with Dr. Noel (Pal Care Consultant on call) Given patient history of being on tramadol (not opioid naive) suggested commencing on CSCI morphine 15mg/midazolam 15mg Q24hrs PRN midazolam 2.5mg Qlhrly SC for breathlessness, glycopyrollate 200mcg SC prn for secretions D/w Dr. Sud re Nepean's policy on visitors for patients on comfort care Dr. Sud will discuss with Dr. Noel re plan for visitation in pal care the context of COVID positivity and advise re same Please note that Kay is in Dubbo and will need about an hr to get to Nepean Leonie is listed as NOK on powerchart and lives In Nepean Contacted Leonie to update of events overnight Phone call from Kay... and updated her of current status

38.64 At 12.32pm, Mrs Yates experienced shortness of breath, especially on exertion, and produced a cough with brown specks. She denied being in pain but was fatigued. RN Khelawan noted:

> Pt is not for obs- for comfort measures. To continue on HFNP for comfort. Ors have been in contact with family re: pts condition. Subcut b'fly inserted to l) upper arm for prn's. Surefuser commenced with midazolam and morphine via subcut b'fly R) upper arm. Pt is currently settled, not requiring prn's. Pt has received multiple phone calls from family

38.65 At 7.36pm, RN Viernes noted that observations had ceased for comfort measures. Mrs Yates continued HFNP FiO2 50%, total O2 flow rate 45L and oxygen flow at 15L. Mrs Yates coughed at times with brown phlegm and was drowsy. Mrs Yates denied being in pain, she had no appetite and had minimal fluid intake. 2.5mg Midazolam was administered.

27 April 2020

38.66 On 27 April 2020, Mrs Yates observations were recorded twice in the palliative care setting. First at 9:00am, SpO2 78% HFNP (Temp 37.5C, RR 28, BP 115/74, FiO2 51%) and then again at 12:37pm, SpO2 79% HFNP (RR 28, Temp 37.5C).

38.67 At 7:00am, Mrs Yates appeared agitated, groaning and was non-verbal. She was administered Midazolam. RN Bayliss noted: "*HFNP* [high flow nasal prongs] *insitu 51% fio2 Initially no observations, team requesting observation during rounds, Sats 79% on HFNP, RR 28, Temp 37.5, other observations stable".*

38.68 At 12:37pm, RN Bayliss noted:

> As per Pall care r/v... connected to S/C butterfly in R upper arm, 2nd sic butterfly insitu for prn meds in L upper arm on attending patient again noted agitation, groaning. pm midazolam given Nursing staff calling family from bedside on pts mobile, each member given opportunity to speak with pt...D/W Team regarding now family has spoken to patient regarding? removing HFNP- they will discuss and let us know. IVF ceased, IVG remains insitu.

38.69 At 3.02pm, RN Bayliss noted that bedside phone calls to family were made. Kay Yates was advised of the plan to remove HFNP and to be put on Nasal Prongs for comfort. RN Bayliss administered Morphine to Mrs Yates and sat with her for an hour.

38.70 At 6.55pm, Mrs Yates was drowsy and non-rousable. She was on oxygen via Nasal Prongs 2L on flow and her family was updated. At 8.27pm, Nepean Hospital staff found Mrs Yates not breathing and non-responsive to stimuli. At 8.29pm, Dr Li declared Mrs Yates as deceased. The family were notified shortly thereafter.

MANNER AND CAUSE OF DEATH

38.71 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle all agreed that Mrs Yates' cause of death was COVID-19 pneumonia.

38.72 **Manner of Death**: Mrs Yates had a progressive decline from the date of diagnosis with COVID-19 to the date of her death. Associate Professor Kotsimbos, Professor French and Professor Kurrle agreed that despite Mrs Yates' death at Nepean Hospital she was one of the "*counter-factual*" cases amongst the various residents who died at Newmarch House. This is because she was transferred to Nepean Hospital on 25 April 2020 following her fall on 19 April 2020, and suspected rib fracture, which was thought to be contributing to her worsening hypoxia and ventilation problems. At Nepean Hospital, Mrs Yates underwent a chest X-ray on 25 April 2020, which showed clear evidence of pneumonia. All experts agreed that during her time at Nepean Hospital she received appropriate care and treatment including oxygen, fluids, antibiotics, secondary antibiotics (either for her chest infection or her urinary tract infection).

38.73 **Impact of any significant co-morbidities**: Nil significant.

38.74 **Issues with care received**: The experts agreed that whilst Mrs Yates was admitted to Nepean Hospital, she received a very good level of care and was appropriately palliated when it was clear that nothing further could be done. In those circumstances, they believed she died a very comfortable death in a hospital setting.

38.75 **Whether different action may have affected the outcome**: No

38.76 Although the experts opined that no different action would have affected Mrs Yates deterioration from COVID-19, Counsel Assisting submitted that Mrs Yates' care and comfort after her fall on 19 April 2020, and prior to her admission to Nepean Hospital 6 days later on the evening of 25 April 2020, would have been improved had she been transferred after her fall.

38.77 The contrast in the detail between the examinations and review of Mrs Yates at Nepean Hospital compared to the reviews and examinations she received at Newmarch House under the care of Dr Kakkat/Dr Sharma and the VACS/HITH team, is stark. This case is a telling example of the difference in care between what was received at Newmarch House by the HITH/VACS model of care and their clinicians and the level of care and consideration in management and treatment received following hospital admission. It also demonstrates that it was not correct to assert to residents and their

families that the level of care being delivered at Newmarch House under the HITH/VACS clinicians was equivalent to care received at Nepean Hospital.

38.78 It was only upon Kay Yates' request that her mother be transferred to Nepean Hospital with a suspected fracture that action was taken. It is also of note that the transfer appears to have occurred in the context of a GP's approval and without VACS' knowledge or involvement when that decision was made by the Newmarch House agency nurses. This should be contrasted with the involvement of Dr Kakkat and VACS with an ambulance being cancelled in the case of Blanche Billinghurst.

38.79 Counsel Assisting submitted that Dr Kakkat's opinion that a fall does not warrant a transfer to hospital, following what appears to be a very rudimentary review of Mrs Yates on 23 April 2020, is concerning. Mrs Yates consistently reported pain on her left side for over five days. It is a clear example of when the words in an ACP "*transfer to hospital if medically indicated*" should prompt transfer, at a minimum for radiological investigation.

38.80 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Shirley Yates

Date of death

Mrs Yates died on 27 April 2020.

Place of death

Mrs Yates died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Yates' death was COVID-19 pneumonia.

Manner of death

Mrs Yates died of natural causes following diagnosis of COVID-19 infection. Following Mrs Yates' fall on 19 April 2020 and reports of pain in her left breast over the days following, it appears that transfer to hospital for further investigations was medically indicated at least by the time of a review on 23 April 2020. Transfer did not occur until 25 April 2020 and management of Mrs Yates' care and comfort is likely to have been improved if hospital transfer had occurred earlier. However, the timing of transfer did not contribute to death, and no other steps in Mrs Yates' management could have been instituted which would have materially altered the eventual outcome.

39. CA

HEALTH

Co-morbidities

39.1 CA was 90 years of age when she passed away on 28 April 2020 at Newmarch House during the COVID-19 outbreak. She had a number of existing comorbidities including dementia (mixed Alzheimer's/vascular), bowel cancer, hyperthyroidism, depression and osteoarthritis. CA also had a history of non-melanomatous skin cancers on both of her lower legs, arms and face. CA also had incontinence of urine.

Background and events leading up to COVID-19 diagnosis

39.2 CA had previously lived with her daughters, but after a severe infection and hospital admission, her mobility and dementia (diagnosed in or about 2015) deteriorated and she was transferred and admitted to Newmarch House on 24 October 2019. CA was not independently mobile and was moved around Newmarch House in a chair.

RELEVANT MEDICATIONS

39.3 CA was prescribed a number of regular medications including Neo-Mercazole 5mg (carbimazole), Osteomol 665mg (paracetamol), vitamin B12 (BM) 110mcg, vitamin D3 25mcg and Molaxole power for oral liquid 3350 12.125g and sodium chloride 350.7mg.

39.4 CA was prescribed various medications on an as needed basis including Candacort cream (hydrocortisone 1% and clotrimazole 1% cream), dilaudid 2mg/mL injection (hydromorphone hydrochloride 2mg/mL injection, amp), sodium bicarbonate mouthwash 1% and Systane 0.4%/0.3% eye drops.

PRN Medication - Midazolam and morphine

39.5 On 17 April 2020, Dr Kakkat prescribed CA Midazolam (accord) 5mg/mL injection, Morphine sulphate (DBL) 10mg/mL injections. Dr Kakkat also prescribed Maxalon 10mg/2mL injection, Rixadone 500mcg (risperidone), Robinul 200mcg/mL injection (glycopyrronium bromide glycopyrrolate 200mcg/mL) and Serenace 5mg/mL injection (haloperidol 5mg/mL injection ampoule).

39.6 CA was administered morphine on 24 April at 16:32, 26 April at 00.25, 20:18 (unsettled), 27 April at 4:46 for pain and dyspnoea and at 17:22 for tachypnoea; and on 28 April at 2:28 for restlessness. CA was administered morphine and midazolam with good effect at 5:03am but this is not recorded in the medication charts. She was found deceased at 8.59am.

COVID DIAGNOSIS

39.7 CA took a PCR COVID-19 test on 10 April 2020. The test returned a positive result on 13 April 2020. She was the first resident to test positive to COVID-19.

ADVANCE CARE PLAN

39.8 CA's daughter and her regular GP, Dr Catherine Bailey, completed an Advance Care Plan (ACP) on 14 February 2020. On the ACP, it stated that CA did not want CPR, or to be kept alive by being artificially fed; she did not want to receive oral antibiotics except to promote comfort; she did not want to be transferred to hospital except to maintain comfort. Additionally, CA had a Not for Resuscitation order signed by her daughter on 11 September 2019.

Discussions around ACP

39.9 On 12 April 2020, CA's GP Dr Farah Al-Mulla was informed of CA's deteriorating condition, and she advised that CA should go to a hospital. CA's daughters were advised the same, but they stated that they did not really want CA to go to a hospital given her comorbidities and quality of life. CA's daughters attended Newmarch House to see their mother that day, and after observing her in bed, they decided that they wanted to keep their mother at Newmarch House. This decision was also informed by information that CA's daughters had received from a nurse, Tegan, at Newmarch House who had contacted Nepean Hospital and was told (presumably by a doctor) that if CA was transferred to hospital, it was likely she would not survive.

39.10 The decision to keep CA at Newmarch House was confirmed by Dr Branley who attended upon CA on 13 April 2020. Dr Branley did not call CA's daughter to advise that, in his opinion, it was the right decision. This information was conveyed to CA's daughter from the Newmarch House Care Manager, Melinda Burns. CA's daughter had no contact from any doctors caring for her mother regarding her condition or treatment, until she deteriorated towards the end of her second week of her COVID-19 infection and was not expected to survive. It was not until 23 April 2020 that CA's daughter was contacted by Dr Branley who informed her that her mother would "*probably not last the day*".

39.11 It is unclear on what basis Dr Branley based this opinion, as there are no clinical notes recording a clinical review of CA by him at any point in time. CA in fact did not pass away that day but died five days later. The phone call from Dr Branley left CA's daughters emotionally distraught and when Dr Branley asked if there was anything that they wanted to ask, she and her sister could not think of any questions for him in that moment. RN Cardwell arranged for CA to speak with her daughter.

PROGRESSION OF ILLNESS

10 April 2020

39.12 At 12.00pm, while dressing a wound on CA's foot, Care Coordinator Melaine Tabuno Taliao observed that CA was coughing on and off and that she sounded "*croaky*". CA stated that she had a sore throat. Permission was given by her daughter to perform a COVID-19 test and isolation precautions were set up. Normal paracetamol was administered. Staff reported that CA was unable to swallow her tablets and had a runny nose. At 5.30pm, CA was attended to. Her temperature was 37.2C and SpO2 was 97% on room air. No coughing or respiratory distress was observed at this time.

11 April 2020

39.13 At 6.28am, an unknown RN noted that CA had no signs of difficulty breathing or coughing. CA was afebrile through the night and had no complaints of headaches or sore throat. Oxygen varied from 90% to 91%. CA was checked at 1.30pm and was alert and responding to staff. Observations were recorded (BP 158/64, HR 74, RR 19, Temp 37.8C, O2 sat 93% on RA). It was noted that CA sounded "*croaky*". Fluids were given. Dr Al-Mulla, CA'S GP, was called and informed of her observations. Dr Al-Mulla decided to prescribe CA antibiotics. At 4.00pm CA was febrile with a temperature of 38.6C. CA was unable to swallow her dose of Paracetamol so 10mls of NI Panamax was administered at 4.30pm. No headache or body aches were voiced but CA was still experiencing a dry cough and sore throat.

12 April 2020

39.14 At 1.00am, CA was seen sleeping and comfortable. Progress notes indicate "*Nil coughing, nil SOB noted. Temperature 37.2. PAC attended*". At 1.30pm, CA was noted to have a sore throat, temperature of 38C, noisy breathing and O2 sat 91% on RA. She was very lethargic but responding to voices. Her care was attended to by care staff and a RN. Crackles were noted on both lungs and CA was unable to tolerate food, and could only tolerate small amounts of fluid. Crushed Panadol was attempted to be administered, but CA was spitting it out and refusing Panadol elixir. Dr Al-Mulla was informed of CA's deteriorating condition, and she advised that CA should go to a hospital. The daughters were advised but stated that they did not really want CA to go to a hospital given her comorbidities and quality of life. CA was noted to have had a small amount of vomit on her dressing gown in the morning. CA was attended to again at 5.00pm. At that time, progress notes state:

> Drowsy. Opens eyes to voice. Minimally communicative, denied pain when asked. CPOT pain score 0. No increased WOB breathing, some drooling. Sp02 88%. RR22. Audible gurgling. Spontaneous coughing. Following PAC large cough and yellow/green/clear sputum cleared. Pulse 89 and peripherally warm and well perfused. T37.4. Pad dry and BNO. Nursed side-to-side. Cream applied. Lips and mouth moist. PO medications withheld as [CA] not appropriate for these ATOR.

39.15 CA was visited by her daughters that afternoon so that they could determine whether to send her to hospital. CA's daughters agreed to keep their mother at Newmarch House and she was to be kept comfortable. RN Dean noted the following:

> Called LMO and received phone order for crisis medications to keep [CA] comfortable in case she deteriorates overnight... [CA] looks very comfortable and has verbally denied being in pain and does not appear to be in any pain.

39.16 CA did not take evening medications as she had difficulty swallowing. She was febrile in the evening with a temperature of 38.6C. An unknown RN administered IN Paracetamol suppository. CA's observations were recorded at 8.30pm (BP 126/61, P 71, sats 89% - 90% on RA, RR 20). Tympanic temperature 38.2C. No Panadol was given, and CA verbally denied pain. Heavy blankets were removed, and her bed was placed at the lowest height for safety with a crash mat in situ. CA was checked at 11.00pm and was noted to be asleep and looked comfortable. An unnamed RN noted "*'tympanic temp 38.3 TSB for 15 minutes. Went down 38.1. Saturating 97% on RA. RR 21. BP 100/58 Pulse 108. Refusing to take any fluids. PAC attended".*

13 April 2020

39.17 On 13 April 2020, CA's observations were recorded seven times. At 1.00am, SpO2 87-88% (Temp 37.7C), at 5.00am, SpO2 89-90% RA, at 7.45am SpO2 97% (BP 159/84, P 81, RR 17, Temp 37C), at 11.00am, SpO2 95% (BP 140/73, P 85, RR 18, Temp 36.5C), at 1.00pm, SpO2 93% (refused BP, P 71, RR 18, Temp 38.4C), at 2.30pm SpO2 83% RA (BP 137/85, HR 90, RR 19, Temp 37.9C), and at 8.00pm SpO2 97% RA (RR 22, Temp 37.5C).

39.18 At 1.00am nil cyanosis was noted. NIM Panadol was given PR and CA refused fluids. TSB was given for 10 minutes. PAC was attended. It was noted that CA looked comfortable. CA was rechecked at 3.00am and was asleep. At 5.00am, nil cyanosis was noted. It was recorded that CA had opened her bowels and was awake and responsive and denied pain. CA was refusing any fluid when offered. PAC was attended and she was noted to be safe and comfortable. At 7.30am, a progress note indicated that CA stated she was cold and staff gave her an additional blanket. Her peripheries were warm to the touch and she was washed. She was able to speak to staff and answered simple questions. She ate porridge but coughed on thin fluids. Her breathing was noted to be regular but she had some wheezes on auscultation. Her antibiotics were crushed and administered with porridge, but other medications were withheld. She was not showing signs of pain.

39.19 At 11.00am CA was noted to be afebrile. She was noted to have an intermittent non-productive dry cough. She tolerated a jar of moderately thickened apple juice. She stated that she was not hungry and was not showing signs of pain. RN Sidney from Nepean Hospital in the Home (HITH) rang Newmarch House to report the COVID positive result and it was noted that CA was being managed by the nursing home. At 2.30pm CA was repositioned and was noted to be febrile with a temperature of 37.9C. She could take small sips of thickened apple juice. At 8.00pm nil pain or discomfort was noted. At 10.00pm CA was noted to have a 37.8C tympanic temperature.

39.20 The details in the progress notes and frequency of observations and attendances that occurred between 10 April and 13 April, namely the days prior to the full testing of all staff and residents on 14 April, are noted. These records appear indicative of the good level of care and attention given prior to the outbreak and are supportive of the reasons why Newmarch House held a good reputation prior to the Outbreak and the furloughing of almost all their usual care staff.

14 April 2020

39.21 On 14 April 2020, CA observations were recorded twice. Once at 6.30am, SpO2 97% RA (RR 18, HR 90 Temp 37.7C), and then again at 11.10am SpO2 90% RA.

39.22 At 6.30am CA was assessed by Uditha Abeyaratne, Clinical Educator. CA was noted to be awake and responding well. She had been given a Panadol suppository at 5.00am by the night RN. She had a few sips of thickened apple juice. CA's blood pressure was not checked as she was keeping her arms very contracted. Ms Aberyaratne noted that CA looked much brighter at 11.00am. She was verbalising well with staff, peripheries were warm and she had nil cyanosis. She still had a dry unproductive cough, but it had improved. She was drinking well and eating small amounts. At 3.45pm, CA was noted to be febrile with a temperature of 37.7C but was awake, alert and responding

well. She was taking antibiotics crushed with a small amount of jam. At 8:00pm, CA refused food but showed no signs of pain or distress. Her tympanic temperature was recorded as 37.1C.

15 April 2020

39.23 On 15 April 2020, CA's observations were recorded three times. At 4.00am, SpO2 91-92% RA (Temp 37.2C), at 7.30am, SpO2 92% (BP 154/85, P 100, RR 17, Temp 37.5C), and again at 11.30am SpO2 93% (BP 101/62, P 78, RR 18, Temp 36.0C).

39.24 At 8.00am, a progress note recorded that CA looked brighter that morning and was chatting and smiling with staff with nil coughing. She was cleaned and ate most of her breakfast. She was able to swallow her regular medications which were small but not Panadol. NI paracetamol 1g was administered. At 11.30am, CA was afebrile with a temperature of 36C and had nil shortness of breath. She was alert and responding to verbal stimulation and had a thickened orange juice. RN Lorena Bestrin contacted Dr Branley to give an update on CA's condition. Dr Branley recommended that CA be encouraged to lie on her back for 15 minutes during the day to aid oxygen saturations. Dr Branley requested a signed ACP. RN Husar from Nepean Hospital made attempts to call Newmarch House to speak with a registered nurse and when this was unsuccessful indicated she would call back daily to check on CA's vital signs.

16 April 2020

39.25 On 16 April 2020, CA's observations were recorded once at 4.05am, SpO2 92% RA (BP 135/90, Temp 36.2C).

39.26 At 4:05am, RN Cenizal noted that CA appeared much more alert today and was talking more than usual. She denied pain and refused fluids. At 6.10pm, Leslie Pearl Dominguez, Clinical Educator, noted that CA was alert, verbally responsive but confused. She asked where she was at multiple times during the day. CA was not coughing and was not in pain when repositioned, nor did she have a runny nose or congestion.

17 April 2020

39.27 On 17 April 2020, CA's observations were recorded three times. At 4.00am, SpO2 91% (BP not taken as patient flexing arm, P 76, RR 16, Temp 36C), over twelve hours later at 5.06pm, SpO2 91% (P 76, Temp 36C, RR 16), and again at 5.28pm SpO2 97% (Temp 36.5C). At 4.00am, RN Cardwell attended to pressure area care and noted that CA was confused but interacting.

39.28 At 5.28pm, a progress note recorded that CA was attended to by staff earlier in the day. She refused to have breakfast but did eat a yoghurt when offered by an RN. CA was noted to be alert and talkative but remained confused. She was complaining of feeling cold and then said she was alright. No pressure injuries were observed.

18 April 2020

39.29 On 18 April 2020, CA's observations were recorded three times. At 6.00am, SpO2 95% (P 55, RR 17, Temp 36.3C), seven hours later at 1.00pm, SpO2 95% (P 104, RR 20, Temp 36.5C), and again at 4.00pm, SpO2 95% RA (refused BP, P 104, RR 20, Temp 36.5C).

39.30 At 6.00am, RN Cardwell noted that CA had no respiratory symptoms. CA was generally settled but refused for her blood pressure to be checked. At 4.00pm a progress note by RN Bhusal recorded that CA had been checked during her shift and was observed to be resting comfortably in bed with no respiratory symptoms. She was generally settled but continued to refuse to have her blood pressure checked.

19 April 2020

39.31 On 19 April 2020, CA's observations were recorded three times. First at 1.30am, SpO2 90% with PAC (BP 129/80, P 101, RR 22, Temp 36.1C), then six hours later at 7.30am, SpO2 96% RA (BP 153/73, P 90, RR 17, Temp 36.3C), over 14 hours later at 10.00pm, SpO2 93% (BP 110/60, P 78, RR 18, Temp 36.4C).

39.32 At 1.30am, RN Cardwell noted that CA was resting in bed and denied pain and had no respiratory symptoms. A progress note at 3.55pm noted that CA was tolerating small amounts of food and fluids, that she was alert and verbalising well with staff.

20 April 2020

39.33 On 20 April 2020, CA's observations were recorded five times. At 6.00am, SpO2 91% (BP 143/75, P 110, RR 18, Temp 36.9C), at 8.00am, SpO2 88% (BP 139/70, P 78, RR 20, Temp 36.5C), at 2.33pm SpO2 not recorded (RR 18, P 110, BP 143/75, Temp 36.9C), at 8.50pm, SpO2 94% (BP 145/85, RR 16, Temp 37.3C), and at 10.00pm, SpO2 91% (BP 153/76, P 120, RR 18, Temp 36.4C).

39.34 At 5.30am, CA was attended to by care staff, she was given fluids and repositioned and looked comfortable. CA ate one Weet-Bix with hot milk and consumed small amounts of fluid. She refused lunch but had a drink. At 4.49pm Nepean Hospital Virtual Aged Care Service (VACS) Nurse Practitioner (NP) Carpen conducted a remote review of the notes recording no new concerns. She noted that CA may benefit from increased fluid intake but Counsel Assisting noted that this recommendation does not appear to have been executed by any of the subsequent nursing or care staff.

39.35 A progress note written by Newmarch House Manager Christine Giles at 8:50pm noted that CA had deteriorated with very minimal intake and was unable to eat or drink. Her family was contacted and CA's daughter agreed to anticipatory medications if required, wanted her mother to be kept comfortable and asked if she could be given rosary beads.

21 April 2020

39.36 On 21 April 2020, CA's observations were recorded once at 8.20pm, SpO2 88%.

39.37 At 11.40am, Dr Kakkat noted that "[*CA] had cough. Dry cough. No wheeze or creps. CVS normal. Chills Plan Rulide 150mg bd*." Counsel Assisting noted that this is one of the few recorded entries made by Dr Kakkat of a face-to-face consultation. We note there is no evidence to support a finding that Dr Kakkat directed subcutaneous fluids, despite team member RN Carpen's entry the previous day for increased fluid intake which was an ongoing concern.

39.38 At 8.20pm, Manager Christine Giles noted that she had contacted CA's daughter to notify her they had commenced oxygen 2 litres via a concentrator. Saturation was 88%. The family were noted to be worried that they were getting conflicting information as they thought CA had improved today.

22 April 2020

39.39 On 22 April 2020, CA's observations were recorded twice. First at 1.18am, SpO2 92% RA (BP 99/73, Temp 37.2C), and then over seven hours later at 8.30am SpO2 93%4L (BP 150/73, P 88, RR 20, Temp 36.4C).

39.40 At 1.18am, RN Cenizal noted that CA was awake and alert at the start of her shift. She tried to give fluids, but CA was spitting it out. CA was started on oxygen 2L via nasal prongs.

39.41 At 10.03am, Dr Kakkat recorded that CA was deteriorating and not taking much orally. She appeared confused and talking to herself most of the time. He noted "*chest few creps. Plan Crisis medication charted. Palliative approach*". The note states that CA was seen by Dr Kakkat however he gives no written direction as to what he intends by "*palliative approach*." There is no direction to cease observations and adopt a comfort care plan.

39.42 It is also of note the very limited information written about CA's presentation when reviewed by Dr Kakkat, and what precisely the clinical basis was for prescribing crisis medication, other than a 'palliative approach'. There is no report of pain or agitation at all, which are the general indicators for prescribing morphine and midazolam. Morphine was administered two days later but there is an absence of explanation as to why, noting that the corresponding note states no signs of distress.

39.43 At 3.30pm, Newmarch House Manager Melinda Burns arranged for a priest to ring CA and her last rites were delivered over the phone. Her family were aware and happy.

23 April 2020

39.44 On 23 April 2020, CA's observations were recorded four times. At 2.00am SpO2 95% on 4L (BP 128/93, P 88, Temp 37.6C), at 4.00am SpO2 93% on 3L (BP not taken distresses resident, P 123, RR 20, Temp 37.9C), at 9.50am SpO2 98% on 3L (BP 147/83, P 95, RR 21, Temp 37C), and at 4.15pm, SpO2 93% on 3L (P 123, RR 20, Temp 37.9C).

39.45 At 2.00am, RN Cenizal noted that CA tolerated fluids that day and took about 150mls of thickened juice, and noted that she was responsive during a phone call with her daughter. CA was given Panadol and at 2.20am her temperature had decreased from 37.6C to was 36.6C. At 10.00am, CA was observed resting in bed but was not communicating verbally. An oxygen concentrator was in use, and she looked comfortable. At 4.15pm, RN Cardwell noted that CA's temperature was 37.9C and

blankets were removed, and the window was opened. She further noted "*Will review temperature for – paracetamol as can only have supp and do not want to cause additional distress. Air mattress in situ. Low low bed. Minimal incoherent verbalisations. As per R/V by HITH and Infectious Disease transition to comfort measures. Family updated by ID consultant. [CA] looks comfortable*."

24 April 2020

39.46 On 24 April 2020, CA's observations were recorded twice. First at 6.00am, SpO2 90% on 3L (BP 145/83, P 126, Temp 36C), and over ten hours later at 4.43pm, SpO2 96% on 3L (BP not taken distresses resident, P 123, RR 22, Temp 37.2C).

39.47 At 4.42pm, CA was administered Morphine. At 4.48pm, an unnamed RN noted that CA was on the decline and was no longer responsive but was showing no signs of distress on O2 via nasal prongs 3L.

25 April 2020

39.48 On 25 April 2020, CA's observations were recorded twice. First at 1.20am, SpO2 83% (BP 115/71, P 66, RR 20, Temp 36.7C), and again at 3.52am SpO2 98% on 10L Hudson mask.

39.49 At 2.17am, CA's oxygen was changed from 2-3L via nasal prongs to 5-6L via a Hudson mask oxygen concentrator. At 3.52am, it was noted that her oxygen saturations were down on a 6L via Hudson Mask, and it was increased to 10L. CA's oxygen saturations increased to 98% and a note was made that a registered nurse was to call the VACS team to inform them of CA's deterioration.

26 April 2020

39.50 On 26 April 2020, CA's observations were recorded five times. The frequency of this appears at odds with Dr Kakkat's direction that she was for palliative care. At 5.00am, SpO2 93% (Temp 36.6C, P 66, R 24, BP 124/80), at 8.10am, SpO2 92% (Temp 36.6C, P 109, R 19, BP 138/84), almost 12 hours later at 7.45pm SpO2 94% (Temp 36.7C, P 120, RR 28), at 9.30 pm, SpO2 94% (Temp 36.4C, P 127, R 21, BP 128/86), and at 11.00pm SpO2 90% (Temp 36C, P 108, R 22, BP 145/83).

39.51 At 1.04pm, Manager Melinda Burns noted that as of 25 April 2020 until further notice staff were to document on paper-based notes. At 3.46pm, progress notes record "*[CA] RIB throughout day, non-verbal, opens eyes to speech. Regular PAC and mouthcare attended*." It was noted that CA was in distress at 12.00pm and was given morphine 0.25mls with good effect. At 7:45pm, progress notes recorded that CA was sitting in bed and feeling hot. She was given Dilaudid and midazolam with settling effect. It was noted by the RN that CA had rosary beads in her hands and was praying. At 8.15pm CA was administered 5mg midazolam, as she was "*unsettled*".

27 April 2020

39.52 On 27 April 2020, CA's observations were recorded five times. Again, the frequency of this appears at odds with Dr Kakkat's direction that she was for palliative care. At 1.30am, SpO2 not taken (P 120, RR 24), at 6.00am, SpO2 89% (Temp 36.6C, P 129, RR 22), at 3.30am, SpO2 88% (refused BP, Temp

36.6C, P 142, R 17), at 4.00pm, SpO2 90% (Temp 36.5C, P 143, R 24, BP 89/63), and at midnight, SpO2 90% (Temp 37C, P 148, RR 23).

39.53 At 4.46am CA was administered 5mg midazolam for "*pain and dyspnoea*." At an unknown time, a progress note recorded that CA's condition was poor, she was drowsy and had increased work of breathing. Analgesia was given with good effect. At 12.05pm, CA was reviewed by RN Cardwell in her room who noted that she was resting in bed and had no verbal or non-verbal signs of pain. CA was not alert enough to have blood pressure taken or mouthcare attended to. Personal care was attended to but medications were withheld. At 5.22pm CA was given 2.5mg Midazolam for tachypnoea. At 5.30pm, RN Cardwell noticed that CA had shallow breathing with associated tachypnoea and 2.5mg of Morphine was given with good effect. It was noted that no pain was evident.

28 April 2020

39.54 On 28 April 2020, CA's observations were recorded once at 5.45am, SpO2 88% (Temp 35.2C, P 148, R 34). No blood pressure measurements were taken at this time.

39.55 At 2.28am, CA was administered morphine for restlessness although this is not recorded in the handwritten progress notes. CA was administered morphine and midazolam "*with good effect*" at 5:03am but this is not recorded in the medication charts. CA was reviewed by RN Huegill at 8.59am who noted that she had passed away. Mr Millard rang CA's daughter to convey his condolences.

MANNER AND CAUSE OF DEATH

39.56 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree that CA's cause of death was COVID-19. Associate Professor Kotsimbos and Professor Kurrle considered that her underlying dementia contributed to her death. Professor Kurrle also considered that CA's status as chair-fast and her frailty were contributing factors.

39.57 **Manner of Death**: CA had COVID symptoms for 18 days prior to her death. CA's family apparently had some concerns with her end-of-life care but in general the experts found her care had been appropriate.

39.58 **Impact of any significant co-morbidities**: Vascular dementia and frailty had an impact.

39.59 **Issues with care received**: In terms of care, Associate Professor Kotsimbos considered that CA's oxygen support, increased fluids and empirical antibiotics were all appropriate and there was nothing else that could have been done to have changed her outcome. Counsel Assisting noted that the records do not in fact reflect fluids being increased after two directions to do so. Associate Professor Kotsimbos' view was that her end-of-life treatment could not have been provided in a more dignified way. He agreed with Professor Kurrle's opinions, which were that CA's clinical deterioration commenced on 21 April 2020 when she was noted to be tachypneic and hypoxic. Further, that Dr Kakkat felt on 22 April 2020 that CA was deteriorating and that a palliative approach was appropriate. On 25 April 2020, CA had increasing oxygen needs met (from 3L/min nasal prongs

to 15/min Hudson Mask). On 26 April 2020, morphine and midazolam were commenced with 5 doses administered over the next two days before she died on 28 April 2020.

39.60 **Whether different action may have affected the outcome:** No

39.61 Associate Professor Kotsimbos noted that CA was diagnosed with COVID-19 on 10 April 2020, making her the first resident to test positive. Therefore, her infection could not have been prevented, unless there were staff members who were noted to be positive before CA contracted COVID-19.

39.62 Professor Kurrle noted that CA's ACP stated that she did not want to be transferred to hospital despite her GP's recommendation for transfer to hospital. CA's family were told that the ambulance would be reluctant and that "[Hospital]" had said that CA would be unlikely to survive if she was transferred. Therefore, it is hard to know whether she would have had a different outcome if she was transferred to hospital, particularly given that she was the first resident to test positive to COVID-19, and she had symptoms for 18 days before she passed away.

39.63 Professor French did not consider that there was anything more that could have been done to prevent CA's death.

39.64 Counsel Assisting noted that although transfer to hospital for CA may not have changed the outcome, one gap in CA's care is the failure to administer subcutaneous fluids in the context of either 'refusing' fluids, 'spitting out' fluids or unable to take fluids as it was difficult to swallow. Notes of this nature are recorded as early as 11 April 2020 and throughout her care. Although NP Carpen records that fluids should be encouraged, Dr Kakkat did not follow up with management of this aspect of her condition, and never ordered the administration of subcutaneous fluids.

39.65 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was CA.

Date of death

CA died on 28 April 2020.

Place of death

CA died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of CA's death was COVID-19 pneumonia with Alzheimer's and vascular dementia being significant conditions which contributed to death.

Manner of death

CA died of natural causes following diagnosis of COVID-19 infection. Although records from 11 April 2020 indicate that CA was not tolerating fluids by mouth, no order for administration of subcutaneous fluids was subsequently made. However, the absence of such an order did not contribute to death, and no other steps in CA's management could have been instituted which would have materially altered the eventual outcome.

40. Blanche Billinghurst

HEALTH

Co-morbidities

40.1 Blanche Billinghurst was 89 years of age when she passed away on 28 April 2020 at Newmarch House during the COVID-19 outbreak. She had a number of existing comorbidities namely dementia (vascular), hypertension, chronic obstructive pulmonary disease (COPD), pulmonary embolus (resolved, surgically provoked, was on warfarin), fractured left neck of femur (2011), osteoarthritis, total hip replacement (2015) and hyperthyroidism. Mrs Billinghurst also had a history of bowel cancer (2008), knee replacement surgery (2016) and urinary incontinence.

Background and events leading up to COVID-19 diagnosis

40.2 Mrs Billinghurst was admitted to Newmarch House on 11 July 2018. She had previously lived alone but after a fall in her house on 14 March 2018 she moved into residential care. She was able to mobilise with a walking frame around her room and to the toilet but required full time care as she needed assistance with getting out of bed.

40.3 Although she had a mobile phone, operating the phone confused her 'a little bit' and generally she required the assistance of somebody else in the room in order to facilitate phone calls.

40.4 Mrs Billinghurst's son, Glenn Billinghurst, gave evidence that the three weeks in isolation prior to the lockdown left his mother very depressed and agitated and her wish was to leave Newmarch House. During window visits (which they attended every day or two after the lockdown commenced) Mrs Billinghurst's family believed that she was distressed with loneliness and anxiety from being separated from her family. Glenn tried to make her understand what was going on but he was unsure as to whether she understood. During one of the window visits Glenn Billinghurst observed a meal being delivered and not eaten. Glenn's impression was that during the early part of the COVID-19 illness his mother wasn't eating or drinking much.

RELEVANT MEDICATIONS

40.5 Mrs Billinghurst was prescribed a number of regular medications including aspirin, cranberry, Mirtazapine, Carbimazole, paracetamol, Prochlorperazine, vitamin D3, Bee Pollen, Chloramphenicol, Clotrimazole cream, Ipratropium Brobimed and Salbutamol. Mrs Billinghurst was also prescribed nebulised Ventolin and Atrovent (COPD).

PRN Medication - Midazolam and morphine

40.6 On 17 April 2020, Mrs Billinghurst was prescribed the following medications by Nurse Practitioner Carpen: morphine 2.5mg – 5mg, midazolam 2.5 – 5mg, glycopyrrolate 0.2 – 0.4mg and metoclopramide 10mg.

40.7 Mrs Billinghurst was administered 2.5mg morphine on 24 April at 3.29 for comfort and at 1.25pm for pain; on 25 April at 10.02am for pain; on 26 April at 11:24am for shortness of breath (SOB), at 6.13pm for SOB and 9.59pm; on 27 April at 12.54am for comfort, and again at 11.16am; and on 28 April at 9.56am for end of life (EOL).

COVID DIAGNOSIS

40.8 Mrs Billinghurst took a combined nose/throat PCR test on 14 April 2020 at 3.45pm. It was found to be positive to SARS-CoV-2. Her son Glenn was informed of the positive result by Newmarch House Facility Manager, Melinda Burns, at 8.40am on 16 April 2020 and informed that his mother had a fever, cough and was generally lethargic and febrile. The result was first recorded in Newmarch House progress notes roughly two days later at 8.45am on 16 April 2020.

40.9 Glenn Billinghurst gave evidence that he has no memory of being informed as to who's care his mother was in after she tested positive to COVID-19; who his mother's doctor was, or who he should have raised issues of treatment and care with. He felt that there were no lines of communication to facilitate that information and discussion.

ADVANCE CARE PLAN

40.10 Mrs Billinghurst prepared an Advance Care Plan (ACP) with her usual GP at Newmarch House, Dr Rezk, on 28 August 2019. Glenn gave evidence that he was present when the ACP was completed. It stated that Mrs Billinghurst did not want cardiopulmonary resuscitation (CPR) and did not wish to be kept alive by being fed artificially. Mrs Billinghurst did want to receive oral antibiotics and she understood that an intravenous administration of antibiotics may require transfer to hospital. She did want to be transferred to hospital if medically indicated.

40.11 Glenn gave evidence that the meaning of "*if needed medical treatment*" on his mother's ACP was never explained to him. The family believed this meant she would receive transfer to hospital and all medical treatment save for being artificially fed. Glenn had no understanding and there were no discussions about HITH with any person at Newmarch House or how it related to his mother. Mrs Billinghurst's family were not given any of the details of the care to be provided under that model or her treatment options.

40.12 Glenn gave evidence that his mother's cognition was such that it affected her short-term memory, however her long-term memory was intact and she was capable of making decisions for herself. Prior to the outbreak she would have consulted or been with a member of her family to make decisions around her care, but she was cognitively capable of making such decisions alone and she knew what she wanted.

Discussions around ACP

40.13 Glenn confirmed in his oral evidence that he and his family received a number of generic emails from Anglicare on 23 March 2020, 12, 14, 15, 16, 17, 18, 19, 22 and 22 April 2020. He did not feel these emails gave the family any better understanding as to the specific care being delivered to their mother.

40.14 On 17 April 2020, Glenn's daughter Kristie called Mrs Billinghurst. Glenn noted "*Whilst Kristie was talking to mum, she heard a nurse in the background asking mum some end-of-life questions*" such as "*do you want to go to hospital, or do you want to remain here*?" Glenn noted that the nurse then introduced herself to Kristie as Therese and said that she would contact Glenn. Glenn believed that Mrs Billinghurst was not capable of answering those questions at that particular point in time.

40.15 At 2.46pm on 17 April 2020, an unknown RN noted:

> Conversation with Blanche regarding advanced care plan, Blanche stated that she does not want to be Cardiopulmonary resuscitated, no Artificial nutrition, she does want to have antibiotics and does want be to transferred to hospital. Blanche requested that staff speak with her son Glenn. RN called Glenn at 1345 Glen stated that he would like his mother to be transferred to hospital if she requires treatment. Glenn stated he agrees and respects his mother's wishes.

40.16 A later entry at 1.50am on 18 April 2020 records:

> Late entry 17/04/2020: ACP review with Blanche. Blanche selected NFR [not for resuscitation]. Refer to ACP form. GP still yet to sign. Nepean Hospital Dr Kakkat contacted and updated on Blanche condition. Noted fever this morning. Attempted to contact sons Paul and Glenn to give them update on Blanches response to ACP but no answer. Message left to return phone call for an update on Blanche. Nepean doctor will review ACP on Monday

40.17 On 22 April 2020, Dr Kakkat noted that "*ACD form signed off as per previous discussion. For hospitalisation if medically beneficial*:" Counsel Assisting added emphasis to the word 'beneficial' in the note of Dr Kakkat noting the standard ACP form 'if medically *indicated*' which arguably has a different meaning to if medically beneficial.

40.18 What followed was a phone call in the middle of the night, the contents of which were the subject of dispute in these proceedings, regarding the decision by nursing staff at Newmarch to transfer Mrs Billinghurst to Nepean Hospital for care and treatment.

40.19 Glen Billinghurst gave the following evidence regarding the phone call he had with Dr Kakkat on 24 April 2020 between 2.35am and 3:12am in the morning regarding his mother's proposed transfer to hospital that evening. He believes the phone call lasted for five minutes. He is certain that Dr Kakkat said that the ambulance had been *cancelled* because the hospital would not provide any additional care as compared to what she was already receiving and that she was 'better off' in the comfort of her own bed. Counsel Assisting noted this is consistent with para [30] of his statement. He is 'very certain' that the doctor said that the ambulance had been cancelled.

40.20 As a result of Dr Kakkat informing him that the hospital could not provide any additional care Glenn Billinghurst asked, "*what if she was put on a respirator*?" to which Dr Kakkat replied, "*If she was put on a respirator there'd be zero chance of recovery*." Glen was "*absolutely certain*" those words were said.

40.21 He gave evidence that at that point he *relented* for her to stay at Newmarch House, as he thought it was in his mother's best interest and in that moment, it dawned on him that his mother would not

recover. In retrospect he feels, "I was being pressured into making the call not to go to hospital although I didn't understand why."

40.22 He disagreed with Dr Kakkat's assertions that they discussed:

- The nature of COVID-19;
- The mode of how COVID-19 is spread;
- Information in relation to how vigorous the virus was;
- How severe the infection was;
- The available treatments at the time;
- That his mother could be placed on fluids at Newmarch House; and
- That his mother could be placed on IV antibiotics.

40.23 Glenn Billinghurst refuted the proposition that *he* made the decision not to transfer his mother to hospital and states that he was persuaded into that position by Dr Kakkat.

40.24 Glenn Billinghurst took exception with the word "[family] *emphasised* that she is not for transfer as discussed earlier" as recorded in the Nepean Hospital clinical records by Dr Sharma. He gave evidence that "*I agreed to her not being transferred under the understanding that mum wouldn't make it either way from what I was told but I certainly wasn't insistent upon it. Not at all. It was sort of a coerced decision that I deeply regret.*"

40.25 The cancellation of the ambulance was inconsistent with his mother's and the family's wishes.

40.26 Dr Kakkat's memory of the phone call was that:

- He denied that he said that the hospital will not provide '*any extra care* than she is receiving' but rather he would have said "The hospital cannot *add anything* other than her current treatment".
- He agreed that he said to Glenn Billinghurst that if his mother was placed on a ventilator she would have about zero chance of survival (as compared to zero chance).
- He believes that he was aware of Blanche Billinghurst's ACP and that it recorded "I do want to be transferred if medically indicated".
- He gave evidence that if a family member requested there be a transfer to a hospital for ventilation, ultimately whether the patient is transferred is a decision to be made by the treating team and not the family.
- He gave evidence that the normal procedure was that an ambulance coming to Newmarch House needed to contact him on every occasion.
- His memory is that the fluids and antibiotics were discussed.

40.27 Perhaps the most reliable evidence in relation to the order of events surrounding the hospital transfer are found in the contemporaneous record made by an unknown RN on 24 April at 3.56am following the above phone call:

> *Staff checked on Blanche this evening at 0230 hrs to PAC and change pad. Observations were recorded as follows. Oxygen saturations were low 76% on 2L via nasal prongs. RN gave 10L of oxygen given via Hudson mask, Blanch saturations increased to 90%Resp 39temp 36.7BP150/90 Doctor Kakkat called*

no answer VACS team called no answer Care manager Renata called, who stated an ambulance to be called as per families wishes RN called ambulance, operator stated that an ambulance will be sent. RN called Blanches son and informed him of Blanches condition and stated that she is for ambulance transfer. Glen asked if he would be able to accompany her to hospital RN stated that she was unsure of the hospital restrictions regarding Covid-19 but would find out from paramedics when they arrived. Doctor Kakkat called RN back and asked for an update regarding Blanches condition. Dr Kakkat stated that he wanted to speak to the family regarding hospital transfer. RN provided Glenn's phone number. Dr Kakkat rang back and stated that he cancelled ambulance transfer after speaking to the family who have decided that she should remain in the nursing home and be kept comfortable. Dr Kakkat stated that he had written up PRN morphine in Blanches medication chart and stated that this should be provided. 0330 RN administered morphine 2.5mg. RN called Renata to ask if family are allowed to come and see Blanche as they have been calling and asking to come in to see her Renata stated to RN that the family must be informed of the risk of Covid-19 and the potential for outbreak also nursing staff must be present with family at all times and that they must wear PPE at all times and follow guidelines an restrictions. RN called Glenn and said that he is allowed to come and see Blanche, but must adhere to strict conditions an remain in the presence of nursing staff. RN all explained the risk to Glenn and also the potential for outbreak. Glenn stated that he wanted.

40.28 This contemporaneous record supports a finding that the family's primary wish was for Mrs Billinghurst to be transferred to hospital and that it was only after Dr Kakkat's phone call that that position changed. The clinical record entry lends support to Glenn Billinghurst's evidence that he felt 'sort of coerced' in agreeing to the cancellation of the ambulance. It also brings into question any suggestion that the 'family *emphasised* that their mother was not for transfer as discussed earlier.' The clinical record entry makes clear that during the initial phone call in which Glenn was informed an ambulance had been called for transfer, he requested to accompany his mother to the hospital.

40.29 Counsel Assisting submitted the following:

(a) The words "*if medically indicated*" are ambiguous, and the family and clinicians interpreted those words differently. This underlines the need to have a fully informed discussion about the circumstances in which transfer to hospital should occur, including the benefits of transfer to hospital or remaining within the home.

(b) The point in time at which transfer should occur must also be discussed, namely before a patient becomes critically ill and has reached a point of 'no return'.

(c) It would be more appropriate for an intensivist to make a determination whether to commence ventilation or not, following a face-to-face review at hospital.

40.30 Counsel for Anglicare submitted that the current version of Anglicare's ACP does not contain ambiguous terminology as it no longer asks residents to state whether they do, or do not, want "*to be transferred to hospital if medically indicated*". Instead, the ACP asks residents, or their families, to consider what medical treatment they would like to receive should there be a catastrophic medical event such as a myocardial infarction or stroke. Further, the ACP asks residents to consider whether they would prefer to receive end-of-life care in the place where they live or in hospital. Finally, the ACP also asks whether a resident who tests positive for COVID-19 would prefer to receive comfort

care consistent with their ACP or treatment aimed at prolonging life, which may require transfer to hospital.

40.31 It is noted that no further explanation is provided as to what might constitute "*treatment aimed at prolonging life*", and that the current version of the ACP does not, for example, expressly identify the differences between supportive care which may be provided in an aged care facility and that which may be provided in a hospital. The evidence has demonstrated that residents and their families may misunderstand such terms, and that an ACP would ideally provide as much clarity, and be free of any ambiguity, where possible. It is noted that Anglicare has indicated that it will review the template for its ACP to ensure that the current version "*reflects contemporary best practice*".

40.32 Therefore, the tenor of Mrs Billinghurst's ACP, namely hospital intervention to place her in the best position to fight any illness or virus, was not adhered to in this case.

PROGRESSION OF ILLNESS

16 April 2020

40.33 On 16 April 2020, Mrs Billinghurst's observations were recorded twice. First at 4.27am, SpO2 96% RA (BP 150/78, P 89, Temp 37.4C), then again, over 12 hours later, at 6.40pm, SpO2 97% (BP 145/90, P 99, RR 21, Temp 37.5C).

40.34 At 4.27am, RN Cenizal noted that Mrs Billinghurst was coughing and sneezing. She denied pain or distress. Clinical Educator Leslie Dominguez notes that Mrs Billinghurst refused breakfast as she felt she did not have an appetite to eat and had a productive cough. At 2.46pm, Care Manager Leann Hinton noted *"I have spoken to Dr Rezk and gained verbal and written consent for Blanche to access virtual consultations from infection control at Nepean hospital and my emergency doctor."*

17 April 2020

40.35 On 17 April 2020, Mrs Billinghurst's observations were recorded once, at 12.00pm, SpO2 97% (BP 123/85, P 95, R 23, Temp 36C).

40.36 The clinical records of Nepean Hospital record an entry made by Dr Kakkat outlining Mrs Billingshurst's comorbidities and recording 'crisis medication and vitamin D charted.' Counsel Assisting submitted that there is no evidence that a bed side consultation took place. At 2.47pm, an unknown RN recorded the entry regarding the ACP and Mrs Billinghurst's wish for transfer to hospital.

40.37 It was submitted on behalf of Dr Kakkat that a nursing entry made at 4:01pm on 17 April 2020 records: "*patient reviewed by VACS today at nursing home. For HITH call tomorrow*", and that Dr Kakkat's own entry records: "*At Newmarch House nursing home*. Similar to what has already been noted above regarding Dr Kakkat's progress note entries for 17 April 2020 for other residents, the very limited nature of the entry for Mrs Billinghurst, and the absence of any entry which could not have been drawn from Mrs Billinghurst's known previous history suggests that it is most likely that no face-to-face consultation was conducted by Dr Kakkat. The reference to "*At Newmarch House nursing home*"

is equally consistent with Dr Kakkat's own evidence that he did not always see patients when he attended Newmarch House and that most of the time in the first two weeks he was focussing on the drawing up of medication charts.

40.38 At 7.56pm an unknown RN notes that they spoke with Glenn and Kristie through Mrs Billinghurst's window, and that Glenn was worried that Mrs Billinghurst was not eating enough. Mrs Billinghurst reassured Glenn that she had been getting plenty of fluid.

40.39 Between 10.44pm and 10.57pm, Mrs Billinghurst was not administered Salbutamol, Ipratrin, Chloraphenicol or Stemzine. A late entry was recorded at 1.50am which noted in part that Dr Kakkat had been called and updated on Mrs Billinghurst's condition.

18 April 2020

40.40 On 18 April 2020, Mrs Billinghurst's observations were recorded five times. At 2.00am, SpO2 92% (BP 128/81, P 95, RR 19, Temp 36.7C), almost 12 hours later at 1.50pm, SpO2 not recorded (BP 98/70, P 68, Temp 38.2C), at 3.00pm, SpO2 97% (BP 110/72, P 68, RR 17, Temp 36.8C), at 5.00pm, SpO2 98% (BP110/73, P 70, RR 17, Temp 37C), and at 8.42pm, SpO2 81% (BP 141/76, P 95, RR 19).

40.41 At 2.00am, Mrs Billinghurst was attended to by RN Cardwell, who noted that Mrs Billinghurst felt more poorly than normal and was not well positioned. Mrs Billinghurst had a dry cough only with no work of breathing. At 10.12am, Mrs Billinghurst was not administered her regular medications due to stock. At 12.40pm, staff member Gordon Andison noted that he called Glenn Billinghurst to provide him with an update. At 1.50pm, an unknown RN noted that Mrs Billinghurst's morning medication was administered (contrary to the earlier entry), that she was febrile and tolerating meals. The RN noted "*Care staff reinforced to assist with feeding*".

40.42 Progress notes from Nepean Hospital indicate that RN Hayes contacted Newmarch House requesting updates on all COVID-19 cases, including observations, status and current condition but had at the time of recording the entry at 3.29pm, no information and had been provided by Newmarch House.

40.43 At 6.30pm, RN Dean acknowledged an alert that Mrs Billinghurst's systolic blood pressure was out of the normal range but there is no record that this was escalated for review by any medical practitioner. RN Dean noted that fluids were encouraged.

19 April 2020

40.44 On 19 April 2020, Mrs Billinghurst's observations were recorded eight times. At 3.00am, SpO2 91% on 3L (BP 110/80, P 80, RR 19, Temp 36.6C), at 3.34am, SpO2 91% on 2L (BP 110/80, P 87, RR 19, Temp 36.6C), at 11.00am, SpO2 97% (BP 100/70, P 75, RR 17, Temp 37.3C), at 4.00pm SpO2 96% (BP 135/75, P 75, RR 17, Temp 36.6C), at 9.00pm, SpO2 85% (BP 106/66, P 85 RR 18, Temp 36.5C), at 9.30pm, SpO2 97% on 3L (BP 123/70, P 75, R18, Temp 36.6C), at 10.00pm, SpO2 94% on 3L (BP 170/81, P 98, RR 16, Temp 36.5C), at 11.34pm, SPO2 94% on 3L NP (BP 170/81, P98, T36.5C).

40.45 At 1.17am, an unknown RN noted that Mrs Billinghurst was provided with all medications throughout the day and stated that she felt tired and not like herself. She did not have an appetite but drank water. The RN noted that Mrs Billinghurst was coughing but did not have a runny nose or sore throat. At 10.29am, staff member Andison recorded that he contacted Glenn Billinghurst, who was pleased that Mrs Billinghurst's temperature had reduced overnight. At 2.47pm, RN Dean recorded that Mrs Billinghurst's blood pressure was out of the normal range. RN Dean encouraged fluids. At 3.00pm, an unknown RN provided Mrs Billinghurst with a nebuliser and noted that her chest was slightly phlegmy and congested. Following the use of the nebuliser, the RN notes that Mrs Billinghurst's chest was clearer.

40.46 At 3.27pm, progress notes from Nepean Hospital indicate that RN Sidney attempted to call Newmarch House on three occasions with no response. Subsequent contact with the VACS team was made who advised that they would contact Nepean Hospital if there was anything major to advise. RN Sidney requested a system to facilitate daily updates from Newmarch House to Nepean Hospital. At 4.30pm, Christine Giles noted:

> Reported to be Positive COVID. No Nebuliser to be used, only spacer to be used. Contacted Glenn and provided an update on Blanches condition, he is aware that Blanche is positive for COVID, also advised that nebuliser should not be used and only a spacer. He was updated on her condition

40.47 At 8.30pm, an unknown RN noted that Mrs Billinghurst stated she felt unwell and did not eat much for dinner. Care staff encouraged Mrs Billinghurst to do breathing exercises. Oxygen was applied via nasal prongs 3L and Mrs Billinghurst's saturation levels increased to 97%. At 11.34pm, an unknown RN noted that Mrs Billinghurst stated she had a wet cough, was feeling very tired and was not very hungry.

20 April 2020

40.48 On 20 April 2020, Mrs Billinghurst's vital signs were recorded three times. First at 6.00am, SpO2 94% on 4L NP (P 77, RR 23), then five hours later at 11.00am, SpO2 94% (BP 100/69, P 70, RR 17, Temp 37.5C), and at 2.47pm SpO2 94% 4L PM (HR 77, RR 23).

40.49 At 3.00am, Mrs Billinghurst's oxygen saturation was 91% on 3L via Nasal Prongs. Mrs Billinghurst was repositioned, and her oxygen was increased to 4L via nasal prongs. Her saturation increased to 94%. She stated that she did not feel well but thought that oxygen was helping. At 6.00am, RN Cardwell noted that Mrs Billinghurst reported that she was feeling poorly but not worse. She was given water.

40.50 At 4.52pm, VACS Aged Care Nurse Practitioner (NP) Carpen conducted a remote review of the clinical records and did not escalate care to a medical practitioner despite recordings indicating Mrs Billinghurst was declining. To date, no medical review had occurred by any geriatrician or member of the VACS team.

40.51 At 6.51pm, Newmarch House manager Melinda Burns provided an update to Mrs Billinghurst's family regarding her symptoms. At 9.28pm, RN Dean acknowledged an alert and encouraged fluids. At 9.38pm, RN Dean acknowledged an alert that Mrs Billinghurst's systolic blood pressure was out of the normal range. Mrs Billinghurst was not administered Ipratrin, Salbutamol and Chloramphenicol,

due to nebulisers not being used due to COVID-19. At 11.15pm, Mrs Billinghurst's temperature was 37.3C. At 11.49pm Mrs Billinghurst was alert and observant and her medications were given. RN Cenzial noted "*medications given as charted… had regular Panadol. TSB given for 15 minutes. Notes was on oxygen this morning. Nil cyanosis or SOB. Coughing was noted. Nil complaints voiced*".

21 April 2020

40.52 On 21 April 2020, Mrs Billinghurst's vital signs were recorded four times. At 1.00pm, SpO2 94% on 1L (BP 124/64, P 88, RR 23, Temp 36C), at 4.30pm, Sp02 on 94% 1L (BP 124/64, P 88, Temp 36.0C, RR 23), at 7.00pm, SpO2 95% (BP 114/75, P 96, Temp 36.3C), and at 10.50pm SpO2 94% on 2L (BP 122/76, P 87, Temp 36.7C).

40.53 At 1.20am, Mrs Billinghurst was coughing and given sips of water as tolerated. At 2.00am, Mrs Billinghurst's oxygen saturations were between 84% and 85% in room air. RN Cenizal noted: "*Administered oxygen via NP, saturations went up 93-94% on 2L. Asked Blanche if it helps, she is unsure, pulse is 78*". At 3.00am, RN Cenizal noted: "*NIM Panadol given, fluids offered as tolerated, TSB rendered, temp went down 37.9… cough noted*". At 6.20am, Mrs Billinghurst stated that she felt tired and did not sleep well the night before and she was given fluids as tolerated. At 4.30pm, an unknown RN noted that Mrs Billinghurst's observations were between the flags, that she was afebrile at lunch and her oxygen saturation was 94-95% on 1-2LPM.

40.54 At 4.35pm, NP Carpen conducted a remote review of Mrs Billinghurst clinical records. There is no evidence that a face-to-face clinical review by a medical officer with VACS or HITH had to date, taken place.

40.55 At 7.00pm, an unknown RN noted: "*remains afebrile: productive cough and frequent sneezing observed, nil SOB noted. O2 sat dropped to 90% on RA*".

22 April 2020

40.56 On 22 April 2020, Mrs Billinghurst's vital signs were recorded five times. At 9.30am, SpO2 80% (BP 114/74, P 89, RR 18, Temp 36.4C), at 11.30am SpO2 88%, at 4.15pm (BP 111/72, P 89, RR 18, Temp 35.5C), at 4.30pm SpO2 91%, and at 9.30pm SpO2 92% on 2L (BP 132/86, P 82, RR 22, Temp 37.7C).

40.57 At 1.33am, an unknown RN noted the following *Now On O2 concentrator running at 2L/min via nasal prongs; O2 sat now sitting at 94%- needs to be checked as she tends to take the tube away. Offered water on rounds. Assist with ADLs.*

40.58 At 1030am, Dr Kakkat noted: "*ACD form signed off as per previous discussion. For hospitalisation if medically beneficial."* At 4.36pm, RN Gonzales noted:

> Nursing: Seen Blanche this morning, alert and awake in bed. Conversant, denied any pain or discomfort. Comfortable in bed while watching TV. Noted as coughing however nil c/o SOB. Obs attended: BP 111/72, PR 89, RR 18 and T: 36.4C, saturating 75% in RA. RN contacted Dr. Kakkat regarding same, ordered to increase oxygen therapy 5LPM via HM [Hudson Mask] . Saturations increased to 88-91% however Blanche feels uncomfortable wearing HM and prefers NP. RN changed back to 2LPM NP. Pls continue to monitor, same will be handed over.

40.59 At 4.39pm, Mrs Billinghurst was not administered Chloramphenicol. A 7.30pm, Mrs Billinghurst was administered Maxolon for nausea. At 8.18pm, Glenn Billinghirst was updated about Mrs Billinghurst's condition. Based on the clinical records, she was next reviewed at 9.30pm.

23 April 2020

40.60 On 23 April 2020, Mrs Billinghurst's vitals were recorded four times. At 9.00am, SpO2 93% (BP 128/90, P 88, RR 20, Temp 36.7C), at 12.30pm, SpO2 94% (BP 122/88, P 90, RR 20, Temp 36.7C), over five hours later at 6.00pm, SpO2 94% (BP 124/77, P 89, RR 20, Temp 36.4C), and at 9.00pm, 92% (BP 116/77, P 97, RR 19, Temp 36.7C).

40.61 At 12.45am, an unknown RN noted:

> Commenced care @1900.Alert and orientated. Observations taken: BP= 132/86mmHg, PR=82bpm, RR= 22cpm, T= 36.7, O2 sat= 92% on 02 concentrator @ 2L/min via np. Very audible crackles noted, can do minimal expectoration of thick++ yellowish mucous, SOB noted at times in between coughing fit. Complaints of nausea- PRN Maxolon given as per order with good result. Fluid continuously given on rounds as Blanch said she feels very dry and thirsty. Assisted with ADLs. RN have spoken to son Glenn with updates regarding Blanche progress- Glenn thankful about the updates. RN will inform morning team to update son tomorrow if any changes. Monitored continuously.

40.62 At 2.45am, an unknown RN noted that Mrs Billinghurst had increased breathing effort: *"Saturation drops to 80% during coughing; 02 increased to 5L/min 02 sat sitting around 90%. Blanche stated feeling of exhaustion due to cough. Closely monitored by the team".*

40.63 At 2.21pm, Dr Kakkat noted: "*Blanche is coughing and she is short of breath. Hemodynamically stable. Chest unremarkable Plan Start on Rulide 15o mg bd Continue other meds".* This is the first indication of a bed side review by a medical practitioner from VACS or HITH.

24 April 2020

40.64 On 24 April 2020, Mrs Billinghurst's vitals were recorded six times. At 1.15am, SpO2 92% 2L NP (BP 116/77, P 97, RR 19, Temp 36.6C), at 2.30am SpO2 76% on 2L (BP 150/90, P 111, RR 39, Temp 36.7C), at 4.20am SpO2 91% on 10L (RR 24), at 8.00am SpO2 83% (BP 131/71, P 100, RR 20, Temp 36.4C), at 9.42am SpO2 89% on 10L face mask, and then 12 hours later at 9.00pm SpO2 91% on 10L (BP 152/84, P 101, RR 30, Temp 36.4C).

40.65 At 12.23am, Mrs Billinghurst remained on 2L of oxygen via Nasal Prongs. At 1.15am, RN Gonzalez noted that Mrs Billinghurst had an on and off cough but denied any pain, shortness of breath or discomfort. At 2.35am, Glenn Billinghurst received a call from staff who informed him that Mrs Billinghurst had taken a turn for the worse and an ambulance had been called. At 3.12am, Glenn received a call from Dr Kakkat the details of which are outlined above in these submissions.

40.66 At 3.29am, Mrs Billinghurst was administered a dose of morphine for "*comfort*". RN Gonzales noted that Mrs Billinghurst's breathing became more settled and her coughing subsided. At 3.36am, Glenn

Billinghurst received a call from staff at Newmarch House, and was informed that he could come and visit his mother as she could pass away at any time. Counsel Assisting noted how rapid her decline appears given Dr Kakkat's entry at 2:21pm the day before noted that Blanche was hemodynamically stable.

40.67 At approximately 4.00am, Glenn and his daughter, Kristie, arrived at Newmarch House to visit Mrs Billinghurst. They wore PPE and were told by a staff member that they would not need to self-isolate as they wore PPE. Glenn noted that Mrs Billinghurst could speak a little, but it brought on coughing, and she was hot to touch. During the visit, Mrs Billinghurst's SpO2 was 65%. It was ascertained that her oxygen tank was empty. It was replaced and Mrs Billinghurst's saturations increased to 90%. At approximately 6.30am, Glenn and Kristie left Newmarch House. At 8am, Dr Sharma recorded in the Nepean Hospital progress notes, presumably based on a conversation she had with Dr Kakkat:

> Deteriorating and a Dr Yudi has written for hospital transfer. Dr Kakkat was called re this and he called family and they had emphasised that she is not for transfer as discussed earlier. Called by Ambulance officer and discussed re transfer advised not for transfer.

40.68 At 9.42am, VACS NP Carpen noted:

> VACS videoconference today with Dr Sharma, Lorena, RNs, and myself Note Blanche has deteriorated overnight Currently resting in bed Appears breathless Receiving oxygen 10L via face mask, SpO2 89 Has had morphine earlier this morning Would benefit from palliative care input Plan: Referral to palliative care, Would benefit from surefuser Morphine 2.5mg prn not for observations
>
> Glenn Billinghurst contacted and informed that visiting his mother will pose a high risk to himself and will need to wear full PPE. Glenn decided to still visit Blanche today and stated he will be here in an hour.

40.69 Between 1.25pm and 1.27pm, Mrs Billinghurst was administered morphine for "pain" and Maxolon. At 1.30pm, Glenn and Kristie visited Newmarch House for the second time, following permission being granted. They were temperature checked. Glenn noted his mother was semi-alert and complained of being hungry and thirsty. Glenn questioned why his mother had not been placed on a drip and was told by a nurse that this would be pointless and that a drip was an invasive procedure. Glenn said that after that point he and his family felt that they had no power in the situation.

40.70 At 2.54pm, Dr Sharma entered a note, written in retrospect:

> Written in retrospect
> has been deteriorating overnigh
> alert but looks unwell
> Dyspnoeic
> T 364 BP 131n1 02 sat on 10/1 Oxygen 83%
> Advise to give morphine and 6/L of Oxygen
> Palliative Care team contacted

40.71 At 3.00pm, an unknown RN noted that Mrs Billinghurst felt nauseous and appeared agitated, restless, breathless and was coughing: "*6L O2 in situ, canister changed today*". At 4.04pm, RN Dean acknowledged an alert that Mrs Billinghurst's diastolic blood pressure was out of normal range. At

4.10pm, an unknown RN noted: "*Contacted Dr Sharma regarding nebulisers, verbal order to be ceased. Pharmacy informed*". At 4.24pm, Mrs Billinghurst was discharged from HITH. It was noted that VACS was aware and "*follow up 2nd daily as per NUM*". At 6.58pm, Mrs Billinghurst was not administered Osteomol (pain medication for her osteoarthritis) per "*doctors instructions*". At 7.01pm, Mrs Billinghurst was not administered Stemzine (anti-nausea), Chloramphenicol (antibiotic), Salbutamol or Ipratrin (for COPD).

25 April 2020

40.72 On 25 April 2020, Mrs Billinghurst's observations were recorded seven times. At 1.47am, SpO2 87-91% on 10L PM Oxygen mask (BP 152/84, P 101), at 10.00am SpO2 89% on 6L (BP 126/79, P 92, RR 30, Temp 36.6C), at 11.00am, SpO2 92% on 5L Hudson mask (RR 35), at 12.20pm SpO2 86% on 6L (BP? P 56, Temp 36.5C), at 5.15pm 81% on 4L (BP 140/68, P 104, RR 24, Temp 36.6C), at 9.00pm, SpO2 84% on 6L (BP 141/83, P 105, RR 29, Temp 36.4C), and at 11.00pm, SpO2 84% on 4Ll rm NP.

40.73 At 1.47am, RN Gonzales noted that Mrs Billinghurst did not show any physical signs of pain and she responded to verbal and touch stimuli. She was given sips of thickened fluid. At 10.02am, Mrs Billinghurst was administered 2.5mg of morphine. At 11.00am, Mrs Billinghurst's respiratory rate was 35 and her saturations was 92% of 5L Hudson mask. She was non-verbal but was able to follow commands. At lunch, Mrs Billinghurst ate half her lunch with nil complaints noted.

40.74 At 2.30pm, Glenn and Kristie attended Newmarch House for the third time. Staff informed them that this visit would be their final one. Glenn noted that he asked a staff member why his mother had not been taken to hospital or put on a drip. The staff member replied stating that *"infusion was an invasive procedure and that it would not make any difference in the long run."* Glenn noted that his mother appeared to be hot, febrile, weak and suffering from dry mouth and nose.

40.75 At 3.10pm, RN Jehalle attended to Mrs Billinghurst. Mrs Billinghurst refused liquids, medications and food. It was noted: "*as advise from management/medical pt reduced from 6L itm to 2L np. Remains on regular xc morph. Family aware*". At 11pm, an RN attended to Mrs Billinghurst and noted *Unable to administer regular oral medications due to inability to swallow and drowsiness. Oral meds withheld – GP to r/v on and off cough. Nil breathlessness, nil SOB. Saturating 84% in 4LM via NP, O2 concentrator decreased to 2LPM as per handover.*

26 April 2020

40.76 On 26 April 2020, Mrs Billinghurst's vitals were recorded four times. First at 4.20am, SpO2 77% 2L NP, then four hours later at 8.30am SpO2 84% on 4L NP (BP 131/77, P 98, R 22, Temp 36.5C), at 10.45am, SpO2 76% on 2L NP (BP 132/89, P 109, RR 24, Temp 36.7C), and eleven hours later at 9.00pm, SpO2 77% on 2L NP (BP 129/67, P 111, RR 25, Temp 36.5C).

40.77 At 1.00am, RN Gonzales noted that Mrs Billinghurst was not administered oral medications due to inability to swallow and drowsiness. She showed no physical signs of pain but had an on and off cough. At 5.59am, Mrs Billinghurst was not administered Salbutamol or Ipratrin. RN Gonzales noted "*GP to chart alternative or to cease".* At 11.24am, Mrs Billinghurst was administered 2.5mg/0.25mL of morphine. At 3.23pm RN Fenech recorded that she and RN Howse had delivered to Newmarch House

morphine 5mg ampoules x 10 and midazolam 5mg ampoules x 10 and noted that there was no S4 register at Newmarch House for S4 drugs such as midazolam to be signed in. However, it is again noted that there was no requirement at the time for an aged care facility to sign S4 drugs into a register. At 6.13pm, Mrs Billinghurst was administered Hypnovel and 2.5mg of morphine for "*SOB*". At 8.00pm, Mrs Billinghurst was given 20mls of fluid to wet her mouth. At 9.59pm, Mrs Billinghurst was administered 2.5mg of morphine.

27 April 2020

40.78 On 27 April 2020, Mrs Billinghurst's observations were recorded twice. First at 12.00pm, SpO2 72% on NP (BP 123/83, P 149, Temp 36.5C), and over four hours later at 4.26pm, SpO2 78% on LPM.

40.79 At 12.45am, Mrs Billinghurst was administered 2.5mg of morphine "*to keep comfortable*". At 3.00am, RN Gatt attended to Mrs Billinghurst who noted that morphine was given over the shift, oxygen saturations were low at 77% on 2L Nasal Prongs and Mrs Billinghurst had a video call with family members overnight. Mrs Billinghurst's pressure care was attended to. At 11.16am, Mrs Billinghurst was administered 2.5mg of morphine. At 2.30pm, Glenn called Newmarch House, but the call was not answered. At 2.54pm, Glenn received a call back from Newmarch House, advising him that he would receive an evening video call with Mrs Billinghurst. This did not occur. At 3.37pm, Mrs Billinghurst was recorded as being unable to communicate verbally and was tachypnoeic, RR 35 – 40, febrile and her skin was "*very hot*" to the touch.

40.80 At 4.26pm, VACS NP Carpen noted a VACS videoconference with Dr Sharma and Newmarch House Registered Nurses:

> Blanche continues to deteriorate Looks comfortable
> SpO2 78% on #LPM[sic] oxygen
> Nil by mouth aspiration risk
> Continue Comfort care, oral care, pressure area care, limit observations, keep comfortable, ACD in place, crisis medications charted

28 April 2020

40.81 On 28 April 2020, Mrs Billinghurst's observations were recorded twice. First at 1.00am, SpO2 on 72% 2L NP, (BP 109/77, P 147, RR 32, Temp 36.8C), and then five hours later at 6.00am, SpO2 75% on NP (P 133, RR 33, Temp 38.8C).

40.82 At 8.04am, Glenn contacted Newmarch House as he had seen on the news that an 89-year-old resident had passed away. RN Therese confirmed that it was not his mother, but that she had received a double-dose of morphine. This 'double dose' is not reflected in the medication charts.

40.83 At 9.00am, Newmarch House manager Christine Giles contact Paul and Glenn Billinghurst and advised that Mrs Billinghurst was nearing the end of her life. Glenn attempted to make three calls to Newmarch House between 9.30am and 9.45am.

40.84 At 9.55am a VACS videoconference occurred with Dr Sharma, Dr Kathiresan and facility RN's and records note that "*continues to deteriorate, frequently requiring morphine and midazolam unconscious, Cheyne stokes breathing*." The plan as recorded was for continuing comfort care, commencement of surefuser, oral eye care, pressure care. 2.5mg of morphine was administered at 9.56am, along with Robinul. At 10.00am, Mrs Billinghurst was administered Hypnovel. Counsel Assisting noted that the entry made by VACS that Mrs Billinghurst 'frequently required' morphine and midazolam is inconsistent with the medication charts which records midazolam being administered on two occasions (18:13 on 26 April 2020 and 10:00 on 28 April 2020) and records morphine being administered twice on 24 April (3:29, 13:25), once on 25 April (10:02) three times on 26 April (11:24,18:13,21:59), twice on 27 April (00:54, 11:16) and lastly on 28 April.

40.85 At 11.30am, an unknown RN noted Mrs Billinghurst had an irregular breathing pattern, was warm to touch and nil observations were taken per ACD. Counsel Assisting noted there was no Advance Care Directive (ACD) and the ACP did not direct nil observations when nearing end of life.

40.86 At 1.30pm on 28 April 2020, staff attended Mrs Billinghurst and noted that she showed no signs of life. Dr El Jamaly confirmed Mrs Billinghurst was deceased. At approximately 1.45pm, a staff member called Glenn to inform him of his mother's death.

40.87 Glen Billinghurst gave evidence that, "*I feel that she was let down in the days prior to that* [her death] *as far as maintaining her strength. I truly believe that she was allowed to dehydrate beyond a reasonable extent and that's why the questions about the drip and I don't think enough effort was put into making sure she ate*."

40.88 Counsel Assisting submitted that there is no evidence to support a finding that subcutaneous fluids were administered at any stage despite a decline in her presentation over the period of her illness and despite countless entries indicating that she was given fluids, encouraged to take fluids, unable to swallow and an entry stating she feels *very dry and thirsty.*

MANNER AND CAUSE OF DEATH

40.89 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree that Mrs Billinghurst's cause of death was COVID-19 infection. Relevant comorbidities included vascular Dementia and Osteoarthritis, which meant that she was unable to move a lot.

40.90 **Manner of Death**: The experts noted that Mrs Billinghurst had quite a progressive decline. They felt there was a delay in anticipatory medications being administered and an implication that fluids and antibiotics were not administered. Mrs Billinghurst's death occurred in the context where her ACP had stated she wanted to be taken to hospital if medically indicated, and the events surrounding an ambulance being cancelled on 24 April 2020.

40.91 **Impact of any significant co-morbidities**: The experts opined that osteoarthritis and a past hip fracture reduced her mobility. She had lung disease of unclear severity and cardiovascular disease. They felt that her dementia had a significant impact in terms of capacity to make decisions about her ACP. However, Counsel Assisting noted that this is not a view shared by the family who said that prior to contracting COVID-19 she was cognitively able to make decisions as to her care.

40.92 **Issues with care received**: Associate Professor Kotsimbos noted that Mrs Billinghurst had previous lung disease and it was unclear how severe or chronic that lung disease was, or how it was managed following her infection with COVID-19. In particular, Associate Professor Kotsimbos noted that Mrs Billinghurst required a bronchodilator for her airways disease, and it was difficult to ascertain whether she was receiving adequate management by way of a nebuliser or spacer. Counsel Assisting noted that the clinical records state that her nebuliser should be ceased after her COVID-19 diagnosis was known.

40.93 Associate Professor Kotsimbos noted that it was difficult to determine whether Mrs Billinghurst received empirical antibiotics or fluid supplementation during her progressive decline over 14 days from the date of diagnosis of infection with COVID-19, as it is not reflected in the clinical records. Associate Professor Kotsimbos considered her supportive care in terms of oxygen seemed reasonable, however she suffered distress at the point in time where her oxygen cannister ran out, which was concerning.

40.94 Further, Associate Professor Kotsimbos considered that the commencement of anticipatory medications was delayed, and then towards the end of Mrs Billinghurst's life, the dose of the morphine was double what was expected to be given. Counsel Assisting noted administration of a 'double dose' is not reflected in the medication charts and it is unclear whether in fact a double dose was administered. Overall, Associate Professor Kotsimbos considered that there were a number of treatment aspects that "*were not quite right,*" including the provision of oxygen, fluids and anticipatory medications, which, taken together, "*may have had an impact*" on Mrs Billinghurst's outcome.

40.95 Professor Kurrle noted that Mrs Billinghurst complained multiple times of being thirsty, and this could have been addressed through subcutaneous fluids being administered via the same route (i.e. via butterfly needle) that was being used for administration of morphine. Ultimately, Professor Kurrle considered that Mrs Billinghurst's could have benefited from fluids and better management of oxygen levels and from being transferred to hospital very early in her illness, noting the slow progression of her illness over 2 weeks.

40.96 **Whether different action may have affected the outcome**: Possibly

40.97 Associate Professor Kotsimbos noted that Mrs Billinghurst was diagnosed in the first wave of COVID-19 infections at Newmarch House, so it is unlikely her infection could have been prevented. However, the combination of multiple issues with her care may have affected her outcome, particularly considering her slow decline. She may have benefited from being taken to hospital very early on in her illness and received better management of her fluids and oxygen levels there, but these measures may not have prevented her death. Professor Kurrle agreed.

40.98 Professor Kurrle raised concerns about whether Mrs Billinghurst's wishes were followed following her COVID-19 diagnosis. Professor Kurrle noted that on 24 April 2020 an ambulance was called to take Mrs Billinghurst to hospital, then cancelled, despite Mrs Billinghurst's ACP expressing a wish to be transferred to hospital. Professor Kurrle considered that this was another aspect of Mrs

Billinghurst's care that did not go "*very well*" for her (in addition to the issues of oxygen, fluid and morphine management raised by Associate Professor Kotsimbos).

40.99 Professor French noted that given Mrs Billinghurst's ACP indicated that she wanted to be transferred to hospital if medically indicated, aspects of her fluid therapy could have been improved in the preceding 24 to 48 hours prior to her death. However, Professor French was uncertain about whether transfer to hospital would have changed Mrs Billinghurst's outcome and formed the view that it probably would not have prevented her death.

40.100 Counsel Assisting submitted that:

(a) Mrs Billinghurst's care and treatment under the HITH/VACS model of care appears to have been suboptimal. The failure to transfer her to hospital at any point in time was contrary to her ACP. The cancellation of the ambulance ordered by Newmarch House staff on 24 April 2020 by Dr Kakkat reflects, it was submitted, an approach that dissuaded transferring COVID-positive patients to hospital.

(b) Further, although observations were taken and recorded, there was little evidence that at points in time when she was hemodynamically unstable there was any escalation to or response by, a medical practitioner. The approach appeared to be palliative from the start, with little to no active treatment such as fluids being administered and no comprehensive and thorough review by any medical practitioner at any stage.

(c) The evidence of the experts and a review of the clinical records suggests that the standard of care provided to Mrs Billinghurst, was suboptimal.

40.101 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Blanche Billinghurst.

Date of death

Mrs Billinghurst died on 28 April 2020.

Place of death

Mrs Billinghurst died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Billinghurst's death was COVID-19 infection with vascular dementia and osteoarthritis being significant conditions which contributed to death.

Manner of death

Mrs Billinghurst died of natural causes following diagnosis of COVID-19 infection. Following her diagnosis, the care provided to Mrs Billinghurst was suboptimal due to certain deficiencies in her fluids and oxygen management, a delay in administration of anticipatory medications, and cancellation of Mrs Billinghurst's transfer to hospital on 24 April 2020, which was contrary to the terms of her Advance Care Plan. If transfer to hospital had been effected, management of Mrs

Billinghurst's fluids and oxygen therapy would have improved, although the institution of such management may not have materially altered the eventual outcome.

41. David Gee

HEALTH

Co-morbidities

41.1 David Gee was 77 years of age when he passed away on 28 April 2020 at Newmarch House during the COVID-19 outbreak. He had a number of existing comorbidities including dementia (vascular) (2016), cerebrovascular accident (CVA), ischemic heart disease (IHD), congestive cardiac failure (CCF), hypertension (HT), atrial fibrillation (AF), diverticular disease and type 2 diabetes mellitus (2014). Mr Gee had a quadruple heart bypass surgery in or about 2000 after suffering a series of small heart attacks.

41.2 Mr Gee had various other comorbidities including depression, anxiety, urinary and faecal incontinence, decreased mobility, osteoarthritis, short term memory loss, pain, pressure ulcer on the left heel, gout, hypotension, shortness of breath, sleep apnoea, arthrosis, fatigue, slurred speech, pulmonary oedema and hypoglycaemia.

Background and events leading up to COVID-19 diagnosis

41.3 Mr Gee moved into Newmarch House in May 2019 following the death of his wife. He was able to walk short distances with a four-wheel walker, had suffered falls and was considered high care. Mr Gee was admitted to Nepean Hospital in April 2019 with right facial droop, unsteady gait and confusion.

RELEVANT MEDICATIONS

41.4 Mr Gee was prescribed various regular medications including Janumet 50/500 tab (sitagliptin/metformin), laxative + senna 50mg/8mg tab (docusate/sennoside), Lorstat 80mg (atorvastatin), Magmax (Health Plus Vitamins) 37.4mg (magnesium), Salpraz 40mg (pantoprazole), Uremide 40mh (furosemide), Vedilol 3.125mg (carvedilol), Molazole powder for oral liquid (macrogel + 3350 13.12g sodium chloride 350.7mg), Norspan 5mcg/hour patch (buprenorphine 5mcg/hour patch), Pradaxa 110mg (dabigatran).

PRN Medication - Midazolam and morphine

41.5 On 24 April 2020, Nursing Practitioner (NP) Carpen from the Nepean Hospital Virtual Aged Care Service (VACS) prescribed Mr Gee morphine 2.5mg, midazolam 2.5mg, glycopyrrolate 200mcg and metoclopramide 10mg. The handwritten medication charts record that morphine at 2.5mg was administered on 26 April at 14:00 and 17:20 for respiratory shortness of breath (SOB); on 27 April at 00:50 for SOB and at 12:50 in combination with midazolam for agitation and SOB; on 28 April at 12:30 in combination with midazolam for end of life (EOL) and again at 16:20 in combination with midazolam and glycopyrrolate for EOL. The handwritten progress notes record other dates and times when morphine was administered but not documented on relevant medication charts.

COVID DIAGNOSIS

41.6 Mr Gee took a PCR COVID-19 test on 14 April 2020 and returned a negative result. Mr Gee was tested again by PCR COVID-19 test on 18 April 2020 and returned a positive result. Nepean Hospital clinical records indicate that Hospital in the Home (HITH) Registrar Dr El Jamaly rang the facility on 20 April at 12:10 with the results.

ADVANCE CARE PLAN

41.7 On 26 April 2019, Russell Gee (one of Mr Gee's sons) on behalf of Mr Gee, completed a Not for Resuscitation Plan at Nepean Hospital. There is no Advance Care Plan (ACP) for Mr Gee in his records provided by Anglicare or NSW Health.

Discussions around ACP

41.8 Once Newmarch House went into lockdown (24 March 2020), Mr Gee's son, Mark Gee, made enquires on 27 March 2020 via email of Leanne Hinton, Anglicare Manager, regarding bringing Mr Gee home. Leann Hinton replied later that day stating that Mark could take his father home but there were a number of things that needed to be considered, including that Mr Gee was only entitled to 52 days social leave. Leanne Hinton suggested that Mark speak with Mr Gee's GP, Dr Sheehan, to get further advice. Mark later spoke with Dr Sheehan who advised him that Mr Gee was "*better off*" staying at Newmarch House.

41.9 On 19 April 2020, Mark received a call from someone at Newmarch House advising him that Mr Gee had tested positive for COVID-19.

41.10 Although progress notes suggest an ACP was discussed on 22 April 2020, there is no ACP form for Mr Gee in the records provided by Anglicare or NSW Health. NP Carpen progress note at 5:24pm that day records that Dr Sharma had a discussion with Mr Gee's son, Russell, and he and his brother (Mark) discussed the ACP with their father. It was noted that their mother had recently died, and their father expressed that he wanted to join her. RN Carpen noted that Mr Gee was not for CPR, intubation, transfer to hospital and was for comfort measures only. Mark Gee's statement does not make any mention of this conference call discussing Mr Gee's ACP.

41.11 On 24 April 2020, Mark received a videocall from RN Lorena Bestrin. RN Bestrin told Mark that Mr Gee's health was a little more concerning than the previous days as he was short of breath and that if he did not improve, morphine would be administered. Mark asked if that meant that Mr Gee would be sedated. RN Bestrin told Mark that the morphine was to make Mr Gee more comfortable, not to sedate him. RN Bestrin held the phone in front of Mr Gee and Mark could see that Mr Gee had opened his eyes but was unable to communicate, as he was in a semi-conscious state.

41.12 On 25 April 2020, Dr Sharma called Mark and informed him that his father's health was deteriorating and suggested a visit. That afternoon Mark and his brother Russell attended Newmarch House to see their father. However, two Anglicare workers told them they could not enter Newmarch House as Mr Gee was not close enough to the end of his life. That night, an RN phoned Mark Gee and told him that Mr Gee was experiencing pain, and she was going to administer morphine. RN Therese made

enquires and ensured that Mark Gee would be able to see his father if he attended Newmarch House. That evening, Mark attended Newmarch House, and wearing full PPE, he was able to spend around 15 minutes with his father. He told Mr Gee that he loved him and he would pray for him. At about 3.00pm that day, Mark received a call from a nurse called Jenny who told him that she was going to increase his father's morphine. Mark requested that someone call him every three hours to update him on his father's condition, but he did not receive another call until about 9pm that evening.

41.13 On 27 April 2020 at 6.30am, Mark received a call from a nurse called Kathleen who informed him that his father was dying. Kathleen facilitated a video call so that Mark and his brother could say goodbye to their father. That day, or the following day, during a conversation with one of the nurses, Mark's wife Sarah discussed the possibility of putting Mr Gee on a drip. The nurse informed them that there was no point. At 2pm on 28 April 2020, Mark received a call from Dr Jane who informed him she was a palliative care doctor. Dr Jane told Mark that Mr Gee was dying and, "*they were no longer doing his observations and there is nothing that will change dad's care plan*". At 3pm, a nurse called Tracy organised a group video call for Mark, Mr Gee and his family. This was Mark's last contact with his father before he died the following day.

41.14 Although there is no copy of an ACP in Mr Gees' records, his wish not to be transferred to hospital was honoured.

PROGRESSION OF ILLNESS

18 April 2020

41.15 On 18 April 2020, Mr Gee's observations were recorded once at 10.40pm, SpO2 97% (BP 117/28, P 73, RR 18, Temp 37.6C)

19 April 2020

41.16 On 19 April 2020, Mr Gee's observations were recorded three times. Once at 11.00am SpO2 98% (BP 115/70, P 68, RR 17, Temp 37.9C), five hours later at 4.00pm SpO2 97% (BP 140/78, P 17 RR 17),and four hours later at 8.30pm SpO2 not recorded (BP 130/62, P 70, RR 19, Temp 36.6C).

41.17 An unnamed RN noted at 12.45pm that Newmarch House was informed of Mr Gee's positive COVID-19 test result. Progress notes indicate that COVID-19 precautions were put in place and a PPE station was set up out the front of Mr Gee's room. That RN noted the following:

> David stated to RN that he would like her to kill him. David asked RN to hold a pillow over his face and kill him or get a gun and shoot him in the head. RN stated that she would not kill him. David stated that he misses his wife and she had passed away and he wanted to be in heaven with her. RN provided reassurance. David stated that he is not currently experiencing any symptoms of COVID.

41.18 At 6:40pm, an RN noted that Mr Gee's son Mark, seeking news to confirm his father's COVID-19 status after failed attempts earlier to have his calls returned by Newmarch House. The RN noted that she apologised to Mark and confirmed that Mr Gee had tested positive to COVID-19.

20 April 2020

41.19 On 20 April 2020, Mr Gee's observations were recorded once at 11.00am SpO2 95% (BP 135/75, P 75, RR 17, Temp 37C).

41.20 At 12.32am, an unnamed RN noted that Mr Gee was settled that evening and that staff facilitated a call with Mr Gee and one of his sons. Mr Gee had stated that he liked talking to his sons as it was reassuring. The RN noted that Mr Gee took his medication as prescribed but did not eat much for dinner, stating that he wasn't feeling very hungry. Mr Gee denied having a sore throat, runny nose or headache, saying he just felt normal.

41.21 At 5.59pm, VACS NP Carpen, recorded that she was unable to contact Newmarch House that day, and conducted a remote review of the clinical records indicating that Mr Gee remained asymptomatic, but no observations were recorded. This is an incorrect remote review of the records as observations were in fact taken at 11am raising an issue about the accuracy of the VACS care and review when largely performed remotely.

41.22 At 11.45pm, RN Cenizal noted that Mr Gee was awake and alert and was assisted with all care. She noted that Mr Gee refused to eat, medication was given as charted and that that there was no coughing, shortness of breath, pain or distress, and no complaints being voiced.

21 April 2020

41.23 On 21 April 2020, Mr Gee's observations were recorded twice. First at 1.00pm, SpO2 98% (BP 123/84, P 77, RR 21, Temp 36.4C), then six hours later at 7.00pm, SpO2 99% (BP 119/53, P 67, RR 20, Temp 36.2C).

41.24 At 4.22pm, Newmarch House Manager Melinda Burns noted that she spoke to Mr Gee's family and let them know that Mr Gee had a dry cough. At 5.00pm, Mr Gee was slightly cranky but cooperative. The RN notes record "*obs between the flags, afebrile, nil distress. He sat on the chair in the morning and went back to bed after lunch*".

22 April 2020

41.25 On 22 April 2020, Mr Gee's observations were recorded four times. At 6.15am, 99% (BP 115/62, P 65, Temp 36.6C), at 10.10am SpO2 96% (BP 115/77, P 69, RR 19, Temp 36.5C), at 4.16pm, SpO2 96% (BP 109/72, P 66, RR 19, Temp 36.5C), and at 10.50pm, SpO2 98% (BP 128/72, P 75, RR 18, Temp 36.8C).

41.26 At 1.24am, an unknown RN noted that Mr Gee remained afebrile, and observed a dry cough. At 4.20pm, RN Gonzales noted that Mr Gee was seen awake and alert that morning. He appeared comfortable and denied any pain or discomfort, and the RN did not notice any coughing. A note was entered by VACS NP Carpen at 5.24pm that Dr Sharma had a discussion with Mr Gee's son, Russell, and he and his brother (Mark) discussed an ACP with their father. RN Carpen noted that Mr Gee was not for CPR, intubation, transfer to hospital and was for comfort measures.

23 April 2020

41.27 On 23 April 2020, Mr Gee's observations were recorded five times. At 10.30, SpO2 98% (BP 110/70, P 79, RR 18, Temp 36.5C), at 12.00pm, SpO2 95% (BP 114/72, P 71, RR 18, Temp 36.5C), at 3.58pm, SpO2 95% RA (BP 114/72, HR 71, RR 18, Temp 36.5C), at 6.00pm, SpO2 94% (BP 128/94, P 99, RR 18, Temp 36.6C), and again at 9.00pm 92% (BP 109/68, P 88, RR 19, Temp 36.8C).

41.28 At 3.10am, an unknown RN noted that observations were stable, with nil cough and nil shortness of breath. Mr Gee was offered fluids. He was assisted with activities of daily living (ADLs) and his needs were said to be attended to. It was noted that Mr Gee was in good spirits that night. At 3.58pm a note was made by HITH RN Sidney at Nepean Hospital as a result presumably of a remote review of the notes that symptoms were nil. At 6.00pm an unknown care worker attended to all ADLs and Mr Gee ate all meals and tolerated fluid intake well. Progress notes indicate pressure area care was attended to every 2 hours.

24 April 2020

41.29 On 24 April 2020, Mr Gee's observations were recorded four times. At 1.28am, SpO2 92% RA (BP 109/68, P 88, RR 19, Temp 36.8C), over eight hours later at 10.00am, 93% (BP 112/73, P 84, RR 18, Temp 36.8C), seven hours later at 5.00pm, SpO2 94% (BP 120/69, P 78, RR 18, Temp 36.8C), and four hours later at 9.00pm SpO2 94% (BP106/65, P82, RR19, 36.7C).

41.30 At 12.11am, an unknown RN noted that a phone call was made to Mark Gee that evening. Mr Gee asked an RN to assist him to stand and help him stretch. His vital signs were all within the normal range, he denied having a cough, shortness of breath, sore throat, or runny nose; he drank approximately 150mls of water, barely ate dinner, and went to sleep at approximately 11.00pm. At 1.28am, Mr Gee was alert and awake noting that he was conversant and denied any pain or discomfort. He was noted to be warm to touch but afebrile and refused blankets. He was noted to be asymptomatic with no coughing or flu like symptoms noted. Progress notes state that Mr Gee was yelling when asking for assistance and was encouraged to use his call bell. At 10.30am a VACS videoconference was held with Dr Sharma and Lorena Bestrin, Newmarch House facility RN. It was noted that Mr Gee "*looked unwell*" and "*reports of being breathless".* The note states "*plan provide reassurance. Give morphine 2.5mg as charted*".

41.31 At an unknown time, RN Fenech entered a progress note as follows:

> Received call from ADON. Requesting crisis med pack for pt. Signed out from N1F by ADON and RN Howse and RN Fenech. RN Howse and RN Fenech took pack to Newmarch House Blaxland ward. PPE worn by nursing staff to enter nursing home. Morphine 5mg ampules x 10 signed into S8 book with RN from Newmarch House. Clonezepam 2.5mg 10mls and Midazolam 5mg 10 ampules were also given to RN from Newmarch House but not signed in as they do not have a S4 register. RN Howse and RN Fenech witnessed same. Pt's name written on all medication.

41.32 At 3.06pm, in a consult letter to Mr Gee's usual GP, Dr Sharma noted that Mr Gee was alert but complains of shortness of breath. She further wrote "*Refuses to have BP measured 02 saturation and temp will be conducted later, obs will be done later. RR26/min. Nil other complaints. Measure O2 saturation if less than 94% give 2L/min via nasal prongs. Give Morphine 2.5mg Morphine stat*".

25 April 2020

41.33 On 25 April 2020, Mr Gee's observations were recorded four times. At 1.11am, SpO2 94% RA (BP 106/65, P 82, RR 19, Temp 36.7C), at 9.16am, SpO2 97% (BP 113/68, P 92, RR 24, Temp 36.7C), at 4.30pm, SpO2 92% (BP 105/50, P 95, RR 25, Temp 36.5C), and at 10.00pm, SpO2 95% on 2L NP (RR 20, Temp 36.5C, BP 96/49, P 68).

41.34 At 1.11am Mr Gee was physically assisted to the toilet. The call bell was noted to be within his reach.

41.35 At 2:00pm, a note from Newmarch House Lifestyle team leader Lisa Courtney stated "*Staff organised phone call for David to contact Steven. David was very tired and not up to talking for long".* At 3.04pm Mr Gee was tolerating fluids but declined food. It was noted that "*obs remain stable. Clinically remains well. Nil resp distress. Son worried about pt SOB on phone all this pm. Will reassess pt may require s/c morphine and other complaints."* Personal care was attended to by an assistant in nursing (AIN) at 3.30pm. He was noted to be a little bit agitated and lethargic. At 4.10pm Mr Gee was given morphine and 2L of oxygen was applied via nasal prongs. At 5.25pm, an RN noted that Mr Gee's observations were stable with nil complaints.

26 April 2020

41.36 On 26 April 2020, Mr Gee's observations were recorded five times. At 5.20am, SpO2 95% (BP 109/72, P 112, RR 22, Temp 36.8C), at 8.30am, SpO2 95% on 2L NP (RR 20, Temp 36.7C, BP 101/60, P 74), at 10.15am, SpO2 96% on2L NP (RR 22, Temp 37.3C, BP 105/65, HR 110), at 2.00pm, SpO2 96% on 2L NP (RR 22, Temp 37.2C, BP 103/67, HR 99) , and at 9.00pm, SpO2 98% on 2L NP (RR 25, Temp 36.5C, BP 110/70, HR 111).

41.37 At 2.14am, an RN progress note indicates that Mr Gee was given PRN (as required) morphine at 12.45am 'as per paper medication chart' but there is no corroborating record of this. The RN noted that observations were within normal range and that Mr Gee remained on 2L of oxygen via nasal prongs, and that Mr Gee unable to swallow medications, so his evening Coloxyl and Senna was withheld. The RN called Mark Gee who was permitted to say his final goodbyes, but must be accompanied by a nurse, wearing full PPE and staying for a maximum of 30 minutes. A Whatsapp call was facilitated with the sons. The RN also called VACs to inform them of Mr Gee's condition.

41.38 Mr Gee's observations were noted to be stable at 5.20am. At 2.00pm, handwritten medication charts indicate 2.5mg of morphine was administered for "*resp/SOB*". At 4.05pm, it was noted that PAC and analgesic were given to Mr Gee by COVID-19 nursing staff. At 6.30pm, Mr Gee was attended to by an RN who noted that he appeared disoriented and was administered 2.5mg of morphine. This was not charted although there is an entry for administration at 5.20pm for "*Resp/SOB*".

27 April 2020

41.39 On 27 April 2020, Mr Gee's observations were recorded once at 12.00am, SpO2 94% on 2L NP (Temp 36.9C, BP 103/65, HR 97).

41.40 At 12.05am Mr Gee was administered 2.5mg morphine for *"SOB".* At 2.54am, RN Gall noted that Mr Gee had been given morphine twice during the night (although only one occasion is recorded). It was noted that Mr Gee appeared settled overnight and oxygen was applied 2L via nasal prongs. Bioten and lip balm were applied regularly to keep Mr Gee's mouth moist. At 12.30pm Mr Gee was administered 2.5mg morphine and 2.5mg midazolam for agitation and shortness of breath. Mr Gee video chatted with his son, daughter in law and grandchildren in the afternoon and had three hourly pressure area care attended to at 9.00pm, 12.00am and 2.00am. At 3.34pm, Mr Gee was attended to by "SVH staff" who noted "*maintaining own airways. Use of accessory muscles present. Tachypnoeic. Resp up. Unable to verbally communicate. 2L NP. Shallow breathing. RR30-35. Hot to touch*".

41.41 At 4:25pm, a VACS videoconference was conducted with Dr Sharma and facility RNs. She noted that Mr Gee was deteriorating, but looked comfortable, was not interacting, and taking nil by mouth. She directed oral care, pressure area care, to cease observations, keep comfortable, and that his ACD was done, and anticipatory medications were ordered. At 7.00pm, Mr Gee was attended to by nursing who noted he was non-responsive and agitated. Morphine 2.5mg was given but not charted in the handwritten medication records.

41.42 It was submitted on behalf of Anglicare that although the relevant progress note entry was written at 7:00pm, this does not mean that morphine was administered at that time. Rather, because the progress note entry records that Mr Gee was experiencing shortness of breath and agitation at 8:30am, and that morphine was administered "with effect", this suggests that the morphine was administered at that time. Whilst this may be so, it also illustrates that the absence of consistent documentation in both progress notes and medication charts leaves such documentation open to interpretation which may be inaccurate.

28 April 2020

41.43 On 28 April 2020, Mr Gee's observations were recorded twice. First at 1.00am 92% NP (RR 22, Temp 37.2C, BP 103/75, HR 114), and then at 6.00am 95% NP (RR 18, Temp 37.4C, HR 113).

41.44 At 1.00am, Mr Gee was attended to, and it was noted that he appeared to be comfortable. At 6.30am, oral care was attended to.

41.45 At 9.39am, a videoconference was held with Dr Sharma, Dr Kathiresan and Facility RNs. It was noted that Mr Gee continued to deteriorate and was given morphine and midazolam that morning, and that he looked comfortable. The family joined the videoconference. Dr Sharma noted the following plan *"comfort care, crisis medication as required, oral, eyecare, pressure care as required. Cease observations."*

41.46 At 11.30am, St Vincent's Hospital (SVH) nursing staff recorded the following after review:

> GCS 5/15 (E2ViM2). 4: patent, own, clear. B: spontaneous RR48bpm. C: warm to touch. D: minimum movement, responsive to pain. E: reddened area on bony prominence. Needs air mattress. F: Pt Nil BM (by mouth) as per orders. G: NA. Pt incontinent of urine and repositioned. EOL paperwork to be completed.

41.47 At 12.30pm Mr Gee was administered 2.5mg morphine and 2.5mg midazolam for "*EOL*" (end of life). At 1.54pm Mr Gee had a Whatsapp discussion with his sons, where they said their goodbyes. At 1.55pm, Mr Gee was on 3L of oxygen. He was washed and repositioned. At 4.30pm Mr Gee was administered 2.5mg morphine and 2.5mg midazolam for "EOL". An AIN note at an unknown time recorded that personal care was attended to, and that Mr Gee hardly ate breakfast, lunch or dinner. A progress note completed at 11.20 pm indicates that Mr Gee appeared comfortable at 7.30pm, but when she and RN McEntee checked him at 9.00pm, nil signs of life were noted.

41.48 Mark Gee was notified about an hour later. The following morning Mark received a call from Grant Millard offering condolences. It should be noted that Mr Millard similarly called the next of kin of each of the other residents who died during the outbreak within 24 hours to pass on his, and Anglicare's condolences, and to ask if there was anything that Anglicare could do to assist.

41.49 Mark Gee's evidence is that he holds no grievance against Newmarch House, but he does wonder whether his father's outcome would have been different if he was transferred to hospital and/or received the drip he asked about or explored other treatments.

MANNER AND CAUSE OF DEATH

41.50 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree Mr Gee's cause of death was COVID-19 lower respiratory tract infection. Contributing factors were diabetes, ischemic heart disease and more generally cardiovascular disease as well as atrial fibrillation and vascular dementia.

41.51 **Manner of Death**: The experts believed that his acute respiratory distress followed clear history of progressive infection involving the lungs associated with hypoxia, and that he transitioned to palliative care fairly quickly.

41.52 **Impact of any significant co-morbidities**: The experts opined that ischaemic heart disease, atrial fibrillation, diabetes and vascular dementia all had an impact.

41.53 **Issues with care received**: In general, Associate Professor Kotsimbos considered that Mr Gee was well supported with oxygen and he moved to palliative care fairly quickly and efficiently. Counsel Assisting noted that there are very poor records outlining precisely what dose of morphine was administered and there are many entries in the handwritten progress notes which appear not to have been chartered in the handwritten medication records. Associate Professor Kotsimbos did not consider there was anything more that could be done once Mr Gee became infected.

41.54 **Whether different action may have affected the outcome**: Possibly.

41.55 Associate Professor Kotsimbos considered whether Mr Gee's infection with COVID-19 could have been prevented because of the timing of his infection, noting that Mr Gee was diagnosed with COVID-19 eight days after the first case, so there had been propagation of infection. He further noted that Mr Gee's infective course was progressive and there was a clear history of progressive infection involving the lungs and subsequent hypoxia.

41.56 Professor Kurrle and Professor French agreed with Associate Professor Kotsimbos' comments on Mr Gee's COVID-19 course and management. However, Professor Kurrle noted that Mr Gee's family did make enquiries of taking their father out of Newmarch House on 27 March 2020, prior to his infection with COVID-19, and queried whether he may have "*done better at home*".

41.57 It is noted however that Mr Gee's express wish was not to be transferred to hospital and he appeared ready to be reunited with his wife who had died prior to his entry into Newmarch House.

41.58 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was David Gee.

Date of death

Mr Gee died on 28 April 2020.

Place of death

Mr Gee died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Gee's death was COVID-19 lower respiratory tract infection with vascular dementia, ischaemic heart disease, atrial fibrillation and type II diabetes mellitus being significant conditions which contributed to death.

Manner of death

Mr Gee died of natural causes following diagnosis of COVID-19 infection. Mr Gee was diagnosed on 18 April 2020, eight days after the index case at Newmarch House, following propagation of infection which indicates that his infection could possibly have been prevented. Following Mr Gee's COVID-19 diagnosis, he was provided with appropriate supportive care, and no other management steps could have been instituted which would have materially altered the eventual outcome.

42. Victor Stone

HEALTH

Co-morbidities

42.1 Victor Stone was 74 years of age when he passed away on 30 April 2020 at Newmarch House during the COVID-19 outbreak. He had a number of existing comorbidities including dementia, schizophrenia, hypertension, anxiety and depression and mild intellectual disability. Mr Stone also had a history of urinary tract infections. He was at increased risk of falls.

Background and events leading up to COVID-19 diagnosis

42.2 Mr Stone had previously lived with his mother and half-sister in poor circumstances with likely neglect. In August 2018, Mr Stone suffered a fall whilst walking home. A passer-by called for an ambulance and Mr Stone was taken to Nepean Hospital where he remained for approximately a month. Mr Stone was then transferred to Springwood Hospital for rehabilitation for approximately three months. During this time, he was diagnosed with dementia. Once Mr Stone was discharged from Springwood Hospital, his sisters Helen Porter and Cheryl decided that he needed full time care. Mr Stone was admitted to Newmarch House on 29 November 2018. After his entry into Newmarch House he was classified as "low care". He was shy and did not attend any social activities or events. He was independently mobile and required prompting with self-care.

RELEVANT MEDICATIONS

42.3 Mr Stone's regular medications included Adesan, Noten, paracetamol, vitamin D3, Zantac, sodium bicarbonate mouthwash and Systane. Mr Stone was also prescribed Candesartan-hydrochlorothiazide and Atenolol (Hypertension).

PRN Medication - Midazolam and morphine

42.4 On 17 April 2020, Nepean Hospital Virtual Aged Care Service (VACS) Nurse Practitioner (NP) Carpen prescribed Mr Stone morphine 2.5mg, midazolam 2.5 – 5mg, glycopyrrolate 0.2 – 0.4mg and metoclopramide 10mg. According to various records, Mr Stone was administered morphine on 24 April at 16.45pm and 22.47pm, for pain. An earlier note at 21:34 stated that at that time he was not conscious and unable to take medication. On 25 April at 12.57pm, Mr Stone was administered morphine for distress. At 12.44pm on 26 April, Mr Stone was administered morphine for '*distress high BP.*' He passed away four days later.

COVID DIAGNOSIS

42.5 Mr Stone took a combined nose/throat PCR test on 14 April 2020 at 3.53pm. It was found to be positive for COVID-19. Newmarch House Facility Manager, Melinda Burns, was informed of the result on 16 April 2020. The result was first recorded in Newmarch House progress notes at 6.14pm on 16

April 2020 and his family were informed at 8.34pm that day. Although Mr Stone's positive COVID-19 test result required him to remain in isolation, he continued to leave his room on multiple occasions.

ADVANCE CARE PLAN

42.6 Mr Stone did not have an Advance Care Plan (ACP). He did have an Enduring Guardianship. Mr Stone's next of kin (NOK) was his sister Helen Porter. Ms Porter noted that no matter how sick Mr Stone was, he did not want to go to hospital. An End-of-Life Pathway and Comfort Care Plan was prepared by Mr Stone with a Newmarch House registered nurse (RN) on 27 April 2020, three days before he passed away.

Discussions around ACP

42.7 On 17 April 2020 at 11.35am, GP Dr Dharmaratnam was involved in a remote teleconference with Mr Stones sister Helen, the notes of which record:

> Case Conf with VACS team/Helen [sister]- Informed about the status of his Covid test coming to be positive. Explained about the management protocol Hospital team will be providing care for her brother and will be updating us of his progress. If in case of him deteriorating, she does not want any intervention for Victor Thus, he is not for resuscitation, intubation, ICU admission or for hospital transfer She is wanting for him to be given comfort care at the nursing home She is wanting to know if there is a possibility for her to see her brother in case he deteriorates I have explained that I will get back to her or someone from the facility will explain the process in case he gets critical She is happy with the explanation

42.8 On 18 April 2020, RN Bestrin noted: "*Helen Porter contacted and updated on Victor's condition. ACP was discussed. Helen and her sister agreed to complete ACP form. Requested that ACP form be posted to Helen*". Helen did not receive this form.

42.9 In relation to an ACP Ms Porter gave evidence that she recalls a phone call where she was asked about whether her brother had an end-of-life care plan and she stated, "*He does not want to go to hospital because to him Newmarch was his home, and he wasn't leaving there no matter what.*"

42.10 Ms Porter also gave evidence that she has no recollection of ever being informed of options in relation to Mr Stone's care, and that she was not advised she would be sent a form, nor in fact ever received a form, namely an ACP form or End-of-Life Plan. She gave evidence that she was unable to make daily contact with Newmarch House for updates regarding her brother, however, when she did get through she was simply told he was comfortable. After her brother deteriorated, she was informed that he would be placed on morphine and oxygen, however, was not informed as to why he was receiving these medications.

PROGRESSION OF ILLNESS

42.11 Between 17 March 2020 and 29 March 2020, Mr Stone continuously reported to Newmarch House staff members and to Ms Porter that he had a headache and felt hot. On 22 March 2020, Mr Stone's observations were recorded: BP 157/95, P57, Temp 37.2C. On 26 March 2020, Ms Porter attended Newmarch House to visit Mr Stone and was informed that the facility was in lockdown.

16 April 2020

42.12 On 16 April 2020, Mr Stone's oxygen saturation levels were recorded once at 2.30pm, SpO2 97% (Temp 37C).

42.13 At 10.50am, Mr Stone was admitted to Hospital in the Home (HITH). At 3.09pm, Nepean Hospital's Dr Hemming appears to have conducted a review of Mr Stone's prior Nepean Hospital records from previous admissions, recording his comorbidities as listed, and recording the standard entry of *"Enrol in HITH. As per New protocol for HITH COVID-19 NH residents Await Aged care facility to send us up to date advanced care planning."*

17 April 2020

42.14 On 17 April 2020, Mr Stone's observations were recorded twice. First at 3.00am, SpO2 94% (Temp 37C, BP 113/64, P 60, RR 17), and then over 14 hours later at 5.46pm SpO2 93% (BP 166/103, P 75, RR 18, Temp 36.3C).

42.15 At 3.00am, RN Cardwell noted that Mr Stone had no respiratory symptoms and refused paracetamol initially, however, he requested it later in RN Cardwell's shift. Mr Stone reported that he had pain generally.

42.16 At 4.04pm, Nepean Hospital RN Sidney noted: "*patient reviewed by VACS today at nursing home. For HITH call tomorrow*". The clinical records of VACS NP Carpen's recorded at 4.38pm are ambiguous as to whether an in-person consultation actually took place. The observations recorded in the Nepean Hospital clinical records record the same exact same vital signs as those recorded at 3.00am. The notes end with *Anticipatory end of life medications ordered today, Advance care plan discussions were had with family by with Dr Manoj* [Dharmaratnam].

42.17 At 5.46pm, Newmarch House Clinical Educator Leslie Pearl Dominguez noted that Mr Stone had no cough or congestion, and that his sister informed her that Mr Stone asked for his Paracetamol frequently, and that it may have been due to his dementia. The notes record that Mr Stone left his room multiple times, in contravention of the lockdown isolation policy.

18 April 2020

42.18 On 18 April 2020, Mr Stone's vitals were recorded twice. First at 6.00am, SpO2 95% (BP 133/70, P 53, Temp 36.4C), then ten hours later at 4.00pm SpO2 96% (BP 157/88, P 62, Temp 37C, RR 20).

42.19 At 3.40am, Mr Stone was not administered Paracetamol. At 6.00pm, RN Cardwell noted "*paracetamol given as charted, iCare not showing as given*". At 2.40pm, a phone call was arranged between Mr Stone and Helen Porter. At 3.35pm, Nepean Hospital RN Haynes noted the following regarding the breakdown in communication between Nepean and Newmarch House:

> Have been in contact with care manager Leanne Hinton in regard to updates on all positive covid 19 residents. We required their observations, status and current condition but have so far been unable to obtain information. was informed that the RN from each ward would contact us in regards to their current condition however no contact has been made at time of report. Have also had a call

> from public health to see if we had been able to contact nursing home as they are having the same sort of issues trying to obtain Information. will attempt to contact Newmarch House again tomorrow.

42.20 At 4.00pm, Mr Stone was attended by RN Bhusal who noted that Mr Stone did not complain of pain or discomfort but complained of a slightly sore throat.

19 April 2020

42.21 On 19 April 2020, Mr Stone's observations were recorded five times. At 2.50am, SpO2 92% (BP 148/88, P 62, RR 19, Temp 36.7C), at 4.30am, SpO2 94% (BP 136/74, P 78, Temp 35.9C), at 11.15am, SpO2 94% (BP 139/75, P 79, RR 19, Temp 38.8C), at 7.57pm SpO2 93% RA (BP 139/81, P 79, RR 19, Temp 35.8C), and at 10.00pm SpO2 93% (BP 150/80, P 88, RR 18, Temp 36.2C).

42.22 At 2.50am, Mr Stone was located wandering in and out of his room, contrary to the isolation mandate. He initially refused paracetamol but requested it later that morning.

42.23 At 3.37pm, Nepean Hospital RN Sidney noted the continuing communication breakdown between Newmarch House and Nepean Hospital.

> *Have attempted to call nursing home on three different numbers with no answer. one of the people called was the case manager Leanne Hinton who also didn't answer the phone so a message was left for her to contact outreach when possible. no return call ATOR. have also called the VACS on call to find out if there is any way of getting Information on the residents and she advised that if there was anything major with any of them she would advise us. if possible could we get a system in place where the AN from each ward where the residents are located call outreach and just give a quick update on each patient when that RN has time to do so. or even one person from the nursing home give outreach a call with an update on each patient.*

42.24 At 4.30am, Mr Stone used his buzzer and was found kneeling on the floor and unable to stand up without assistance. He denied pain. It is unclear from the records whether the nursing staff reviewed Victor again that evening.

20 April 2020

42.25 On 20 April 2020, Mr Stone's observations were recorded twice. First at 11.00am, SpO2 90% (BP 120/70, P 80, RR 17, Temp 36.7C), and then eleven hours later at 10.00pm SpO2 90% (BP 113/72, P 80, RR 18, Temp 35C).

42.26 At 12.30am, an unknown RN noted that Mr Stone was afebrile, asymptomatic and had stable observations.

42.27 At 2.42pm, a Nepean Hospital HITH RN noted that Mr Stone was asymptomatic, based on a remote review of the Newmarch progress notes.

42.28 At 5.48pm, VACS NP Carpen recorded her remote review of the Newmarch records and recorded *"Mr Victor Stone 74 year old man with a new diagnosis of COVID19 under the care of HITH Unable to contact facility today Remote review of the notes Remains Asymptomatic Unfortunately no observations recorded today. Please perform a set of observations Will review again tomorrow."* However, the 'Vital Signs' chart does record observations, namely at 11am.

21 April 2020

42.29 On 21 April 2020, Mr Stone's observations were recorded once at 4.43pm SpO2 95% (BP 154/91, P 95, Temp 35.2C).

42.30 At 12.00am, an unknown RN noted that Mr Stone was assisted into bed in the evening and stated he was thirsty and refused to put his bedsheets on. At 4.24pm, Nepean Hospital administration officer, Dale Narelle Eather, noted: "*Pt observation below obtained from Newmarch N/H progress notes, accessed by Hailey Carpen VACS team. T35.9C*". At 4.25pm, VACS NP Carpen recorded in the Newmarch House progress notes that "*Review of line listing from facility Remains afebrile today, Remains asymptomatic Will review again tomorrow*". No face to face consultation appears to have taken place.

42.31 At 5.47pm, RN Dean acknowledged an alert that Mr Stone's diastolic blood pressure was out of normal range. RN Dean noted Mr Stone remained asymptomatic. At 6.20pm, Newmarch House manager Melinda Burns contacted Ms Porter to provide an update on Mr Stone following the VACS team review.

22 April 2020

42.32 On 22 April 2020 Mr Stone's observations were recorded five times. At 1.00am, SpO2 91% RA (BP 123/7[?], P 69, Temp 36.4C), at 5.45am, SpO2 96% RA (BP 125/87, P 82, Temp 36.7C), at 9.35am SpO2 90% RA (BP 166/93, P 61, RR 18, Temp 36.8C), at 2.25pm, SpO2 91% RA (BP 168/78, P 73, RR 18, Temp 36.6C), and at 11.00pm, SpO2 90% RA (BP 128/66, P 76, Temp 36.6C).

42.33 At 1.00am, Mr Stone was noted to be coughing, but had no shortness of breath or pain. He refused dinner. At 10.04am, Mr Stone was located on the floor. Redness to his forehead was noted. Ms Porter was updated, and she stated that Mr Stone rolls out of bed when trying to ambulate.

42.34 At 10.18am, it appears Dr Kakkat reviewed Mr Stone in person and noted: "*Victor had a fall today. Slipped from bed. No signs of head injury No pain Wt bearing OK No external injuries Chest clear Plan Monitor the patient*". An earlier entry by an agency nurse at 10:04am recorded "*Redness on forehead?*"

42.35 At 3.00pm, Mr Stone was again located on the ground. He reported pain in his legs. He was provided Panadol after refusing morphine. Ms Porter was informed. At 3.34pm, Nepean Hospital RN Smith noted: "*Contacted VACS team. Team are currently reviewing COVID patients at Newmarch House. Team will fax details of patients and their condition when finalised to HITH*".

42.36 At 5.50pm, RN Dean acknowledged an alert that Mr Stone's blood pressure was out of the normal range. His regular medications were given. At 11.00pm, RN Cenizal noted that Mr Stone was found on the floor lying beside his bed. No injuries were observed, and it was noted that he was not taking anticoagulants.

42.37 On three occasions on 22 April 2020, Mr Stone was located on the floor in his room. Delirium had not been excluded as the cause. There is no evidence that this was raised or escalated for review by a medical practitioner after the first fall at around 10am. There is a record stating "*check for UTI*" but there is no evidence to suggest this was done.

23 April 2020

42.38 On 23 April 2020, Mr Stone's observations were recorded three times. First at 10.35am, SpO2 92% (BP 156/89, P 88, RR 26, Temp 36.8C), then at 1.00pm SpO2 95% (BP 108/70, P 73, RR 22, Temp 36.6C), and again at 4.15pm SpO2 93% (BP 124/77, P 67, RR 24, Temp 36.6C).

42.39 At 10.40am, RN Cardwell noted that Mr Stone communicated "*at baseline. Sore throat and slight lethargy.*" At 4.25pm, RN Cardwell noted that Mr Stone was sitting in his chair. He was prompted to consume fluids and had a slightly increased respiratory rate, however he did not appear to be in distress.

24 April 2020

42.40 On 24 April 2020, Mr Stone's observations were recorded twice. First at 6.00am, SpO2 90% (BP 156/85, P 83, Temp 37.8C), then over 14 hours later at 8.30pm SpO2 89% (BP 129/62, P 92, RR 20, Temp 36.2C).

42.41 At 3.59am and 4.27pm, RN Dean acknowledged alerts that Mr Stone's systolic blood pressure was out of the normal range. At 4.31pm, Nepean Hospital RN Malaihollo noted: "*Pt d/c from HITH. VACS aware. Follow up 2nd daily as per NUM*". At 7.45pm, records note "*unsure of normal state. But not opening eyes or obeying commands. Managed to take meds crushed with yoghurt. Needs regular oral care*". At 8.50pm, Mr Stone was responding to minimal pain stimuli and "*LMO notified earlier this PM. Rt. For comfort measures and given morphine PRN*". At 4.45pm, and 10.47pm, Mr Stone was administered morphine for pain.

25 April 2020

42.42 On 25 April 2020, Mr Stone's observations were recorded four times. At 1.10am, SpO2 was not recorded (BP 112/82, P 63, RR 20, Temp 36.3C), at 2.15am, SpO2 91% (B P170/75, P 55, RR 12, Temp 36.4C), at 11.18am, SpO2 94% on 3L (BP 120/52, P 71, RR 19, Temp 36C), and at 5.42pm, SpO2 91% on 2L (BP 125/81, P 58, Temp 37.1C).

42.43 At 3.25am, an unknown RN noted:

> VACS team notified of Victors decreased level of consciousness, LMO stated to provide oxygen 2-3L Via Nasal prongs and to provide morphine. RN called Victors Sister Helen, Helen stated that she did not want to come in to see Victor but wanted regular updates. Helen has called x 2 and spoken to

RN regarding Victors condition several times throughout the evening. Victor has been settled in bed on 3L of oxygen via nasal prongs evening medical withheld as Victor would not be able to swallow.

42.44 At 12.50pm, Mr Stone's Glasgow Coma Scale score (GCS) was 9 (defined as moderate head injury). It was observed that he did not appear to be in respiratory distress, but a mild cough was present. His respiratory rate was 20. At 12.57pm, Mr Stone was administered morphine for distress. At 2.04pm, Mr Stone was diagnosed with a respiratory tract infection. It was noted that Mr Stone was "*…initially asymptomatic however symptoms presented on 23/4/2020 and he is currently receiving ongoing management of infection with VACs team HITH, GP and nursing staff. PHU/Dept health aware of positive results."*

42.45 Counsel Assisting noted that save for the administration of oxygen there is no record in the clinical notes which reflects management of Mr Stone's respiratory infection. No antibiotics were prescribed or administered.

42.46 At 8.55pm, Ms Porter was informed that her brother Mr Stone was not doing well.

26 April 2020

42.47 On 26 April 2020, Mr Stone's observations were recorded twice. First at 5.00am, SpO2 93% (Temp 36.2C, P 71, R 22, BP 139/79), and then at 8.00am SpO2 92% (Temp 36.4C, P 80, RR 21, BP 160/90).

42.48 At 2.02am, Mr Stone responded to voice and touch by groaning. He showed no signs of shortness of breath or "*SOB*". At 12.44pm, he was administered morphine for "*distress high BP*". Between 2.41pm and 2.48pm, Mr Stone was not administered Noten, Zactin and Adesan due to an inability to swallow. At 3.50pm, RN Austin noted *"Pt remained RIB throughout shift. Warm + well perfused, gcs 9, non-verbal, limbs flexing. Pad changed as PU. Sacral PA risk – skin blanching, sudocream applied. Pt's sister Helen phoned & update*." At 9.20pm, Assistant In Nursing (AIN) Sydney noted that Mr Stone's observations were taken, however no results were recorded.

27 April 2020

42.49 On 27 April 2020, Mr Stone's observations were recorded six times. At 1.30am SpO2 was not recorded (P 60, RR 18), at 6.05am, SpO2 91% (Temp 36.7C, P 85, RR 24), at 8.00am, SpO2 94% RA (Temp 36.4C, P 79, RR 28), at 2.00pm, SpO2 94% (RR 22), at 4.10pm, SpO2 93% RA (Temp 36.7C, P 84, RR 26, BP 122/105), and at 9.00pm, SpO2 90% (Temp 37.1C, P 80, RR 25).

42.50 At 3.59am, Nepean Hospital Nursing Unit Manager (NUM) noted: "*patient continues to* [be] *followed up by VACS team. VACS to contact HITH/outreach ID team as required*". The clinical records do not disclose any face to face or telehealth review of Victor Stone between the date of his diagnosis on 16 April 2020 and this entry of 27 April 2020, a period of 11 days. The 'follow up' appears to be limited to remote review of clinical records and a direction to administer oxygen.

42.51 On 28 April 2020, Mr Stone's observations were recorded five times. At 5.30am 92% (Temp 35.6C, P 78, RR 22), at 8.30am 91% (Temp 37C, P 65, RR 16, BP 93/65), at 11.50am, SpO2 91% RA (RR 24, Temp

37C), at 4.00pm SpO2 92% (Temp 36.5, P 75, RR 14), and at 9.00pm SpO2 94% (Temp 36.7C, P 84, RR 22).

42.52 At 3.13pm, Mr Stone remained non-verbal and did not show any obvious signs of distress or discomfort. His oxygen saturation was 90%. At 9.34am, Mr Stone was attended by a physiotherapist who noted that Mr Stone was non-communicative, but appeared comfortable with no facial grimaces. He was placed on an air mattress. At 11.50am, the first review of Mr Stone by VACS took place, via videoconferencing, but it is unclear whether this took place at his bedside:

> Videoconference with Dr Sharma, Dr Kathieresan, Facility RN's COVID+ve resident Deteriorating, Limited oral intake Note oral thrush Decreased level of consciousness P65 AA24.Sp02 91 % on RA, T37 Plan Nil stat oral Push oral fluids Oral cares

42.53 At 3.00pm and 7.00pm, Mr Stone was unable to take his medications as he remained unresponsive. It was noted that Mr Stone was on end-of-life care. Ms Porter was updated on Mr Stone's condition.

29 April 2020

42.54 On 29 April 2020, Mr Stone's observations were recorded twice at 3.00am, SpO2 was not recorded (P 100, R R24), and at 4.30am, SpO2 90% (Temp 36.4C, RR 16).

42.55 At 10.30am, Ms Porter spoke to Mr Stone who did not verbally respond. At 11.55am, a doctor attended upon Mr Stone. The details of that examination and assessment are unknown, as no records were made. Between 1.32pm and 1.59pm, Mr Stone was not administered Zactin, Noten, Paracetamol, Adesan and Vitamin D3 due to Mr Stone having a low level of consciousness. At 6.30pm, staff at Newmarch House contacted Ms Porter and provided her with an update on Mr Stone's progress.

30 April 2020

42.56 At 10.10am, VACS Aged Care Nurse noted: "*Video conference with Dr Sharma, Or Kakkat, Dr Kalhiersen, Dr Sehil and Facility RN's Victor resting in bed Continues to deteriorate Looks comfortable Oral thrush Plan continue supportive care – nil stat for thrush.*" At an unknown time, an unknown RN noted: "*nil obs – however resting comfortably*".

42.57 At 3.10pm, Newmarch House staff attended upon Mr Stone, and he was found deceased. At 3.25pm, Newmarch House staff contacted Ms Porter to advise her of her brother's death.

MANNER AND CAUSE OF DEATH

42.58 **Cause of Death**: Associate Professor Kotsimbos and Professor Kurrle considered that Mr Stone's cause of death was COVID-19 lower respiratory tract infection. Professor Kurrle considered his background of dementia and schizophrenia to be relevant to the cause of death in terms of Mr Stone's ability to understand what was happening to him.

42.59 Professor French could not say that COVID-19 was the clear cause of death. Professor French noted that Mr Stone had a significant number of mechanical falls that may have been a possible alternative

cause of his death. That is, a neurological diagnosis arising from a head injury of some description causing some sort of intracranial pathology leading to death. Professor French raised this as an alternative cause of death given Mr Stone's relatively long delay between his positive COVID-19 diagnosis and his death (approximately 16 days), and noted that Mr Stone did not have severe symptoms of COVID-19 infection (only a slight temperature and a bit of a cough and sore throat). Mr Stone then seemed to quickly deteriorate after 23 April 2020. In those circumstances, Professor French indicate that he "*kept [his] mind open to other potential diagnoses*" but noted that "*it may be that COVID-19 caused [Mr Stone's] death*". In the absence of clear evidence from investigations that Mr Stone had sustained intracranial pathology which contributed to death, it is most likely that the cause of his death was COVID-19 infection.

42.60 **Manner of Death**: The experts note that Mr Stone passed away 16 days after a positive COVID test but his symptoms were only ever mild. His deterioration was primarily after three falls on 22 April 2020, although there had been a long gradual decline prior to this. He remained afebrile with relatively mild symptoms of headache, cough and sore throat until about 23 April 2020. From 23 April 2020, Mr Stone displayed signs of increasing lethargy. From 24 April 2020, Mr Stone was administered morphine. From 24 April 2020 Mr Stone was showing signs of tachypnoea and hypoxia requiring increasing oxygen supplementation. He became unresponsive on 28 April 2020.

42.61 **Impact of any significant co-morbidities**: Dementia and schizophrenia affected his ability to understand what was happening.

42.62 **Issues with care received**: Associate Professor Kotsimbos considered that oxygen therapy and overall management was generally good including his end-of-life care. However, because of the lack of documentation, Associate Professor Kotsimbos considered that it was difficult to know whether there were other factors contributing to Mr Stone's death, such as the various falls around 22 April 2020. The experts noted that Mr Stone could have been transferred to hospital for investigation and management of a possible intracranial haemorrhage, but the head injury observations did not indicate the need for this, and the risk of a bleed was less than in an older person or someone on anti-coagulants.

42.63 **Whether different action may have affected the outcome**: No.

42.64 Associate Professor Kotsimbos did not think that there was anything further that could have been done to change Mr Stone's outcome. Associate Professor Kotsimbos noted that Mr Stone was diagnosed with COVID-19 infection on 14 April 2020, placing him in the first wave of COVID-19 infections at Newmarch House, and therefore infection could not have been prevented. Professor Kurrle and Professor French agreed with Associate Professor Kotsimbos' analysis of Mr Stone's treatment whilst infected with COVID-19 and his manner of death.

42.65 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Victor Stone.

Date of death

Mr Stone died on 30 April 2020.

Place of death

Mr Stone died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Stone's death was COVID-19 lower respiratory tract infection with dementia and schizophrenia being significant conditions which contributed to death.

Manner of death

Mr Stone died of natural causes following diagnosis of COVID-19 infection. Whilst investigations may have been performed to investigate the possibility of intracranial pathology following falls suffered by Mr Stone around 22 April 2020, subsequent observations provided no clinical indication for transfer to hospital for these investigations to be performed. Although there is a paucity of documentation during this period of time, it appears that the supportive care provided to Mr Stone was appropriate, and no other management steps could have been instituted which would have materially altered the eventual outcome.

43. Ann Fahey

HEALTH

Co-morbidities

43.1 Ann Fahey was 76 years of age when she passed away on 2 May 2020 at Nepean Hospital following her transfer from Newmarch House during the COVID-19 Outbreak. She had a number of existing comorbidities namely a mild cognitive impairment and transient ischemic attack (TIA), ischemic heart disease (IHD), congestive cardiac failure (CCF), chronic obstructive pulmonary disease (COPD), cervical spine pain, hypertension and osteoarthritis. Mrs Fahey also had a number of other health conditions including ischemic gangrene of the feet, delirium, headache disorder, viral illness, anxiety, sinusitis and migraine. Mrs Fahey had previously undergone a cholecystectomy and was an ex-smoker.

Background and events leading up to COVID-19 diagnosis

43.2 Mrs Fahey had been living alone and was not eating well or looking after herself prior to her entry into Newmarch House on 30 November 2017. She was independently mobile and enjoyed socialising with other residents in the café and communal spaces. She appeared happy to call Newmarch House her home.

RELEVANT MEDICATIONS

43.3 Mrs Fahey was prescribed a number of regular medications including Alprim, Axit, Betavit, Bispro (IHD/CCF), Cardasam Colese, cranberry, Eliquis (Mild Cognitive Impairment and TIA), Lorstat, Motilium, Moxicid, Nupentin, paracetamol, Span K, Targin, vitamin D3, Cystitis Relief, Hirudoid cream, Lamisil, Novasone ointment, Refresh tears eye drops, Solveasy tinea cream, Clonea, Endone, Gaviscon Dual Action oral liquid, Nitrolingual spray, Temaze and Ventolin inhaler (COPD). Mrs Fahey was also prescribed Gabapentin and Targin for her cervical spine pain.

PRN Medication - Midazolam and morphine

43.4 Mrs Fahey was not prescribed anticipatory medications such as morphine or midazolam.

43.5 She is the only resident who had tested positive to COVID-19 at Newmarch House who was not prescribed these drugs. The evidence suggests that this was simply an oversight rather than a deliberate clinical decision. Counsel Assisting noted that she had no allergies that would prevent their prescription.

COVID DIAGNOSIS

43.6 On 14 April 2020, Mrs Fahey took a combined nose/throat PCR test. It was found to be negative. Mrs Fahey took further combined nose/throat PCR tests on 17 April 2020, 20 April 2020 and 23 April 2020, which were all found to be negative. A nasopharyngeal swab was taken on the morning of 29 April 2020. There are no examination results produced for Mrs Fahey's positive COVID-19 test result

however the result was first recorded in the Nepean Hospital Virtual Aged Care Service (VACS) progress notes at 12.28pm following a videoconference where Mrs Fahey was noted to be alert and there was a plan for 'supportive care' and a need for an 'ACD'. Subsequently a record was made in the Newmarch House progress notes at 4.20pm on 30 April 2020. Newmarch House staff members did not contact Ann Fahey's son Mark Fahey to inform him of the result, and he learnt of the result accidentally during a phone call that day.

ADVANCE CARE PLAN

43.7 Mrs Fahey completed an Advance Care Plan (ACP) with her usual GP, Dr Amir, on 20 November 2018. It stated that Mrs Fahey did want cardiopulmonary resuscitation (CPR) and did want to be kept alive by being fed artificially. Oral antibiotics were to be administered. Mrs Fahey did want to be transferred to hospital if medically indicated. The ACP noted "*needs medical r/v if she deteriorate*s". This ACP was confirmed in Mark Fahey's oral evidence.

43.8 The Newmarch House records also contain a second copy of the first page of the ACP, once again ticking the box "*I DO want to be transferred to hospital if medically indicated*."

43.9 Mrs Fahey also had a Resuscitation Plan dated 2 November 2017. It stated that Mrs Fahey was to be resuscitated unless she verbalised otherwise. Mark Fahey gave further evidence that he did not fill out an ACP for his mother during the COVID Outbreak period, nor was he sent a form. His belief was that the position had not changed from the signed documents dated 2018, which stated that Mrs Fahey wanted to be transferred to hospital if it was medically indicated and was to be reviewed if she deteriorated.

43.10 The family believed at all times that the aforementioned ACP and Resuscitation Plan remained in place after their mother contracted COVID.

43.11 Of note is a record of 2 May 2020 at 8.48am by Medical Intern Ezra Suria upon Mrs Fahey's transfer to hospital which records as follows:

> … Discussed at morning handover with EDSS Saw Her advanced care directive is unclear
>
> Verbally ED was told that this patient is not for CPR or ICU and is only transferred for Investigation with a CTB Documentation that accompanied patient was not clear
> - it Is documented that she is only for symptomatic treatment in context of COVID, but for treatment of reversible causes in context of other pathologies (paraphrasing as documentation is in contaminated area with patient)
>
> - there is another documented ACD which states she is for CPR, for parenteral nutrition, IV Abx, as well as transfer to hospital Given the uncertainty above it was decided that she is still for full measures
>
> …….
> Sons number obtained by clerical staff D/W Mark Fahey (son)
> he states that she is for all interventions including ICU and intubation…….

43.12 Counsel Assisting noted that the documentation which followed Mrs Fahey to hospital includes Dr Kakkat's progress note of 1 May 2020 at 1.34pm and Dr Amir's progress note of 30 April 2020. These notes are outlined below, along with Mrs Fahey's ACP, which arguably would result in confusion by the admitting team at Nepean Hospital. The issue in this case is that Mrs Fahey's family do not believe the clinical records of Dr Kakkat and Dr Amir accurately reflect Mrs Fahey's capacity to make decisions, or the family's express wishes for full intervention and hospital transfer.

Discussions around ACP

43.13 Mark Fahey gave evidence that on 30 April 2020, after he became aware of his mother was COVID-19 positive, he made a call to Newmarch House and expressed his concerns to Dr Kakkat. Dr Kakkat informed him that the mortality rate for COVID-19 was 60% and that his mother would be more comfortable where she was, rather than being taken to hospital. Mark Fahey gave evidence that Dr Kakkat informed him that *"because his mother had COVID-19 she in fact <u>could not</u> go to hospital."* Dr Kakkat asked to confirm that Mrs Fahey had a Do Not Resuscitate Plan in place, which was incorrect.

43.14 At 12.12pm on 30 April 2020 VACS Aged Care Nurse Practitioner (NP) Hailey Carpen notes the following:

> Videoconference with Dr Sharma, Dr Kakkal, Dr Kathiresan, Or Sahil and Facility RN's COVID +ve resident…
> Plan
> - for supportive care
> - Needs ACD
> ADDIT:
> GP contacted to complete ACD
> GP informed Dr Kathiresan that the family felt they need more time to make a decision Dr Amir will discuss ACD with Mrs Fahey and document their discussion

43.15 On the same day, at 1.33pm, Dr Kakkat's recollection of the conversation was recorded in the progress notes as follows:

> Advance Care Directive is discussed with son Mark Fahey. Mrs Ann Fahey is with COVID 19+ve. She will be treated in the nursing home for COVID 19. Symptom treatment only. She may be transferred to hospital for any other disease like fall, other bacterial infection etc. BP127/82, Sao293%, T 36.2, Resp 18/min.

43.16 At 3.00pm, Dr Amir recorded the following in the Nepean clinical records:

> Just recently and has been diagnosed with COVID 19 positive Discuss with her family with Mark about his mom condition and Discuss about the advanced care plan Mark prefer to discuss the conditions with his mother. In my opinion the patient she is able to take a decision and can advise about her conditions and we can depend on her opinion for the advanced care plan if her son not willing to have the decision (added emphasis).

43.17 Mark Fahey gave evidence that he "*disagreed entirely*" with the above entry regarding his mother's ability to make decisions about her ACP at that point in time. There is no evidence that Dr Amir had any previous dealings with Mrs Fahey in order to assess what her usual baseline was, and there was

no evidence as to the length of his consultation with Mrs Fahey to assess the reliability of his opinion that she was capable of making a decision about her ACP. Further, there is no evidence (save for what Dr Kakkat told Mark Fahey) as to what information Mrs Fahey was given about her diagnosis, prognosis, expected illness trajectory, treatment plan and what medical management she could receive at Newmarch House to inform her decision making in relation to her ACP.

43.18 The following day on 1 May 2020 at 4.02pm a Locum Medical Officer (MO) examined Mrs Fahey and noted that she had a fall the previous day as well as diarrhoea over the last two days. The recorded note also states that Mrs Fahey was unaware of her COVID-19 positive status, although there was no evidence of delirium at that time which might explain her present 'unawareness' (assuming she had been informed the day before that she was COVID-19 positive). Mrs Fahey was noted to be confused and lethargic in the morning. A discussion was had with Dr Sharma and the note records that VACS was to update Mrs Fahey's 'ACD' and speak with her family.

43.19 The progress notes contain a subsequent untimed note by an RN that records that Mrs Fahey continued to appear confused and lethargic in the morning, with saturations at 83% and recorded that "*on Dr ** to continue care at Newmarch as Ann would not like to go to hospital. O2 therapy increased to 4L*". At 5pm, Mrs Fahey participated in a WhatsApp family videocall. Mark Fahey noted that Mrs Fahey appeared slightly confused and was not herself. At 6pm, Mark Fahey appeared on the Channel 7 news with a pre-recorded interview. He believes the airing of this interview on television is the reason why Mrs Fahey was transferred to Nepean Hospital the following morning.

43.20 Mark Fahey gave evidence that in the 48 hours leading up to his mother's death he felt that his mother was certainly confused, and that he would not be comfortable with her having a direct conversation with a doctor about her ACP in his absence. Counsel Assisting noted that the RN's note and the entry at 4pm on 1 May 2020 written by the Locum MO supports Mark Fahey's evidence that his mother was not capable of making decisions for herself at this time, given her state of confusion.

43.21 Mark Fahey further gave evidence that the family was told she would be cared for until the end under Hospital in the Home (HITH) and that in response to a question "*is it correct that your mum is not to be revived or resuscitated?*" his reply was "*Absolutely* [not]*, give her every chance, this is incorrect information*". The family were in disbelief that this suggestion was being made.

43.22 Associate Professor Kotsimbos' opinion was that there was relatively poor end of life management on multiple levels. The ACP and Resuscitation Plan for Mrs Fahey was somewhat ambiguous, and it was not clear that treating doctors, Mrs Fahey and Mark Fahey, understood their terms in the same way, resulting in "*slippage*" in interpretation. In his expert opinion, this was further confounded by the clinical assessment, diagnostic likelihoods, and management options regarding the risks and benefits and communication with family of Mrs Fahey's deteriorating state.

43.23 On balance, the evidence supports a finding that Mrs Fahey's ACP, and her and her family's express wishes regarding early transfer to hospital as soon as it was medically indicated, were not followed. Her transfer to hospital occurred after the family had turned to the media, although there is no evidence that this was the reason for Mrs Fahey's transfer. However, it remains the case that the intent of Mrs Fahey's ACP was not adhered to.

PROGRESSION OF ILLNESS

23 April 2020

43.24 During the morning, Mrs Fahey vomited and the notes record that as a result staff had commenced isolation procedures as a precaution. This is a curious entry given the Outbreak was declared on 10 April 2020 and all residents were required to isolate, in theory, from this time. It implies breaches of infection control protocols by some residents were occurring which Counsel Assisting noted was certainly the case with respect to Victor Stone and Barry Jehan leaving their respective rooms. At this stage her PCR tests were all negative and she appears to have next been tested 6 days later on 29 April 2020.

25 April 2020

43.25 On 25 April 2020, Mrs Fahey's observations were recorded once at 5.00pm, SpO2 95% (RR 15, BP 132/76 HR 62, Temp 36.6C). It was recorded that Mrs Fahey had no respiratory issues but complained about having gastro. As no repeat PCR test was performed at this stage it is unclear what Mrs Fahey's COVID-19 status was at this point.

26 April 2020

43.26 On 26 April 2020, Mrs Fahey's observations were recorded twice at 9.21am, SpO2 95% (BP 115/62, P 64, Temp 36.5C, RR 18), and at 3.40pm, SpO2 95% (BP 114/66, P 70, Temp 36.4C, RR 18). As no repeat PCR test was performed at this stage it is unclear what Mrs Fahey's COVID-19 status was at this point. She was checked by a carer/nurse at 5.30pm and required no assistance.

27 April 2020

43.27 On 27 April 2020, Mrs Fahey's observations were recorded four times. At 5.30am, SpO2 96% (BP 121/67, P 70, Temp 35.6C, RR 16), at 9.30am, SpO2 96% (BP 135/84, P 74, Temp 36.7C), at 2.30pm, Spo2 94% (BP 146/74, P 69, Temp 36.4C, RR 18), and at 9.30pm SpO2 95% (BP 127/77, P 66, Temp 36.3C, RR 18). As no repeat PCR test was performed at this stage it is unclear what Mrs Fahey's COVID-19 status was at this point. At 2:30pm she was assisted by care staff with activities of daily living (ADLs) and no complaints were reported.

28 April 2020

43.28 On 28 April 2020, Mrs Fahey's observations were recorded three times at 6.00am, SpO2 was not recorded (Temp 36.2C), at 11.30am, SpO2 96% (BP 143/99, P 76, Temp 36C, RR 18), and at 9.00am, SpO2 97% (BP 111/72, P 61, Temp 36.2C, RR 16). As no repeat PCR test was performed at this stage it is unclear what Mrs Fahey's COVID-19 status was at this point. At 5.30pm when attended to by a nurse, Mrs Fahey reported that she was 'not herself', but was eating well with no pressure injuries.

29 April 2020

43.29 On 29 April 2020, Mrs Fahey's observations were recorded four times: first at 6.00am, SpO2 92% (BP 154/83, P 83, Temp 36.3C, RR 20), then at 7.30am, SpO2 96% (BP 132/76, P 83, Temp 36.5C, RR 16), at 4.30pm, SpO2 94% (BP 131/83, P 72, Temp 36.9C), and at 8.30pm, SpO2 95% (B P143/80, P 72, Temp 36.6C, RR 21). A PCR test was performed sometime prior to 9am. She ate breakfast and lunch and bathed and spoke with family on the phone resulting in an improvement in mood.

30 April 2020

43.30 Mrs Fahey's observations were recorded seven times: at 5.30am, SpO2 92% (BP 164/79, P 89, Temp 36.6C, RR 20), at 6.00am, SpO2 92% (BP 154/81, P 83, Temp 36.6C, RR 22), at 6.30am, SpO2 93% (BP 138/80, P 87, Temp 36.6C, RR 22), at 7.30am SpO2 96% (BP 133/77, P 91, Temp 36.7C), at 8.30am SpO2 91% on RA, (BP 154/79, P 103, RR 21, Temp 38.9), at 9.15am SpO2 was not recorded (Temp 38.2C), twelve hours later at 9.00pm, SpO2 89% on 2L 02, (BP 108/65, P 73, Temp 36.2C, RR 19), and at 11.00pm, SpO2 82% on RA.

43.31 At 5.30am Mrs Fahey was found seated on the floor in her room by nursing staff. She stated that she lost her balance whilst returning from the bathroom and as she felt she was going to fall, she lowered herself to the floor. She was afebrile and did not complain of pain and no injury noted.

43.32 At around 8.30am Dr Amir completed a Glasgow Coma Scale review resulting in a score of 14/15, defined as a mild head injury. An Accident and Incident Form stated that the unwitnessed fall was a category 4, Minor and "*Hospital Transfer not Required*". Mark Fahey gave evidence that he did not know that a Glasgow Coma Scale had been performed on his mother after the fall and that on preliminary testing she graded 14/15.

43.33 At 10.05am Newmarch House contacted Mark Fahey and informed him of Mrs Fahey's fall, and that her temperature was 38.9C. Mark Fahey then contacted Mrs Fahey who told him she sat on the floor after feeling dizzy, she had a sore back, felt cold and it was difficult to breathe. At a later time in the morning, Mark Fahey contacted Newmarch House and asked how Mrs Fahey was. The staff member stated "*oh, don't you know I am not dealing with Mum anymore as she's positive for COVID-19*". That is how he learnt of his mother testing positive to COVID-19.

43.34 At 12.12pm, a video conference with Dr Sharma, Dr Kakkat, Dr Kathiresan, Sahil and Facility RN's took place and the notes record "*Resting in bed, alert, having lunch Feels tired Denies cough, or sore throat*." The plan was for supportive care needs and contact regarding the 'ACD' which Dr Amir followed up as outlined above in these submissions under the ACP discussion. No mention is made in the notes to fall, or the assessment by Dr Amir, or any planned re-assessment.

43.35 At 4.20pm it was recorded in the Newmarch House handwritten notes that Mrs Fahey had tested positive for COVID-19. At this time, a physiotherapist attended to Mrs Fahey and noted that she was febrile, had some shaking and hey eyes were rolling back in her head. At 4.23pm, Mrs Fahey was administered Endone. At 11.00pm, Mrs Fahey denied any pain or discomfort. Her temperature was recorded as 36.2 – 36.4C and she was saturating at 82% oxygen in RA and commenced on 2L O2 via

Nasal Prongs, which increased her saturation to 89%. Counsel Assisting noted that these saturation levels place her well below the normal range of at least 92-93%.

1 May 2020

43.36 On 1 May 2020, Mrs Fahey's observations were recorded six times. At 1.00am, SpO2 was not recorded (Temp 36.4C), at 5.30am, SpO2 92% on 2Lpm (BP 143/72, P 93, RR 16), at 10.00am, SpO2 93% RA (BP 127/82, P 91, Temp 36.2C, RR 18), at 1.20pm, SpO2 83% (BP 93/53, P 83, Temp 35.8C, RR 23), at 1.33pm SpO2 93% (BP 127/82, Temp 36.2C, RR 18 (Dr's note) at 3.00pm, SpO2 87% on 3L NP (BP 88/56, P 97, Temp 36.3C, RR 24), at 8.10pm, SpO2 92% on 2L NP (BP 109/60, P 85, Temp 36.5C, RR 20).

43.37 At 1.30am, it was noted that Mrs Fahey experienced no coughing or respiratory distress. She had an episode of diarrhoea. At 6.45am Mark Fahey indicated he wished to speak to the GP as the family were interested in having Mrs Fahey transferred to hospital. At 1.33pm, Dr Kakkat noted her observations as being BP127/82, SaO2 93%, T 36.2, Resp 18/min. He spoke with Mark Fahey and recorded that conversation (as outlined above) as follows "*Advance Care Directive is discussed with son Mark Fahey. Mrs Ann Fahey is with COVID 19+ve. She will be treated in the nursing home for COVID 19. Symptom treatment only. She may be transferred to hospital for any other disease like fall, other bacterial infection etc* (emphasis added)."

43.38 At 2.40pm, a nursing attendance noted no signs of respiratory distress, breathing naturally with 2L of oxygen via nasal prongs, nil complaint of pain or discomfort; tolerating some food, and that Mrs Fahey appeared settled with no complaints.

43.39 At 4.02pm on 1 May 2020 a Locum Medical Officer examined Mrs Fahey and noted the fall from the previous day as well as diarrhoea over the last two days and Mrs Fahey's *unawareness* of her COVID-19 positive status. There was no evidence of delirium at that time to explain her lack of awareness as to her COVID-19 result. Mrs Fahey was noted to be confused and lethargic in the morning. Her observations were stable, she was afebrile, had a clear chest, and she was assessed as having a mild diarrhoea illness with no significant dehydration, which was considered likely to be due to her COVID-19 diagnosis. Mrs Fahey was not immediately transferred to hospital. A discussion was had with Dr Sharma and the note records that VACS was to update Mrs Fahey's ACD and speak with her family.

43.40 At 5pm Mark Fahey states that he participated in a Whatsapp video call with his mother where she appeared confused and unable to answer certain questions.

43.41 Following this entry an untimed entry by RN Vincent recorded that "*Ann appeared confused and lethargic this am. Took all medications orally. STAS were 83% on 2L O2. On Dr ** to continue care at Newmarch as Ann would not like to go to hospital. O2 therapy increased to 4L. We will continue to monitor closely. Personal care given regularly, drinking well. Poor intake of food, we will continue to encourage. Doctor has spoken with family and I have set up a video chat*."

43.42 At 6pm on the evening of 1 May 2020 Mark Fahey's pre-recorded interview with Channel 7 regarding the Outbreak at Newmarch House was aired.

2 May 2020

43.43 On 2 May 2020, Mrs Fahey's observations were recorded seven times: at 5.30am, SpO2 92% on 2L NP (BP 143/72, P 93, Temp 37.1C, RR 16), at 7.25am, SpO2 92% (RR 28, P 133, BP 171/100, Temp 39.7C, P 124), at 7.40am, SpO2 92% on 2L (HR 131, BP 171/80 (emergency department)), at 9.40am SpO2 **73%** 15L (BP 151/120, Temp 40.6C), at 10.30am SpO2 79% NRB (BP 133/75 P 154, Temp 39.2C (initial obs), at 11.09am, SpO2 84% NP (160bpm) and at 11.35am on NRB SpO2 68% (RR 40). Counsel Assisting noted the concerningly low SpO2 saturation readings where any reading below 92-93% is considered outside the normal range.

43.44 At 1.30am Mrs Fahey's Glasgow Coma Scale (GCS) was recorded as 15/15, and the attending nurse found there was nil cough, respiratory distress pain or discomfort.

43.45 At 5.30am clinical notes record that Dr Kakkat was informed of Mrs Fahey's vital signs (which now records her GCS of 12/15) as there "*is a confusion between transferring to hospital /update ACD*." Dr Kakkat ordered continuous observations until 9am when an update would be given. 15 minutes later, the clinical notes record that "*Dr Kakkat called back and asked if Ann had a fall. She had fall on Thursday @ 0620. She is also taking Eliquis 2.5mg. Dr Kakkat ordered CT Brain today @900. He will organise morning team please follow-up."*

43.46 At 6.45am, Mrs Fahey's oxygen saturations were 89 – 91% on 2L via Nasal Prongs. At 6.49am, Dr Fitzpatrick received a call from triage and noted:

> Newmarch House resident, COVID positive Fall Thursday, confused initially, then returned to baseline. Newly drowsy - ?ICH On Pradaxa For CTB"

43.47 At 6.50am, an ambulance arrived at Newmarch House to transfer Mrs Fahey to Nepean Hospital. At 7.13am, Mrs Fahey was admitted to Nepean Hospital following her fall.

43.48 At 7.59am, Medical Specialist Mahesh Jagada Gangadharaiah noted:

> *PT seen By Dr Ezra Documented by me*
> *HOPI: From New March nursing home - presented to ED with reduced GCS on background of fall 2- 3 days ago*
> *PT known covid positive - teleconference from Geriatric team and GP - COVID symptomatic treatment In Nursing but for cpr and transfer to hospital for other medical condition* [f]*all 2-3 days ago. unwitnessed - was doing ok till last night when the gcs deteriorated hence ref to the hospital*
> *...*
> *O/E*
> *HR 131 BP 171/80 Spo2 92% on 2 Is febrile tachypnoeic*
> *Tender in the right hip cvs: hsd, nil added increased RR. scattered wheeze b/1 Pearl GCS 12 E3V4MS Moving all four limbs*
> *Impression: respiratory distress due to covid*
> *? underlying uti ? head injury*
> *Plan: bloods cxr, pelvic x ray*

discuss with family - not able to contact with both the number on the system - no answer. need to chase the family details

43.49 It is noted that the detail in the examination and assessment made at Nepean Hospital upon admission, which can be contrasted with the detail of the note made by the VACS team, which on 30 April 2020 at 12.12pm.

43.50 At 8.04am, Mrs Fahey's pelvis X-ray results were recorded: "*No acute fracture or dislocation of the pelvic bones is identified. There is suggestion of vascular calcification involving the distal aorta and iliac arteries. Bowel gas pattern appears non-specific.*"

43.51 At 8.48am, Medical Intern Ezra Suria noted:

> Plan:
> Bloods Cxr. Pelvic x ray
> discuss with family - not able to contact with both the number on the system - no answer. need to chase the family details
> ADDIT 0800
> Discussed at morning handover with EDSS Saw Her advanced care directive is unclear Verbally ED was told that this patient is not for CPR or ICU and is only transferred for Investigation with a CTB Documentation that accompanied patient was not clear
> - it Is documented that she is only for symptomatic treatment in context of COVID, but for treatment of reversible causes in context of other pathologies (paraphrasing as documentation is in contaminated area with patient)
> - there is another documented ACD which states she is for CPR, for parenteral nutrition, IV Abx, as well as transfer to hospital Given the uncertainty above it was decided that she is still for full measures Requested ICU review Patient is in type 2 respiratory failure based on VBG obtained later
> ADDIT 0900
> Sons number obtained by clerical staff D/W Mark Fahey (son)
> he states that she is for all interventions including ICU and intubation
> she Is known to have delirium during bouts of UTIs but reportedly has a good level of function with no dementia
> Patient continued to deteriorate, increasingly hypoxic and drowsy Not stable for CTB as per previous plan moved to resus 4

43.52 At 9.46am, it was suggested that Mrs Fahey had developed a urinary tract infection. Between 10.03am and 10.08am, Mrs Fahey was administered Ketamine, Suxamethonium and Rocuronium. At 10.05am, Mrs Fahey was intubated. At 10.09am, Mrs Fahey was administered Metaraminol following intubation. At 10.24am, Mrs Fahey was administered Furoemide and Ceftriaxone. At 10.30am, Nurse Practitioner Linda Hasler noted:

> Respiratory failure
> Fall on apixaban
> Covid positive
> Family discussion- for full measures
> Transferred to Resus 4 for assessment and getting ready for icu transfer but as pt deteriorated decision made for intubation
> ICU aware and creating a bed

43.53 At 11.17am, Dr Sharma noted:

> Ann had an unwitnessed fall this am aprox 0230 on Pradaxa therefore sent to th[e] hospital Family notified by Dr Kakkat
> At the hospital she was desaturating
> Family called all interventions wanted
> Therefore ICU on call for COVID 19 contacted Pt was taken to ICU
> Dr Branley notified

43.54 Dr Sharma's notes incorrectly record when the fall took place, namely it did not occur on 2 May 2020 at 2.30am but in fact occurred two days earlier and was reported on 30 April 2020 before 5.30am.

43.55 At 11.25am, Dr Saw noted:

> 76 yo with background of mild dementia TF from Newmarch house with reduced LOC, increased respiratory distresss
> Covid positive
> hypoxic respiratory failure
> DW Son Mark - for full resuscitation including intubation Given 40mg laslx, ceftriaxone prior to transfer Assessment in Resus 4
> on NAB, SaO2 68%
> RR 40/min
> eyes open , no response to pain
> Started BiPAP 100% FlO2 IPAP17, EPAP 10 best SaO2 82% Intubation RSI
> Sux 200mg ketamine 100mg
> Gd 1 laryngoscopy
> ETT 7.5cm cuffed to 22cm at lips Good ETC02 trace
> Sa02 up to 98%
> hypotensive to 70 systolic - given metaraminoll In 2mg aliquots to 12mg in total Hartmanns iv commenced
> Fentanyl sedation iv
> Rocuronium
> TF to ICU

43.56 At 11.37am, Dr Balakrishana noted: "*D/W Dr Menon (ID physician) agreed for admission Continue IV azithromycin and ceftriaxone".*

43.57 At approximately 3:39pm, Mark Fahey attended the Nepean Hospital to visit his mother. An unknown staff member asked Mark Fahey to confirm the "Do Not Resuscitate" Plan, to which he replied, "*absolutely not.*" It is noted that the only documentation recording a "Do Not Resuscitate" Plan dates back to 2 November 2011 and was only applicable during that specific admission as stated on the tick box above the signature form.

43.58 At 3.39pm, Mrs Fahey's chest X-ray results were recorded as follows:

> The tip of the endotracheal tube is 2 cm above the carina. Central line tip is in the cavoatrial junction. Feeding tube is seen to extend below the gastro-oesophageal junction. Increased translucency of

the lungs is compatible with chronic airways disease and mid to lower zone opacifications in the lungs have moderately reduced when compared to the previous chest film.

43.59 At approximately 4.00pm, Mrs Fahey's intubation was removed. At approximately 4.06pm, Mrs Fahey passed away. At 6.00pm, Manager Christine Giles contacted Mark Fahey to ask how Mrs Fahey was, as the Nepean Hospital would not provide such information. Mark Fahey advised Ms Giles that Mrs Fahey had passed away.

MANNER AND CAUSE OF DEATH

43.60 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree that her death was from COVID-19 pneumonia. An illness related to COVID-19 was likely present before COVID-19 was diagnosed as she was confused, febrile and tachypnoeic for several days prior to testing positive.

43.61 **Manner of Death**: Mrs Fahey suffered a suspected heart attack followed by further deterioration and type 2 respiratory failure despite O2/BiPAP support. Mrs Fahey died immediately after she was extubated. She died in hospital in circumstances where her family felt too much supportive care was provided in a manner that may have compromised her end-of-life care and made it more distressing.

43.62 **Impact of any significant co-morbidities**: The experts opined that cardiovascular disease, lung disease, osteoarthritis and mild cognitive impairment may have had an impact.

43.63 **Issues with care received**: Mrs Fahey was transferred to Nepean Hospital following a fall and was managed initially with intubation in ICU, partly to facilitate further investigations due to the fall (such as a brain CT to rule out intracranial haemorrhage). She received increased interventional support, including mechanical ventilation, IV fluids, oxygen therapy (BiPAP support), IV antibiotics and metaraminol support. As a result of her admission into ICU, Mrs Fahey received increased support, including intubation, which meant that her end-of-life care was even more distressing and not as comfortable as it could have been. The experts opined that the increased care did not make a difference to her outcome and was disproportionate in relation to her presentation. Counsel Assisting noted that she had an ACP saying she wanted all interventions. Associate Professor Kotsimbos considered that once Mrs Fahey was diagnosed with COVID-19 her deterioration was quite rapid, and her care was "*quite good*" in terms of her assessment, but not necessarily in terms of the comfort and end-of-life management.

43.64 **Whether different action may have affected the outcome**: Yes.

43.65 The experts' view was that Mrs Fahey's infection *may* have been preventable, but once infected, different treatment would not have prevented her death. However, her comfort and end of life management at Nepean Hospital were sub-optimal.

43.66 Further, Associate Professor Kotsimbos noted that Mrs Fahey's case was particularly complicated. Her positive COVID-19 diagnosis was made on 29 April 2020, making her the last one of the residents to be diagnosed with COVID-19. Mrs Fahey had four negative COVID-19 tests prior to testing positive, indicated that by the time she contracted COVID-19 there was a propagated wave of infections, spreading within Newmarch House. Professor Kurrle also noted that Mrs Fahey had not complied

with rules requiring isolating and had moved into common areas increasing her risk of contracting the virus.

43.67 Professor MacIntyre was of the view that COVID-19 infections after 18 and 19 April 2020 were potentially preventable for the reasons outlined above. Given the four negative tests in the case of Mrs Fahey, more than one of those negatives was likely a true negative. As a result, if a different model of care had been adopted, involving in the initial period a transfer of COVID-19 positive residents out of Newmarch House until infection control measures were properly in place, and sufficiently skilled staff were present, Mrs Fahey's death was likely preventable.

43.68 It is noted that a particularly distressing aspect of Mrs Fahey's passing is that the family is left with a sense that both the family and their mother's wishes regarding transfer to hospital at an earlier stage, was not honoured.

43.69 The manner of Ann Fahey's death, in particular the late timing of her transfer to hospital (not based on her deteriorating state from her COVID illness) highlights the need for an early and comprehensive face-to-face or videoconference assessment by a geriatrician in consultation with other relevant specialists such as a respiratory physician. A comprehensive assessment would have informed individualised care and management, incorporating a resident's wishes when they are still cognitively capable of understanding their diagnosis and prognosis and should always allow for transfer to hospital at an early stage for optimal care and intervention.

43.70 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Ann Fahey.

Date of death

Mrs Fahey died on 2 May 2020.

Place of death

Mrs Fahey died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Fahey's death was COVID-19 pneumonia.

Manner of death

Mrs Fahey died of natural causes following diagnosis of COVID-19 infection. Following Mrs Fahey's transfer to hospital after her fall on 30 April 2020, the comfort and end-of-life care provided to Mrs Fahey at Nepean Hospital was disproportionate to her presentation, and caused additional distress for her family, although this increased care did not materially affect the eventual outcome. However, given the timing of Mrs Fahey's COVID-19 diagnosis when a propagated wave of infections was spreading within Newmarch House, her infection may have been prevented if a different model of care had been implemented and the terms of her Advance Care Plan regarding transfer to hospital had been adhered to. Following Mrs Fahey's COVID-19 diagnosis, no other management steps could have been instituted which would have materially altered the eventual outcome.

44. Marko Vidakovic

HEALTH

Co-morbidities

44.1 Marko Vidakovic was 72 years of age when he passed away on 4 May 2020 at Newmarch House during the COVID-19 Outbreak. He had a number of existing comorbidities including behavioural and psychological symptoms of dementia (BPSD), cerebrovascular accident (CVA) (multiple) with aphasia (no speech), ischemia heart disease (IHD), congestive cardiac failure (CCF), chronic obstructive pulmonary disease (COPD) and hypertension. Mr Vidakovic also had peripheral oedema, urinary incontinence, aggression, chronic pain and was at risk of falls. He was independently mobile but required prompting with many activities of daily living. Mr Vidakovic arrived in Australia from the former Yugoslavia in 1971 and spoke Serbian and English. He communicated with the staff at Newmarch House primarily through the use of cue cards.

Background and events leading up to COVID-19 diagnosis

44.2 On 2 March 2018, Mr Vidakovic was admitted to Nepean Hospital by police after he was found confused and displaying strange behaviour. Prior to this, he was living in public housing. At Nepean Hospital he was diagnosed with dementia and expressive/receptive aphasia. As Mr Vidakovic did not have any family or friends in a position to care for him, on 23 April 2018, the NSW Public Trustee and Guardian commenced managing Mr Vidakovic's affairs. Mr Vidakovic was admitted to Newmarch House on 30 August 2018. Unsurprisingly, he was considered "High Care," presumably in part due to his inability to communicate effectively.

RELEVANT MEDICATIONS

44.3 Mr Vidakovic was prescribed a number of regular medications including laxative + senna, Lorstat, paracetamol, Syquet, Targin, Uremide, Urex-M, Vitamin D3, Aspro clear, Epilim syrup, Spiriva (COPD) and Zopral. Mr Vidakovic was also prescribed Frusemide for his IHD and CCF.

PRN Medication - Midazolam and morphine

44.4 On 22 April 2020, Mr Vidakovic was prescribed morphine and midazolam by Dr Kakkat. Dr Kakkat also prescribed accompanying end of life (EOL) medications such as Hypnovel, Maxolon, Robinul, Serenace and sodium bicarbonate mouthwash. He was administered 2.5mg morphine on 25 April at 5.25pm (as per doctor's instructions); 27 April at 10.08pm; 30 April at 9.54am for pain; 1 May at 9.30am, 2.17pm and 4.30pm along with 5mg midazolam for pain and agitation; 2 May at 6.00am, 8.29am for pain; and at 12.07pm; 2.19pm and at 5.54pm along with 5mg midazolam for terminal agitation. On 3 May 2020, Mr Vidakovic was administered 5mg of morphine and midazolam in combination at 1.20am, 5.30am and 10.20am for terminal agitation and pain, which was recorded in the handwritten medication charts. He passed away the following day.

COVID DIAGNOSIS

44.5 Mr Vidakovic took two combined nose/throat PCR tests on 14 April 2020 and 17 April 2020. They were found to be negative. Mr Vidakovic took a combined nose/throat PCR test on 19 April 2020 at 5.00pm. It was found to be positive for SARS-CoV-2.

44.6 Newmarch House Facility Manager Christine Giles contacted the NSW Trustee and Guardian staff member Bonnie Guthrie at 11.59am on 20 April 2020. Mr Vidakovic's positive COVID-19 test result was first recorded in the progress notes on 20 April 2020. He was moved to the Blaxland wing after his positive diagnosis.

ADVANCE CARE PLAN

44.7 Mr Vidakovic did not complete an Advance Care Plan (ACP). As he did not have a Next of Kin (NOK), the Public Guardian was appointed to determine Mr Vidakovic's health care and to make substitute decisions about medical treatment, where Mr Vidakovic was incapable of giving valid consent. A Comfort Care Plan was completed for unknown dates with two hourly attendance completed for portions of those undated days. This is one of the very few comfort care plans implemented by Newmarch despite a context of palliative care being adopted as the management plan for all 19 residents who died.

Discussions around ACP

44.8 On 22 April at 2.58pm, RN Lorena Bestrin recorded *"Bonnie-Guthrie NSW Trustee & Guardian returned phone call. Bonnie stated Marko is for hospital transfer if medically indicated. Bonnie stated she will email an end-of-life form for GP to review and complete. Same form will need to be returned to Bonnie-Guthrie once completed by Dr Kakkat*.

44.9 On 23 April at 5.47pm, Virtual Aged Care Service (VACS) Nurse Practitioner (NP) Carpen recorded, "*… Dr Sharma has contacted Dr Manoj to complete the Guardianship requirements for Advance Care Planning, Form has been sent to him*."

44.10 The task of completing the Guardianship requirements for Advance Care Planning was delegated to Dr Dharmaratnam, GP, by Dr Sharma on 23 April 2020. The task appears to have originally be allocated to Dr Kakkat, who was the medical practitioner delegated to be present at Newmarch House. Dr Dharmaratnam was not able to physically attend Newmarch House.

44.11 At 6.00pm on 23 April 2020 Dr Dharmaratnam noted, "*I am informed that he is positive for Covid 19. This has been intimidated to the Guardianship Board - as informed to me by the RN. Dr Sharma has contacted me and discussed with me about completing the Guardianship forms for further management in the scenario of Advance Care I shall contact the Guardianship Board tomorrow as it is after hours now. Will complete the forms and the requirement for the same."*

44.12 Dr Dhamaratnam's entries on 24 April 2020, in the Newmarch clinical records are instructive as to the process adopted by the Public Guardian prior to consenting to end of life care.

44.13 At 9.00am, Dr Dharmaratnam recorded:

> D/W Public Guardian in regards to advanced care management with Ms Bonnie Zain (Public Guardian)- Discussed end of life planning - She says that she has no authority to consent to advanced care directive- She has received an email from Dr Kakkat but she wants more details.- She wants information which is proposed and also palliative care plan with doses of all medications Apparently they do not have the auth for end of life planning as Marko hasn't been in a mental capacity to discuss this with them I shall email her the details of the proposed meds planning for ACD She wants to know what his clinical status is at the moment - which I am unable to give her as I have not seen him in a while. [emphasis added]

44.14 At 10.00am, Dr Dharmaratnam noted:

> Copy of Email sent to Public Guardian Hello Bonnie As discussed with yourself, Mr Vidakovic has been tested positive for Covid 19.He is under the care of the 'hospital at home team' led by doctors from the Nepean hospital VACS team. It has been decided that all residents at New March house will be treated at New March house and they will not be transferring them to the hospital in the event of them deteriorating further. All medications and comfort measures will be given to them at the facility. Planned medications for Mr Vidakovic in the event of an emergency for comfort care:- Oxygen @2-4 lts / min- Inj Morphine 2.5 - 5 mgs Q2H/PRN - S/C- Inj Midazolam 1 mgs Q4H/PRN - S/C- Inj Maxolon 10 mgs TDS/PRN - S/C- Inj Rubinol 1 amp TDS/ PRN - S/CIf he deteriorates further we would like to start him on an infusion pump which can contain Morphine 10 mgs + Midazolam 5 mgs to be run subcutaneously over 24 hrs All these meds are for PRN Hope the information given is adequate, if not pls revert back to me and I can endeavour to update the details for you Regards Dr Manoj Dharmaratnam. [emphasis added]

44.15 At 10.30am, VACS Aged Care Nurse Practitioner Carpen noted:

> Videoconference with Dr Sharma today Present; Dr Sharma, Lorena, Facility RNs Resting in Bed Refusing medications Aggressive at times Not short of breath Plan Do not force with medications GP in contact with Guardianship regarding advance care plan.

44.16 The Public Guardian consented to the proposed palliative plan.

44.17 Associate Professor Kotsimbos noted the extensive questions asked by the Public Guardian prior to consenting to the proposed treatment plan. Professor Kurrle considered the Public Guardian's approval of Mr Vidakovic's Palliative Care Plan was appropriate.

44.18 This correspondence is instructive as to the process and formalisation of consent, and the medication regime with this resident under public guardianship as compared with the balance of residents. Families were not provided a similar level of detail regarding the plan for palliation. Many families were simply not informed that end of life "anticipatory" medications were being prescribed and why.

PROGRESSION OF ILLNESS

19 April 2020

44.19 At 6.00pm, the Nepean Clinical Records record that Mr Vidakovic was admitted to HITH, suggesting the positive results were acted upon within an hour of the test results becoming available. In contrast, most results were not made available as quickly.

20 April 2020

44.20 At 9.48am, Nepean Hospital's Dr El Jamaly noted "*Informing NH of +ve COVID result Called the NH 3x since 8am this morning. Unable to reach. Left a voicemail to call me back with urgent priority for result notification re: COVID-19. Will try again to reach NH staff."* At 10.52pm, Dr El Jamaly noted: "*Tried calling again; left a 2nd voicemail. advised nursing home to take all precautions of single room; isolation; covid19 precautions".* At 11.47am, Dr El Jamaly noted: "*call made to NH and spoke directly to staff and informed them of the +ve COVID-19 results; need for strict isolation; single room and PPE's".*

44.21 Mr Vidakovic's observations were recorded twice. First at 5.50pm, SpO2 97% (BP 139/92, P 102, RR 21, Temp 36.9C), then almost five hours later at 10.30pm, SpO2 was not recorded (BP 148/84, P 92, Temp 38.2C).

44.22 At 6.03pm, VACS NP Hailey Carpen noted:

> Mr Marko Vidakovic, 72 year old man with a new diagnosis of COVID19 under the care of HITH Unable to contact facility today Remote review of the notes Some concern around agitation, addressed by Dr Kakkat Unfortunately no observations recorded today. Please perform a set of observations Will review again tomorrow

44.23 It is unclear from the evidence how Dr Kakkat addressed the issue of agitation, if at all, as there is no corresponding clinical record in the Newmarch House or Nepean Hospital records. If the entry by NP Carpen from VACS is based on a conversation with Dr Kakkat, any response by him to the agitation or direction to a nurse is unknown. Further, although NP Carpen stated that "*no observations were recorded,*" observations were recorded in the Newmarch House notes at 5.50pm.

21 April 2020

44.24 On 21 April 2020, Mr Vidakovic's observations were recorded twice. First at 1.00pm, SpO2 98% (BP 125/83, P 88, RR 20, Temp 36C) and then ten hours later at 11.05pm, SpO2 97% (BP 128/86, P 62, Temp 36.1C).

44.25 At 4.30pm, Mr Vidakovic was moved from Wentworth Wing to Blaxland Wing two days after his COVID-19 positive status was known. Mr Vidakovic was noted to be afebrile.

22 April 2020

44.26 On 22 April 2022, Mr Vidakovic's observations were recorded four times. At 10.40am, SpO2 88% (BP 135/75, P 87, RR 18, Temp 36.5C), at 4.00pm, SpO2 91% (BP 141/71, P 84, RR 18, Temp 36.7C), at 7.38pm, SpO2 88% on RA then commenced on 2L PMNP (BP 141/71, P 84, RR 18, Temp 36.7C), at 10.30pm SpO2 94% (BP 124/69, P 96, RR 20, Temp 36.2C).

44.27 At 2.58pm, RN Bestrin spoke with the Guardianship Board in relation to Mr Vidakovic's ACP. At 3.29pm, Nepean Hospital Nursing Unit Manager (NUM) noted "*Contacted VACs team. Team are currently reviewing COVID patients. Team will fax details of patients and their condition when finalised to HITH*".

44.28 At 3.59pm, VACS NP Carpen noted: "*Mr Marko Vidakovic, 72 year old man with COVID19 under the care of HITH Observations stable".* This appears to be based upon a remote review of the notes. At 7.38pm, Mr Vidakovic had no flu-like symptoms and no shortness of breath. Mr Vidakovic refused care and food, and Dr Kakkat was notified. Mr Vidakovic's observations were taken and his SpO2 was 88% in RA. Oxygen therapy of 2L via Nasal Prong was commenced and Mr Vidakovic's SpO2 increased to 92%.

44.29 On 23 April 2020, Mr Vidakovic's observations were recorded five times: at 12.30pm, SpO2 94% (BP 132/75, P 99, RR 20, Temp 36.2C), at 4.25pm, SpO2 94% RA (BP 124/69 Temp 36.2C, RR 20, HR96), at 6.00pm, SpO2 97% (BP 136/99, RR 18, Temp 37C), at 7.00pm, SpO2 94% RA (BP 124/69, RR 20, Temp 36.2C), at 9.00pm, 82% (BP 154/90, P 90, RR 18, Temp 36.5C).

44.30 At 3.40pm, Dementia and Mental Health Manager Jenny Houston reviewed Mr Vidakovic and recorded the following:

> Distance review due to Covid requested by the Manager to identify any additional care needs/strategies. 1.Observation/trigger: Marko has documented chronic pain especially his knees which can result in him being less tolerant of others. Marko is currently declining/spitting out his medications including targin, and paracetamol. Marko's Abbey pain score at present is moderate. Suggest: •Marko is unlikely to be able to accurately identify if he has pain due to problems with receptive/expressive communication. •Use communication cards to assist •Please only use the Abbey pain scale for Marko. Please complete the Abbey pain scale each shift for the next 3 days and when Marko has a changed behaviour. •Discuss analgesia with GP as Marko is spitting out medications. Suggest GP review medications to only the essential ones for Marko. •Marko may benefit from an Analgesia patch due to the arthritis in his knees and he is declining/spitting out medications •Physio review 2.Observation/trigger: Marko has receptive and expressive aphasia. The words we use don't always have the same meaning for Marko or they may not make sense to him. He often wants to say something, but the wrong word comes out, making communication even more difficult for him. He is sometimes embarrassed when staff are trying to understand what he wants, and this frustration can lead to him putting his fist up to staff as a warning. Suggest: •Staff to continue to use gestures such as thumbs up and down as Marko can understand this and responds well. •Continue to complete behaviour charts for Marko when he has a changed behaviour •When Marko shakes his fist at staff they must use "Step back" •When communicating with Marko staff gain his attention by moving their hand to their face as this will draw Marko's attention •Do not move quickly as this can make Marko anxious •Staff need to introduce themselves in a soft calm manner •Serbian communication cards sent in an email and another 2 sets.

44.31 This is the only dementia assessment of a COVID-19 positive resident at Newmarch House during the Outbreak. The inference is that it was required to be done for the Public Guardian prior to making decisions about Mr Vidakovic's ACP. A similar assessment is not found in any of the other patients who had dementia. The Abbey Pain scale was not completed each shift over the subsequent three days and was limited to one assessment on 23 April 2020 at 2:14pm with a score of 0-2 (no pain). It is noted that the Abbey Pain scale was utilised numerous times prior to the Outbreak.

44.32 At 4.26pm, Nepean Hospital RN Sidney recorded "*Taken from nursing home notes with VACS in attendance symptoms: nil BP 124/69 temp 36.2 sats 94% RA RR20 HR96.*" The VACS record of 5.47pm states that a remote review of notes was made and detailed the entry from the Dementia and Mental Health Manager.

24 April 2020

44.33 On 24 April 2020, Mr Vidakovic's observations were recorded three times. At 12.11am, SpO2 92% RA (BP 154/90, RR 18, Temp 36.5C), at 8.00am, Temp 36.2C, at 10.00am (refused SpO2/BP), at 5.30pm, SpO2 93% (BP 129/88, P 90, RR 18, Temp 36.7C), and at 11.10pm, SpO2 95% (BP 143/74, P 85, RR 16, Temp 36.7C).

44.34 At 12.11am, Mr Vidakovic was asymptomatic and had no shortness of breath. He refused to be toileted and continued to refuse care. Mr Vidakovic drank a cup of water but refused food. Mr Vidakovic refused oxygen therapy and the RN recorded "*GP to review meds tomorrow as he continues to refuse them.*"

44.35 At 10.30am, VACS NP Carpen noted: "*Videoconference with Dr Sharma today Present; Dr Sharma, Lorena, Facility RNs Resting in Bed Refusing medications Aggressive at times Not short of breath. Plan Do not force with medications. GP in contact with Guardianship regarding advance care plan*. A subsequent Nepean note recorded '*Does not want to talk and or have obs done Has been agitation and wandering However more settled today. Dr Manoj D have spoken to the guardian and written in the NM house notes.*" The videoconference on 24 April 2020, 5 days after his Covid positive status is the first in person/videoconference review by the VACS team. A second review occurred a week later on 1 May 2020.

44.36 At 1.30pm, Mr Vidakovic had no symptoms but was confused and unhappy with staff changing his pad. At 4.29pm Mr Vidakovic was discharged from HITH with VACS aware and to follow 'second daily'. As stated above, VACS followed up with a review a week later.

25 April 2020

44.37 On 25 April 2020, Mr Vidakovic's observations were recorded once at 11.20pm, SpO2 93% RA (BP 122/68, HR 73, RR 18, Temp 36.2C).

44.38 At 5.25pm, Mr Vidakovic was administered morphine for the first time. At 9.30pm, Mr Vidakovic was given 250 mls of oral fluids. Apart from this record of fluid being given to Mr Vidakovic, the provision of fluids to seven other residents (Maria James, CA, David Gee, Olive Grego, Fay Rendoth, Margaret

Sullivan, and Alice Bacon) was also recorded on hard copy Fluid Balance Charts and electronic Fluid Intake Charts. Many of these entries were made on hard copy records after 25 April 2020, when use of the iCare electronic medical notes was ceased. The records only show intermittent, and not daily, entries of fluids being provided.

26 April 2020

44.39 On 26 April 2020, Mr Vidakovic's observations were recorded three times. At 8.30am, SpO2 83% RA (BP 104/98, HR 76, RR 18, Temp 36.7C), at 11.10am, SpO2 86% RA (BP 159/73, HR 102, RR 20, Temp 36.9C), at then ten hours later at 9.25pm SpO2 97% RA (BP 104/98, HR 88, RR 18, Temp 36.6C).

44.40 At 12.43am, Mr Vidakovic ate one and a half bananas and was observed to have no cough or shortness of breath. At 1.04pm, Newmarch House Manager Melinda Burns noted that as of 25 April 2020 until further notice, staff are to document on paper-based notes. At 1.20pm, Mr Vidakovic was attended by a physiotherapist who noted "*NESB* [non English speaking background]*, RIB poorly positioned, being assisted to eat, RR's @ rest 18/min, Nil moist cough...please staff elevate head of bed so Marko sits upright to assist ease of breathing."*

27 April 2020

44.41 On 27 April 2020, Mr Vidakovic's observations were recorded once at 12.00pm, SpO2 96% (BP 141/78, HR 106, Temp 36.6C).

44.42 At 10.08pm, Mr Vidakovic was administered morphine.

28 April 2020

44.43 On 28 April 2020, Mr Vidakovic's observations were recorded three times. At 6.00am, 92% on 2L NP (BP 141/95, HR 100, RR 22, Temp 36.6C), at 4.00pm, SpO2 84% (BP 137/92, HR 120, RR 40, Temp 36.7C), at 8.00pm SpO2 98% RA (BP 132/78, HR 100, RR 42, Temp 36.2C).

44.44 At 10.00pm, Mr Vidakovic's observations were recorded, and he was given fluids.

29 April 2020

44.45 On 29 April 2020, Mr Vidakovic's observations were recorded twice: first at 10.10am, SpO2 89% (BP 111/77, HR 115, RR 22, Temp 37.4C), and then twelve hours later at 10.10pm, SpO2 89% (BP 142/70, HR 110, RR 18).

44.46 At 5.30am, Mr Vidakovic refused to have his observations taken. At 10.10am, Mr Vidakovic's observations were recorded, and he was given oxygen of an unknown measurement.

30 April 2020

44.47 On 30 April 2020, Mr Vidakovic's observations were recorded six times. At 6.00am, SpO2 89% RA (BP 90/49, HR 80, RR 18, Temp 37C), at 6.30am SpO2 84% (BP 140/96, P 130, RR 18, Temp 37C), at 10.00am, SpO2 95% on 2L, (BP 142/83, P 103, RR 18, Temp 36.5C), at 3.00pm (BP 136/89, P 112, RR

18, SpO2 86% on 2L, Temp 36.4C), at 9.00pm, SpO2 85% on 2L (BP 139/83, P 120, RR 19, Temp 36.7C), and at 11.00pm, SpO2 85% on 2L NP.

44.48 At 6.00am, Newmarch House staff noted that Mr Vidakovic was located on the floor with no obvious injuries, he had low oxygen of SpO2 84%, but refused oxygen. At 11.00pm, Mr Vidakovic showed no facial grimace or physical signs of pain, discomfort, or shortness of breath. Mr Vidakovic's oxygen was saturating at 85% on 2L Nasal Prongs. He refused medications, food and drink. Staff noted that a message was left in the doctor's list for Mr Vidakovic to be reviewed the next day.

1 May 2020

44.49 On 1 May 2020, Mr Vidakovic's observations were recorded once at 10.00pm, SpO2 89% on 2L NP (BP 114/83, P 88, RR 18, Temp 36.1C).

44.50 From 1 May 2020, Mr Vidakovic was not administered his usual medications. He continued to be administered with anticipatory medications. At 12.00am, Mr Vidakovic's pulse was 112. At 9.45am, Mr Vidakovic was administered 5mg of morphine and midazolam. At 1pm, he was reviewed by the VACS palliative care physician Dr Kathiresan:

> Entry terminal phase V. comfortable / Nil symptoms needed 2 BT's / 1 miday cold periphery [?]dry mucosa[?] ... Plan – TC = oral care – eye care – BT/PIW before personal[?] care

44.51 At 2.17pm, Mr Vidakovic was administered 5mg of morphine and midazolam.

2 May 2020

44.52 At 8.27am, Mr Vidakovic was administered 5mg of midazolam and 5mg of morphine. At 12.07pm, Mr Vidakovic was administered 5mg of morphine for pain and 5mg of midazolam for agitation. At 2.19pm, he was administered 5mg of morphine and midazolam for pain and agitation. At 2.30pm, Dr Dharmaratnam noted: "*MIN checked and signed No new issues Status Quo Continue same Mx*". At 5.33pm, Mr Vidakovic was administered 5mg of midazolam for agitation and 5mg morphine for pain.

44.53 At 6pm nursing records note loss of consciousness, responding only to pain, and to reposition every two hours, oral care administered.

3 May 2020

44.54 On 3 May 2020, Mr Vidakovic's observations were recorded once at 11.35am, SpO2 72% on 2L NP (BP 81/31, P 110, RR18, Temp 36.4C).

44.55 Mr Vidakovic was administered 5mg of morphine and midazolam in combination at 1.20am, 5.30am and 10.20am for terminal agitation and pain. The progress notes indicate that Mr Vidakovic was observed, provided with personal and pressure area care, and administered midazolam and morphine for agitation on other occasions on 3 May 2020. However, as the timing of these events are not recorded it is unclear precisely when they occurred.

4 May 2020

44.56 At approximately 2.30am on 4 May 2020, staff attended to Mr Vidakovic to provide care and found he was not breathing. RN Gatt confirmed he was deceased. At 10.40am, Newmarch House staff contacted Ms Guthrie and informed her that Mr Vidakovic had peacefully passed away.

MANNER AND CAUSE OF DEATH

44.57 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agreed that the cause of death was COVID-19 Lower Respiratory Tract Infection. Associate Professor Kotsimbos also noted that Mr Vidakovic had suffered a cardiorespiratory arrest and had significant comorbidities including Dementia.

44.58 **Manner of Death**: In terms of the course of Mr Vidakovic's illness, he was diagnosed with COVID-19 on 19 April 2020 and was largely asymptomatic until 27 April 2020. Up until that point in time he was able to eat and be interactive. From 28 April 2020, Mr Vidakovic's health declined with increasing drowsiness, agitation, shortness of breath and hypoxia on a background of Mr Vidakovic being non-compliant with oxygen therapy. On 30 April 2020, Mr Vidakovic had a fall. Between 30 April 2020 and 3 May 2020, Mr Vidakovic's oxygen saturations progressively declined on 2L/min Nasal Prongs (95% to 85% to 72%). He was reviewed by the Palliative Care Team on 1 May 2022 and was considered to be entering the terminal phase. morphine and midazolam were administered on 1 May 2020 and 2 May 2020 before lapsing into unconsciousness. He died in the early hours of the morning on 4 May 2020. Professor French considered that palliative care review was appropriate based on the several doses of morphine and midazolam which were administered. Counsel Assisting noted that the records indicate that the palliative comfort care plan was only partially adhered to.

44.59 **Impact of any significant co-morbidities**: Dementia, chronic lung disease and cardiovascular disease including a stroke which had left him aphasic (meaning he either could not understand language and/or could not express himself using language).

44.60 **Issues with care received**: Associate Professor Kotsimbos considered that Mr Vidakovic's oxygen therapy was suboptimal, but that this was in part due to Mr Vidakovic's non-compliance with the mask, likely consequential to his Dementia but also partly because he was not being monitored effectively. One of Associate Professor Kotsimbos' main concerns was that Mr Vidakovic was Serbian and there was no evidence of attempts by Newmarch House to contact and obtain an interpreter to assist Mr Vidakovic make decision about his care and treatment. It was noted that Mr Vidakovic had Dementia, cognitive impairment, language problems and subsequent confusion and therefore it is unclear what Mr Vidakovic would have understood and or requested.

44.61 The experts felt that Public Guardian's enquires seeking information, prior to the approval for palliative care, was appropriate.

44.62 **Whether different action may have affected the outcome**: No

44.63 The experts opined that there was no treatment that could have changed his outcome. Associate Professor Kotsimbos noted that Mr Vidakovic was diagnosed with COVID-19 on 19 April 2020, which

was later on in terms of the Newmarch House Outbreak. He believed it was *possible* therefore that Mr Vidakovic could have avoided infection with COVID-19 given the date of his diagnosis. Professor MacIntyre was of the view COVID-19 infections after 18 and 19 of April were *potentially* preventable for the reasons already discussed above. It is noted that there were two negative test results on 15 and 18 April 2020 and a positive test result on 19 April 2020. In those circumstances, the possibility of a false negative appears greater than, say, in the case of Ann Fahey. It is difficult to conclude therefore whether Mr Vidakovic was infected in the first wave or second wave of infection, and the avoidance of infection appears to be no greater than a possibility.

44.64 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Marko Vidakovic.

Date of death

Mr Vidakovic died on 4 May 2020.

Place of death

Mr Vidakovic died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mr Vidakovic's death was COVID-19 lower respiratory tract infection, with ischaemic heart disease, hypertension and chronic obstructive pulmonary disease and dementia being significant conditions which contributed to death.

Manner of death

Mr Vidakovic died of natural causes following diagnosis of COVID-19 infection. Mr Vidakovic's oxygen therapy was suboptimal, partly because he was not being monitored effectively, and it is unclear whether Mr Vidakovic had capacity to understand and make decisions regarding his care and treatment given his cognitive impairment and absence of assistance from an interpreter. However, neither of these last two matters had any bearing on the eventual outcome. The timing of Mr Vidakovic's diagnosis raises the possibility that his infection may have been avoided. No other management steps could have been instituted which would have materially altered the eventual outcome.

45. Olive Grego

HEALTH

Co-morbidities

45.1 Olive Grego was 88 years of age when she passed away on 5 May 2020 at Newmarch House during the COVID-19 Outbreak. She had a number of existing comorbidities including dementia (mixed Alzheimer's/vascular), hypertension, generalised vascular disease and osteoarthritis (chronic hip and back pain), gastroesophageal reflux (GORD) and macular degeneration. She had a history of back pain, peripheral vascular disease, urinary tract infections and hyponatremia.

45.2 Mrs Grego required assistance with most activities of daily living (ADLs), and suffered urinary and faecal incontinence. She was not independently mobile.

Background and events leading up to COVID-19 diagnosis

45.3 Mrs Grego's daughter Helen Kerrigan stated that her mother underwent vascular surgery on her legs and keyhole surgery for her spine at Nepean Hospital around the age of 80. Upon arriving back home, Mrs Grego's mental health began to slowly decline. Her fine motor skills and gross motor skills were worsening. Daily movements such as doing up buttons, folding clothes, and holding a cup and saucer slowly regressed to a point where she required assistance walking. Mrs Grego's ability to talk deteriorated but when she did respond to conversation, what she said made sense. On 18 July 2018, Mrs Grego was admitted to Newmarch House as she was no longer able to be cared for by her husband due to her dementia and poor mobility.

RELEVANT MEDICATIONS

45.4 Mrs Grego was prescribed a number of regular medications including Abistart 150mg (irbesartan) (Hypertension/Generalised Vascular Disease), Cavstat 20mg (rosuvastatin), Eye Formula (Health Plus Vitamins) Tab (ascorbic/dl-alpha-tocopherol), Loxolate 10mg (escitalopram), Estradot 25mcg/24 hours patch (estradiol 25mg/24 hour patch), Elexon-5 4.6mg/24 hour patch (rivastigmine 4.6mg/24 hour patch) (Dementia), Molaxole powder for oral liquid (macrogel-3350 13.12g + sodium chloride 350.7mg), Novasone 0.1% cream (mometasone 0.1% cream), Optifresh Tears 0.5% eye drops (carmellose sodium 0.5% eye drops, unit dose), Solprin 300mg disp tab (asprin) and Zopral ODT 30mg (lansoprazole).

45.5 Mrs Grego was also prescribed a number of medications on an as needs basis including Asmol CFC-Free 100mcg/actuation inhalation (salbutamol 100mcg/actuation inhalation, actuation) and paracetamol (apo) 500mg.

PRN Medication - Midazolam and morphine

45.6 On 1 May 2020, Mrs Grego was prescribed morphine 2.5mg, midazolam 2.5mg and glycopyrrolate on an as needs (PRN) basis. That same day she was administered morphine 2.5mg and midazolam 5mg via subcutaneous butterfly 2/2 at 11.00am, 2.00pm, 4.45pm for "*PAL care, agitation and settlement*".

45.7 On 2 May 2020 the medication chart records that 5mg of midazolam and 2.5mg of morphine was administered at 6.00am, 8.30am, 12.00pm, 2.30pm, 5.30pm and 9.30pm for pain relief and agitation. On 3 May 2020 the handwritten medication charts records that 5mg of midazolam and 2.5mg of morphine was administered at 1.20am, 5.35am and 4.30pm for pain relief and agitation. On 4 May 2020, 2.5mg of morphine and 5mg of midazolam was administered at 10.15am for pain and agitation. This appears to be the last dose of anticipatory medication administered prior to her death the following day.

COVID DIAGNOSIS

45.8 Mrs Grego took a PCR COVID-19 test on three occasions, being 14 April 2020, 17 April 2020 and 21 April 2020 and returned negative results on each occasion. Mrs Grego took a further PCR COVID-19 test on 23 April 2020 and returned a positive result. On 24 April at 6:30pm, after many failed attempts of contact, Newmarch House was informed of the result. Dr Sharma notified Mrs Grego's daughter of the result, who had been told earlier in the day that the results were clear.

ADVANCE CARE PLAN

45.9 Prior to being diagnosed with COVID-19 on 23 April 2020, Mrs Grego did not have an Advance Care Plan (ACP) or Advance Care Directive (ACD) in place.

Discussions around ACP

45.10 Ms Kerrigan states that around the time that she was informed of her mother's COVID-19 positive status on 24 April 2020, she was asked to re-visit the end-of-life plan. Ms Kerrigan states that Newmarch House staff informed her that it would be better for her mother to stay in the nursing home and be kept comfortable as nothing could be done.

45.11 On 28 April 2020, Dr Sharma spoke to Ms Kerrigan, following a review of Mrs Grego, where she was found to be "*deteriorating, looks comfortable, responsive to pain, and a plan for comfort care*" was directed by the Virtual Aged Care Service (VACS) team. Ms Kerrigan's evidence is that she had discussed the ACD with her father, and they were of the opinion that Mrs Grego was not to be transferred to hospital, she was for supportive care at Newmarch House, and she was not for CPR or ventilation. There is no written record of the ACP.

45.12 Ms Kerrigan gave evidence that she chose to keep her mother in Newmarch House, as she was informed that if she was transferred to Nepean Hospital she would be intubated, which is an invasive procedure, and this would not have made any difference to the outcome.

PROGRESSION OF ILLNESS

21 April 2020

45.13 At 6.14pm, on 21 April 2020 prior to Mrs Grego's known COVID-19 positive status, an unnamed Registered Nurse (RN) noted *"Resident was having difficulty in breathing and AIN Care staff notified RN. Resident encouraged to sit upright in the bed and checked after 10 minutes. SPO2 - 98% RA and*

difficulty in breathing decreased. Rechecked resident and resident reported that she is all right and now it is much better".

22 April 2020

45.14 At 1.00pm, Care Worker Rose O'Hara noted that Mrs Grego was very congested with her breathing, so she had been kept upright as requested by an RN.

23 April 2020

45.15 On 23 April 2020, Mrs Grego's observations were recorded twice. First at 9.50pm, SpO2 95% (BP 127/70), and again at 10.03pm, SpO2 95% RA (BP 127/70, HR 85, Temp 36.5C, RR 18).

45.16 At 7.00pm, an unnamed Care Worker noted that Mrs Grego was heavily congested. At 10.03pm, an unnamed RN noted pressure sores and recorded "*AIN notified to RN of Pressure area on sacrum, and it looked red (Level 1). Lifted pressure off the sacrum and now Olive is lying on her side. Notified AIN to change side every 2 hours to minimise the risk of PA. OBS - BTF. BP - 127/70, SpO2 - 95% RA, HR - 85, T - 36.5, RR - 18. She was coughing at times and congestion in chest noted as per handover. nil complains of breathing difficulty ATOR."*

24 April 2020

45.17 On 24 April 2020, Mrs Grego's observations were recorded four times. First at 6.00am, Sp02 97% (BP 99/60, P 76, Temp 36.6C), at 3.30pm, SpO2 94% (BP 78/53), at 6.00pm, SpO2 97% (BP 99/60), and at 8.57pm SpO2 (BP 104/75).

45.18 At 3.15am, Mrs Grego's care needs were attended to, during which it was noted that she had redness on the sacral area. She was repositioned into a comfortable position using slide sheet; her bed was placed on the lowest level with a crash mat in place, and the call bell was placed within reach. She was then checked from time to time and observed to be sleeping.

45.19 Twelve hours later at 3.34pm, Dr El Jamaly of Nepean Hospital noted the following "*Multiple calls made to Newmarch nursing home to inform them of +ve result for Mrs Grego. No answer and interestingly automated voicemail doesn't allow option to leave any messages. Will handover to evening RMO to contact the nursing home later today.*" At 4.21pm, it was noted by RN Sidney at Nepean Hospital that Mrs Grego had been discharged from Hospital in the Home (HITH), and VACS were aware and would follow up "*second daily*".

45.20 At 6.00pm, an unnamed RN noted that Mrs Grego appeared to be settled in bed and comfortable and her observations were recorded.

45.21 At 1.56am an unnamed RN noted the following in relation to what appears to be care delivered around 7.00 pm on 24 April 2020 namely, "*BP 104/75mmHg, offered more fluid via syringe, able to consume 300mls. All other obs stable, afebrile. Productive cough, nil SOB. Indwelling catheter in situ draining with yellow cloudy urine; pungent in odour – output recorded. BO today with type 6 stool.*

Sacral area appears red but still intact. PAC maintained – positioned to her side with pillow. Attended ADLs. Settling well ATOR."

25 April 2020

45.22 At 5.45pm, Mrs Grego was assessed by an unnamed RN, who noted that Mrs Grego was verbal, had dry skin and no apparent wounds. She was otherwise settled in bed. Progress notes at this time state "*O/E – IDC* [in dwelling catheter] *does not have date? Need to trace back*".

45.23 At 10.50pm, her observations were recorded as SpO2 97% RA (BP 135/80, HR 75, RR 16, Temp 36.7C).

26 April 2020

45.24 Mrs Grego was attended to at 2.20am by RN K Magunsod whose notes record that intermittent coughing was observed but Mrs Grego had no respiratory distress.

45.25 Mrs Grego's observations were recorded four times, namely at 8.30am, SpO2 97% RA (BP 137/81, HR 79, RR 18, Temp 36.7C), at 1.00pm, SpO2 92% RA (P 124/68, HR 82, RR 26, Temp 36.5C), at 2.30pm, SpO2 92% RA (RR 21), at 7.50pm, SpO2 94% RA (BP 118/65, HR 72, RR 20, Temp 36.3C).

45.26 At 2.30pm, Mrs Grego was attended to by a physiotherapist, J Thomas who noted the following:

> S: Olive supine with head of the bed 3D, LL's scissored positioning.... Olive non-communicative ... IDC in situ. Not following verbal prompts. Signs of pain, facial grimacing on re-positioning. D: RR21 RA, O2 sats 92% RA. V poor basal chest expansion. Cough during 40 mins of repositioning to high side lying. Rx: D/w care staff approp. Positioning in bed for Olive ie side-side, high long sitting. Ax: Rec bed relocate to create of room rather than by window when 2nd crash mate available to put on other side of lo-lo bed. Plan: r/v as requested.

45.27 At 6.39pm, and unknown RN attended to Mrs Grego who noted that full assistance was given with activities of daily living (ADLs), PAC [post-acute care] and that Mrs Grego ate minimal amounts, oral fluids were encouraged and that the family were contacted regarding the slow deterioration and all meds were charted. Regular medication appears to have been administered.

27 April 2020

45.28 On 27 April 2020, Mrs Grego's observations were recorded once at 12.00pm, SpO2 sat 97% RA (BP 103/65, HR 86, RR 12, Temp 36.2C).

45.29 At 3.43am, Mrs Grego had a very productive cough but was unable to expectorate. The RN noted that Mrs Grego was in no respiratory distress and her needs were attended and noted her indwelling catheter was in situ. A WhatsApp call with the family was organised.

45.30 Twelve hours later at 3.54pm, Mrs Grego was attended to by St Vincent's Hospital (SVH) staff, her airways were maintained, and she had verbal communication ability, was breathing spontaneously and her skin looked "*okay*". It was further noted that Mrs Grego responded to pain stimuli when her

bed was rolled. Mrs Grego had her needs attended to, she was cleaned and repositioned, with a plan for more frequent PAC, pad checks and oral hygiene.

28 April 2020

45.31 On 28 April 2020, Mrs Grego's observations were recorded four times. At 1.00am, SpO2 91% RA (BP 124/76, HR 92, RR 16, Temp 36.2C), at 6.00am, SpO2 91% RA (BP 123/76, HR 92, RR 16, Temp 36.0C), at 4.00pm, SpO2 90% RA (BP 120/77, HR 94, RR 26, Temp 36.4C), at 11.00pm SpO2 94% RA (BP 110/68, HR 89, RR 28, Temp 36.8C).

45.32 At 1.00am, it was noted that Mrs Grego was resting quietly overnight and had all her care needs attended to. At 3.32am, an unknown RN noted that Mrs Grego has an IDC in situ which was draining moderate amounts of urine. She was breathing spontaneously, and pressure areas and pad changes were attended to.

45.33 At 10.52am, a VACS videoconference with Dr Sharma, Dr Kathiresan, Nurse Practitioner (NP) Carpen and facility RNs took place with notes recording "*deteriorating, looks comfortable, responsive to pain, minimal oral intake. Plan – comfort care, need to complete ACD".* This appears to be the first VACS consultation.

45.34 At 3.20pm, Mrs Grego was attended to by an RN from SVH who noted that she had no signs of respiratory distress, and that her care needs were attended to. As noted earlier in these submission, Dr Sharma spoke about Mrs Grego's ACP. At 5.30pm, an assistant in nursing (AIN) noted that Mrs Grego's personal care had been attended to but that she had hardly eaten. Pressure areas were checked, and mouth swabs were performed every two hours as per service agreement although we note that the two hourly checks are not recorded in the clinical records. At 7.15pm, it was noted that Mrs Grego was very sleepy and drowsy with poor oral intake. She was changed on to an air mattress.

29 April 2020

45.35 On 29 April 2020, Mrs Grego's observations were recorded four times. At 4.00am, SpO2 94% RA (Temp 36.8C, BP 110/68, RR 28, HR 89), at 6.20am, SpO2 88% RA (BP 120/78, HR 82, Temp 36.5C), at 10.25am, SpO2 93% (BP 80/54, HR 91, RR 23, Temp 36.9C), and at 11.00pm, SpO2 98% (BP 95/61, HR 65, RR 16, Temp 37.9C)

45.36 At 4.00am, Mrs Grego was attended to by an unnamed nurse and was observed to be sleeping comfortably in bed. She took medication and was given some more water. The unnamed nurse's note record "*When I was on the round, I found her lying on the floor... There was no wound. Both feet are mottled. Her vitals were T36.8, BP 110/68, R28, HR89, O2 94% on RA".* Mrs Grego was then attended to by RN Vincent at an unknown time and the following was noted *Repositioned Olive in bed and made more comfortable. Manage to take oral meds this AM with some yoghurt. Pad changed and bowels open a small amount. Observations taken. Needs lots of encouragement with diet and fluids. Pressure area intact but vulnerable. I will update family later. Mouth care given."*

45.37 At 4.05pm, Mrs Grego was attended to by SVH staff. It was noted that Mrs Grego was "*breathing naturally. Skin colour okay. Warm to touch. Non-verbal, responds to pain. Eyes open spontaneously.*

IDC draining. Dark, concentrated urine. BO, pad changed. Bilateral heel redness, nil broken areas. Recommended 2hour PAC, pad checks. Pt condition unchanged". At 5.25pm, Mrs Grego's temperature was 36.6C.

30 April 2020

45.38 On 30 April 2020, Mrs Grego's observations were recorded six times. At 2.00am, SpO2 was not recorded (BP 95/61, Temp 37.9C), at 5.20am, SpO2 97% (BP 110/52, HR 90, RR 18, Temp 36.2C), at 10.00am, O2 sat 90% RA (BP 114/73, HR 91, RR 18, Temp 36.0C), at 3.00pm, SpO2 77% on 2L O2 (BP 107/80, HR 92, RR 16, Temp 36.3C), at 6.57pm, SpO2 77% on 2L NP, and at 9.00pm, SpO2 75% on 2L O2 (BP 98/75, HR 105, RR 22, Temp 36.2C).

45.39 At 2.00am, an agency RN noted the following:

> Olive care taken at 2100. When I arrived at around 2300 to give her meds Olive was lying out of bed on crash mat facing on her right side lying on it. IDC [in dwelling catheter] marked her skin and right arm. No bruise, only redness on right side. She was lying on check the mouth no fears noted. Had some old food coming out of mouth. Was cleaned, BP 95/61 [illegible] Temp was 37.9. Was given [illegible]. Rechecked at 0100 down to 37.0. Stable, repositioned in bed and follow support. Her right side has been checked... TL informed of Olive found on crash mats. Said they don't regard as fall as long as there are on crash mats.

45.40 At 8.00am it was noted that staff attended to Mrs Grego and repositioned her and attended to her oral care, eye care, PAC and checked her pad.

45.41 At 12.07pm, VACS videoconference was conducted with Dr Sharma, Dr Kakkat, Dr Kathiresan, Dr Sahil and facility Registered Nurses. NP Carpen noted the following:

> Resting in bed, continues to deteriorate, non-responsive, distressed at times, ulcer on lip, difficult to perform mouth care, ACD documented. Plan: mouthcare, pressure care, continue comfort care, give small dose of midazolam for distress.

45.42 At 6.57pm, an unnamed RN noted that "G*eneral pt condition noticed to be declined. Obs attended and saturating 77% on 2L O2/NP. Other obs in normal range. Afebrile. Repositioned. Reviewed by Dr this AM. IDC in situ. Continue to monitor".* At 8.20pm it was noted that Mrs Grego's daughter, Ms Kerrigan, had been informed that Mrs Grego was drowsy and was therefore unable to be provided food and fluids. Mrs Grego had cyanosis to her nails and her peripherals were cold to touch. It was noted that Ms Kerrigan was unable to visit her mother, as she is immunocompromised.

45.43 At 11.00pm, an unnamed Registered Nurse recorded the following:

> General decline, resps 22-24, rapid and shallow however nil difficulty of breathing. Nil facial grimace or any physical signs of pain. For comfort care. Nil verbal nor physical agitation noted. Due meds withheld due to increased risk of aspiration. Unable to provide food/fluids due to down LOC. GP to cease oral meds, message left in Doctor's list to r/v tomorrow. Significant cyanosis to fingers and hands, peripherals cold to touch – extra blanket provided. PAC maintained Q2H c x2 GA via slide sheet. Daughter notified of same, emotional support given. Continue to monitor, commenced on comfort care.

1 May 2020

45.44 On 1 May 2020, Mrs Grego's observations were taken once at 10.00am. Her temperature was recorded as 36.3C.

45.45 At 6.20am, an unnamed RN noted that they were constantly checking on Mrs Grego throughout their shift. It was noted that Mrs Grego continued to decline, and her fingers and hands were purplish in colour. At 3.00pm, Mrs Grego was seen by an SVH RN who recorded *"Asleep and PIB ATOR. Comfort care measures in place. RR 24/min on RA. SIV. Nil signs of respiratory distress/SOB. [illegible]... nil signs of pain. NRM, IDC in situ. VCS & cloudy. BO x 1, soft PAC, nil OI's seen [illegible]... sacrum/heels intact. Repositioned and pad changed. Oral care attended. To continue to monitor."*

45.46 A progress note at 3.10pm noted that Mrs Grego was unresponsive and was for terminal care, oral and eye care. At 5.00pm, Mrs Grego was attended to by an unnamed nurse who noted medications had been ceased and palliative care had been continued. Mrs Grego was administered morphine 2.5mg and midazolam 5mg via subcutaneous butterfly 2/2 at 11.am, 2.00pm, 4.45pm for "*PAL care, agitation and settlement."*

2 May 2020

45.47 At 1.30am, RN K Magunsod attended to Mrs Grego and noted that she appeared to be comfortable in bed with no physical signs of pain or discomfort, and no agitation nor respiratory distress. It was further noted that PAC was maintained, and her mouth was kept moist. Additionally, the following was recorded "*NBN status maintained. Nil output noted in IDC. RN spoken to daughter Helen on the phone regarding update, thankful for the care the team is giving. Monitored continuously. Comfortable ATOR."*

45.48 At 4.00pm, an AIN noted that care was provided to Mrs Grego including oral care, dress changed, and pad changed. The AIN noted that Mrs Grego was not alert, so food was not given. Her bed was noted to be on the lowest height with a crash mat in situ, her catheter was to continue, and her pad was changed. At 6.45pm a nursing note indicated that a palliative care plan had been attended to, all anticipatory medications were given via subcutaneous butterfly, and Mrs Grego appeared settled. Handwritten records note that 5mg of midazolam and 2.5mg of morphine was administered at 6.00am, 8.30am, 12.00pm, 2.30pm, 5.30pm and 9.30pm for pain relief and agitation.

45.49 No observations were recorded on 2 May 2020.

3 May 2020

45.50 At 2.30am, RN K Magunsod noted that Mrs Grego appeared comfortable in bed with no physical signs of distress or agitation. PAC was administered and oral hygiene was attended to. Her IDC was in situ and draining, but there was very minimal concentrated urine observed. At 10.30am, AIN Ken Jepkenei noted that Mrs Grego's personal care, pressure care, mouth care and observations were completed as per service agreement. At 1.00pm, Mrs Grego's temperature was recorded to be 34.3C although Counsel Assisting questioned the accuracy of this recording. At 1.45pm RN Vincent noted that Mrs Grego appeared comfortable. RN Vincent noted the following *"Fingers and lips are cyanosed,*

2L O2 remains in situ for comfort. Regular mouth and personal care given. We will call daughter Helen to reassure her mum is comfortable. No concerns with current care plan."

45.51 At 6.30pm, Mrs Grego was again attended to by AIN Ken Jepkenei who noted that pressure care, mouth care and observations had been performed and recorded. Handwritten records note that 5mg of midazolam and 2.5mg of morphine was administered at 1.20am, 5.35am and 4.30pm for pain relief and agitation.

4 May 2020

45.52 At 6.20am, an RN noted the following "*Olive appears to be comfortable. Pressure area care performed regularly and sides changed to minimise pressure area. Residents fingers and legs were cold, so appropriately tucked in to blanket. It appears that she has lost or has very low blood circulation in both arms and legs. Oral wash performed regularly to ensure her mouth stays moist. Nil pain or work of breathing noted upon observation. Nil pain relief provided due to same".*

45.53 At 10.10am, a videoconference was conducted with Dr Sharma, Dr Kakkat, Dr Kathiresan and facility RN Monica. RN Carpen noted the following:

> Resting in bed, appears comfortable. Entering terminal phase. No longer performing observations. Plan: continue comfort measures, oral/eye care, pressure care. Dr Sharma attempted to contact daughter Helen. Left message on answering machine.

45.54 At 10.15am, 2.5mg of morphine and 5mg of midazolam was administered for pain and agitation. This appears to be the last dose of anticipatory medication administered to Mrs Grego.

45.55 At 2.40pm, RN Smith noted *"Olive appears to be comfortable. Personal care attended. PAC attended. BO once this morning, small amount type 7 eyedrops given. Residents fingers and feet cyanotic. On 2L oxygen via NP. NOK contacted."*

45.56 On 4 May 2020, Ms Kerrigan received a call from Dr Kakkat, who informed her that her mother's condition was improving. This was contrary to Ms Kerrigan's understanding, based on conversations with staff at Newmarch House, which indicated that her mother was deteriorating and close to the end of her life. After the call with Dr Kakkat, Ms Kerrigan called a nurse at Newmarch House and was informed that the information provided by Dr Kakkat was incorrect. Subsequently, Dr Kakkat called Ms Kerrigan apologising for his error and indicated that he had mistakenly read from another residents' records.

45.57 Ms Kerrigan's evidence is that the mistake caused her a lot of distress and made her feel like her mother was just a number and not a real person.

5 May 2020

45.58 At 3.30am, an unnamed RN noted *"Olive seems comfortable and pressure area care performed regularly. Nil signs of respiratory distress noted ATOR. RR = 20-22. RIB. Lying on her back and mouth open. Mouth care performed to keep mouth moist. Nil issues ATOR. Confirming comfort measures*."

45.59 A progress note entry made at 3.40pm records that Mrs Grego was found deceased by a nurse during morning rounds for medications and vitals. The medication charts recorded a 9.35am entry of "*missed*" for her usual medications. There is no entry noting the reason. RN Shrestha notified the nurse in charge and informed the doctor.

45.60 Dr Branley spoke to Ms Kerrigan to inform her of her mother's death. Ms Kerrigan noted that it was more upsetting because she had been told false information the previous day which Dr Branley was unaware of. A short time later Ms Kerrigan received a call from Grant Millard, CEO of Anglicare, who gave his condolences and apologised for the misinformation given by Dr Kakkat.

MANNER AND CAUSE OF DEATH

45.61 **Cause of Death**: Associate Professor Kotsimbos, Professor French and Professor Kurrle agree that the cause of death was COVID-19 infection with significant comorbidities including widespread vascular disease, poor mobility and dementia.

45.62 **Manner of Death**: Mrs Grego was noted to be coughing on 21 April 2020 and on 22 April 2020 she showed signs of shortness of breath and tachypnoea (98% oxygen saturation on room air). Between 26 to 28 April 2020 Mrs Grego's clinical state deteriorated with her becoming increasingly drowsy and decreasing her oral intake. On 28 April 2020, Mrs Grego sustained a fall, and her oxygen levels were decreasing (75%). On 30 April 2020, Mrs Grego was noted to be "*distressed at times*" and "*non-responsive.*" Mrs Grego was seen by the Palliative Care Team on 1 May 2020, following which end of life medications were administered (midazolam and morphine). Comfort care continued (morphine and midazolam administration) until the day prior to death. The experts considered her end-of-life care was quite protracted, with anticipatory medications being given over four days.

45.63 **Impact of any significant co-morbidities**: Significant dementia, very poor mobility and widespread vascular disease all played a role. Professor Kurrle considered that Mrs Grego's peripheral vascular disease contributed significantly to Mrs Grego's death because she probably was not able to cooperate with her treatment. Professor Kurrle did not think that anything more could have been done to change Mrs Grego's outcome.

45.64 **Issues with care received**: The experts noted that some empirical antibiotics were given for a urinary tract infection, and it is not clear how much oxygen support she had been given, as there was minimal documentation after she was diagnosed with COVID-19. The experts found that observations of her appear to have been quite limited because of the incorrect message which was conveyed by Dr Kakkat, however it is noted that this may have been the individual error of Dr Kakkat and not reflective of the care nursing staff at Newmarch House were delivering. The experts opined that the extent of her dementia likely resulted in her inability to cooperate with treatment. Associate Professor Kotsimbos (and Professor French) further noted that the progress notes were very sparse, with observations being limited, which made it very difficult to determine whether Mrs Grego received adequate oxygen therapy.

45.65 **Whether different action may have affected the outcome**: Yes

45.66 Associate Professor Kotsimbos noted that Mrs Grego was diagnosed with COVID-19 on 23 April 2020, and that she had three negative results before her positive test results. Therefore, the query is raised (as has been done with other residents who died at Newmarch House prior to Mrs Grego) whether Mrs Grego's infection could have been avoided. Associate Professor Kotsimbos noted that Mrs Grego displayed symptoms of COVID-19 on 22 April 2020, the day before she tested positive for COVID-19. Given the sparse notes, Associate Professor Kotsimbos could not determine whether anything more could have been done to change Mrs Grego's outcome.

45.67 Professor MacIntyre was of the view that COVID-19 infections after 18 and 19 April 2020 were potentially preventable for the reasons outlined above. Given three negative tests on 14, 17 and 21 April 2020 in the case of Olive Grego, more than one of those negatives was likely a true negative. As a result, if a different model of care had been adopted, involving in the initial period a transfer out of COVID-19 positive residents until infection control measures were properly in place and sufficiently skilled staff were present, Mrs Grego's death was likely preventable.

45.68 It is noted that the evidence of Olive Grego's daughter Ms Kerrigan is that she was "*impressed*" with the regular updates from George and the nursing staff and that she received daily updates and all of her questions answered. This evidence reflects the generally better management and communication that commenced with the increase in staffing number, including the highly skilled nursing staff from St Vincent's Hospital and Baptist Care around 24 April 2020, two weeks into the Outbreak.

45.69 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Olive Grego.

Date of death

Mrs Grego died on 5 May 2020.

Place of death

Mrs Grego died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Grego's death was COVID-19 infection with Alzheimer's and vascular dementia and generalised vascular disease being significant conditions which contributed to death.

Manner of death

Mrs Grego died of natural causes following diagnosis of COVID-19 infection. Due to the paucity of documentation it is unclear whether Mrs Grego received adequate oxygen therapy, although it is unlikely that any other management steps could have been instituted which would have materially altered the eventual outcome. However, given the timing of Mrs Grego's COVID-19 diagnosis on 23 April 2020, her infection may have been prevented if a different model of care had been implemented.

46. Fay Rendoth

HEALTH

Co-morbidities

46.1 Fay Rendoth was 92 years old when she passed away on 8 May 2020 at Newmarch House during the COVID-19 Outbreak. She had a number of existing comorbidities including ischemic heart disease with stenting (IHD), acute myocardial infarction (AMI), hypertension, chronic obstructive pulmonary disease (COPD), osteoarthritis, hypothyroidism, anxiety and depression. Mrs Rendoth had also laboured under multiple falls/fractures, urinary and faecal incontinence, chronic pain, recurrent urinary tract infection (UTI), macular degeneration, hearing loss, delirium, and a chronic ulcer to her left leg (2019). Ms Rendoth was able to mobilise but she needed assistance with activities of daily living.

Background and events leading up to COVID-19 diagnosis

46.2 Mrs Rendoth previously lived alone. On the evening of 14 June 2019, Mrs Rendoth experienced a fall and an ambulance were called. Mrs Rendoth did not require transfer to hospital and was able to walk afterwards. On 17 June 2019, Mrs Rendoth called her daughter, Jayne Finlay and informed her she was not able to get out of bed. An ambulance was again called, and she was transferred to Katoomba Hospital.

46.3 On 2 October 2019, Mrs Rendoth experienced a fall and broke her hip, was operated on and subsequently spent time in Springwood Hospital for rehabilitation until 29 October 2019 when she moved into Newmarch House. Prior to her move she started to experience occasional hallucinations, sometimes referred to as "Sunset Dementia." After her entry to Newmarch House, Mrs Rendoth preferred to stay in her room and did not socialise with other residents. In December 2019, Mrs Rendoth became verbally resistive towards personal care and was prone to UTIs. On 20 February 2020, a case conference occurred with the family to discuss Mrs Rendoth's decreased mobility and associated risks. She was able to walk independently with a walker.

RELEVANT MEDICATIONS

46.4 Mrs Rendoth was prescribed a number of regular medications including Axit 15mg, Diovan 160mg (IHD/AMI/Hypertension), Eutroxig 75mcg, Ostelin Vitamin D 25mg, Pariet 20mg, Plavix 75mg, Buprenorphine 10mcg/hour patch, Transdermal check patch, Mestal cream, Ventolin 200mcg (COPD), Gastrogel antiacid oral liquid, Laxative + Senna, Palexia IR 50mg, Panamax Elixir 240mg/5mL, Systane 0.4% eye drops, Ventolin inhaler (COPD) and Seroquel. She took Clopidogrel for her IHD/AMI and Hypertension. On 6 April 2020, Mrs Rendoth was also prescribed Syquet 20mg of half tablet twice daily PRN (as required) to a maximum of 1 tablet per day, Norspan 10mcg/L and Mirtazpre 15mg.

PRN Medication - Midazolam and morphine

46.5 On 22 April 2020, five days after Mrs Rendoth's COVID-19 positive diagnosis, Mrs Rendoth was prescribed 'anticipatory medication,' namely Hypnovel (midazolam) 5mg/mL injection of 0.5mL to 1mL every one hour to a maximum of 12mL per day PRN for agitation; Maxalon 10mg/2mL injection of 2mL three times a day to a maximum of 6mL PRN for nausea; morphine sulphate 10mg/mL injection of 0.25mL every one hour PRN to a maximum of 4mL per day, for shortness of breath and pain; Robinul 200 mcg/mL injection of 1mL to 2mL every two hours PRN to a maximum of 8mL per day, for mucous secretion and sodium bicarbonate mouthwash.

46.6 On 1 May 2020, Mrs Rendoth was not administered her usual medications. At 10.25am, Mrs Rendoth was administered with 0.25ml of morphine sulphate (DBL) 10mg/mL injection for terminal agitation.

46.7 On 2 May 2020 at 9.53am, it was recorded for the first time that Mrs Rendoth was administered a dose of 2.5mg of morphine due to terminal agitation; at 10.25am for agitation; at 3.15pm for pain; at 5.09pm for pain and agitation; and at 5.10pm Mrs Rendoth was administered 5mg midazolam due to agitation.

46.8 On 3 May 2020 she was administered 2.5mg morphine and 5mg midazolam for pain and agitation at 1.20am, 5.25am, 8.05am and 5.30pm. From 8.05pm onwards, Mrs Rendoth refused medications and was not given her usual medications as she was drowsy.

46.9 On 4 May 2020 Mrs Rendoth was administered 2.5mg morphine and 5mg midazolam for pain and agitation at 9.45am, 1.20pm and 4.30pm.

46.10 On 5 May 2020 at 6.49am, Mrs Rendoth was administered 2.5mg of morphine for pain but not midazolam as it was out of stock; and at 12.36pm Mrs Rendoth was administered 2.5mg of morphine.

46.11 On 6 May 2020, Mrs Rendoth was administered 2.5mg morphine at 11.00am, 3.30pm and 5mg midazolam at 1.00pm and 6.15pm.

46.12 On 7 May 2020 Mrs Rendoth was administered 2.5mg morphine and 5mg midazolam for pain and agitation at 12.10am, 6.00am 11.10am, 12.29pm(?), and 2.40pm.

46.13 On 8 May 2020 she was administered 2.5mg morphine for pain. She passed away later that day.

COVID DIAGNOSIS

46.14 Mrs Rendoth took a combined nose/throat PCR test on 14 April 2020 and tested negative to SARS-Cov-2. She took another combined nose/throat PCR test on 17 April 2020. It was found to be positive for COVID-19. Her daughter, Ms Jayne Finlay, was informed of the positive COVID-19 test result by Dr Rezk, (Mrs Rendoth's usual GP) at 7.30pm that day. Following a third combined nose/throat PCR test on 5 May 2020, Mrs Rendoth returned a negative result on 6 May 2020. Her daughter was informed of the negative result on 9 May 2020, following Mrs Rendoth's death on 8 May 2020.

ADVANCE CARE PLAN

46.15 Mrs Rendoth did not have an Advance Care Plan (ACP). Her daughter Ms Finlay prepared and signed an Enduring Power of Attorney on 28 October 2015, appointing herself as Power of Attorney.

Discussions around ACP

46.16 On 18 April at 8.29pm, Newmarch House Care Manager Leann Hinton informed Ms Finlay of Mrs Rendoth's positive test, and noted:

> [Jayne] was surprised as she was just talking to her and that she was coughing for a long time and needs nicer cough medicine. I discussed with her advanced care directive and she mentioned that she discussed with her family and prefers not to transfer to hospital or use any life support medicine in case she suffered any complications related to Covid 19. Notes by Dr Rezk.

46.17 On 22 April 2020 at 5.31pm, the notation in relation to an ACP discussion between Nepean Hospital Virtual Aged Care Service (VACS) Nurse Practitioner (NP) Carpen, Dr Natalie Fox and Ms Finlay was:

> Advance Care Planning Dr Natalie Fox (Geriatrician at Nepean Hospital) has had a discussion with Fays daughter Jayne. Agreeable that Fay is not for resuscitation in case of cardiopulmonary arrest Not for intubation and ventilation Agreeable for comfort measures if Fay deteriorates.

46.18 However, Dr Fox's note in the Nepean Hospital notes at 4.21pm recorded Ms Finlay's wishes regarding her mother being transferred to hospital:

> Contacted daughter Jayne.
> Agreeable that Fay is not for resuscitation in case of cardiorespiratory arrest and not for intubation/ventilation.
> Agreeable for comfort measures if deteriorates. Jayne however has expressed that she would like her mother transferred to hospital if there is insufficient nursing staff at Newmarch House to provide appropriate care to her mother.

PROGRESSION OF ILLNESS

46.19 Of note is that prior to Mrs Rendoth's COVID-19 positive diagnosis, she experienced coughing on 28, 29 and 30 March 2020, for which she was given cough medicine. On 5 April 2020 she complained of a cough and stated that she had been coughing all night. Staff offered her cough syrup, however, she refused. Mrs Rendoth placed a sheet over her head.

17 April 2020

46.20 Mrs Rendoth returned a positive result for SARS-CoV-2. At 8.48am, Mrs Rendoth was administered her regular medications. Newmarch House Care Manager Hinton asked an RN to write up cough medicine. At 11.07pm, Mrs Rendoth refused her Ventolin.

18 April 2020

46.21 On 18 April 2020, Mrs Rendoth's observations were recorded once at 8.45pm, SpO2 98% (BP 137/79, P 103, RR 20, Temp 36.7C).

46.22 At 5.46pm, Mrs Rendoth was admitted to Hospital in the Home (HITH). She was asymptomatic, except for what was considered a long-term cough, which she suffered from prior to the Outbreak. Her GP, Dr Rezk, informed the family and Ms Hinton had a discussion with Ms Finlay about Mrs Rendoth's ACP as noted above in these submissions. Throughout the day, Mrs Rendoth was administered her usual medications.

19 April 2020

46.23 On 19 April 2020, Mrs Rendoth's observations were recorded three times. First at 11.00am, SpO2 was not recorded (BP 115/75, P 78, RR 17, Temp 37.2C), and then over four hours later at 3.30pm SpO2 97% (BP 135/72, RR 17, Temp 37.2C), then at 4.00pm, SpO2 97% (BP 130/72, P 77, RR 17, Temp 36.5C).

46.24 At 1.45am, an unknown nurse noted:

> RN informed Fay this evening that she was Covid-19 positive, [F]ay was extremely distressed by this news and was asking RN if she will survive. RN stated that as this stage all her vital signs were looking good. Fay stated that she currently doesn't have any symptoms but has requested Panadol and cough medicine overnight. All other medications given as charted. Fay stated that she recently started praying to God that she would die to be with her husband, and maybe this was a way that she could be with him. Fay went on to talk about how her husband would have been married for 70 years this year. RN spoke to [F]ays daughters Kaye and Jayne, who stated that they were happy with the care that there mum was receiving and would like to be provided with updates as regularly as possible.

46.25 At 7.30am, Mrs Rendoth refused breakfast and was "*grumpy.*" She was administered cough medicine. At approximately 10.30am, Ms Finlay contacted Newmarch House to advise that Mrs Rendoth had not been provided with her breakfast. Ms Finlay was informed that Mrs Rendoth refused breakfast and refused alternative food options. At 2.00pm, Mrs Rendoth was given two plates of crackers and biscuits and an unknown RN offered to administer eye drops to her. Mrs Rendoth refused.

46.26 At 3.35pm, Nepean Hospital RN Sidney noted:

> have attempted to call nursing home on three different numbers with no answer. one of the people called was the case manager Leanne Hinton who also didn't answer the phone so a message was left for her to contact outreach when possible. no return call ATOR. have also called the VACS on call to find out if there is anyway of getting information on the residents and she advised that ii there was anything major with any of them she would advise us. if possible could we get a system in place where the RN from each ward where the residents are located call outreach and just give a quick update on each patient when that RN has time to do so. or even one person from the nursing homo give outreach a call with an update on each patient

46.27 At 5.20pm, Newmarch House Manager, Christine Giles contacted Ms Finlay and updated her on Mrs Rendoth's condition. At 9.11pm, Mrs Rendoth was administered 20mls of Panamax Elixir and 10mls of Senega and Ammonia mixture. Throughout the day, Mrs Rendoth was administered her usual medications.

20 April 2020

46.28 On 20 April 2020, Mrs Rendoth's observations were recorded twice. First at 12.24am, SpO2 99% (BP 170/76, P 84, RR 19, Temp 36.7C), then almost 12 hours later at 11.57am, SpO2 was not recorded (BP 178/91, P 98, Temp 36.3C).

46.29 At 12.09pm, Dr El Jamaly informed Newmarch House of the positive COVID-19 result. Counsel Assisting noted the delay of three days from tests results being known, however also notes the recorded entries of HITH regarding difficulties on 18 and 19 April 2020 in contacting Newmarch House.

46.30 At 12.24am, it was noted that Mrs Rendoth refused dinner. At 7.54am, Nepean Hospital Nursing Unit Manager (NUM) Jillian Hennessy contacted Newmarch House staff who stated that Mrs Rendoth was showing "*a few symptoms that she wasn't showing before"* and that staff were happy to keep Mrs Rendoth at Newmarch House. NUM Hennessy was to contact the VACs team to inform them of the same.

46.31 At 7.08pm, Newmarch House Manager, Melinda Burns, provided Mrs Rendoth's family with an update. At 9.57pm, Mrs Rendoth was administered cough medication, and 20mls of Panamax Elixir for her temperature of 38.3C. At 11.57pm, Mrs Rendoth was awake and alert and stated that she felt much better. Mrs Rendoth requested Panadol for her knee pain and Senegal for coughing.

21 April 2020

46.32 On 21 April 2020, Mrs Rendoth's observations were recorded four times. At 4.45am, SpO2 97% on RA (Temp 36.7C, P 66), at 9.00am, SpO2 97% (BP 100/64, P 88), at 1.00pm, SpO2 96% (BP 100/64, P 88, RR 21, Temp 36.8C), and at 7.00pm, SpO2 was not recorded (BP 119/97, P 69, RR 20, Temp 36.2C).

46.33 At 9.00am, Mrs Rendoth complained of shortness of breath. At 10.15am, Mrs Rendoth was administered her usual medications. At 5.00pm, an unknown RN noted that Mrs Rendoth was attended to by a doctor, who spoke calmly to her as she was anxious. Her medications were given. At 6.29pm, Manager Renata Zdziebko provided an update of Mrs Rendoth's condition to Ms Finlay and advised that Mrs Rendoth's leg wound would be attended to. At 6.39pm, Mrs Rendoth was not administered her usual medication. At 7.55pm, Mrs Rendoth refused to be administered Axit 15mg.

22 April 2020

46.34 On 22 April 2020, Mrs Rendoth's observations were recorded four times. At 6.50am, SpO2 97% (BP 105/82, P 87, Temp 36.5C), at 10.50am, SpO2 98% (BP 137/72, P 82, RR 18, Temp 36.5C), at 7.30pm,

SpO2 98% (BP 133/69, P 79, RR 18, Temp 36.6C), and at 9.00pm, SpO2 98% (BP 116/76, P 68, RR 18, Temp 36.3C).

46.35 Newmarch House staff member Sandra Dean noted that Mrs Rendoth commenced Rulide 105mg BD "*when* [she] *became symptomatic"* for what was suspected and confirmed as a respiratory tract infection. However, there are no notes suggesting this was prescribed or administered to Mrs Rendoth. At 10.39am, Mrs Rendoth was administered her usual medications. At 10.50am, no shortness of breath was noted. At 2.20pm, Newmarch House Lifestyle Team Leader Lisa Courtney provided Mrs Rendoth with emails sent in by her family for her wedding anniversary. At 3.05pm, Nepean Hospital Dr Natalie Fox contacted Ms Finlay about Mrs Rendoth's ACP, as outlined above in these submissions. At 4.58pm, VACS NP Carpen recorded notes from her remote review of Newmarch House notes, namely:

> Mrs Fay Rendoth 92 year old lady with COVID19 under care of HITH Documentation reveals ongoing cough Note mild hypotension Please encourage oral fluids If hypotension persists will need to withhold morning antihypertensive Please continue to monitor BP.

46.36 At 5.55pm, Mrs Rendoth was administered her usual medications. Two hours later at 7.27pm, Mrs Rendoth she was not administered her usual medications, with no recorded reasons as to why. At 7.30pm, no shortness of breath was noted. At 7.52pm, RN Lawrence Gonzales attend on Mrs Rendoth who denied pain or discomfort. Mrs Rendoth made complaints about the food.

23 April 2020

46.37 On 23 April 2020, Mrs Rendoth's observations were recorded five times. At 10.40am, SpO2 was not recorded (BP 116/60, P 58, RR 16, Temp 36.6C), at 2.00pm, SpO2 98% (BP 111/76, P 63, RR 18, Temp 36.6C), at 2.10pm, SpO2 98% RA (BP 111/76, Temp 36.6C, RR 18, HR 63), at 6.00pm, SpO2 97% (BP 110/90, RR 19, Temp 36.4C), at 9.00pm, SpO2 92% (BP 129/88, P 93, RR 18, Temp 37.2C), at 11.40pm, SpO2 92% RA (BP 129/88, P 93, RR 18, Temp 37.2C).

46.38 At 3.44am, an unknown RN recorded that Mrs Rendoth had no cough or shortness of breath during their shift. Mrs Rendoth was administered with her dose of Rulide and the RN apologised for the delay. She did not consume her dinner of fish. Ms Finlay was informed of her mother's minimal food intake. Ms Finlay requested that staff not put pepper on her food, and advised that Mrs Rendoth likes hot milk, Weetbix and a banana for breakfast. At 11.00am, Newmarch House Manager Christine Giles noted that she contacted Ms Finlay to discuss concerns about Mrs Rendoth's toilet door being locked, and that the lock will be disengaged.

46.39 At 11.34am, it appears that Dr Kakkat may have conducted one of the very few in person reviews of a COVID-19 positive resident. The clinical note records "*Pt is afebrile BP /pulse normal No symptoms Chest clear Plan continue same medications*".

46.40 It is noted that the ambiguity in the direction 'continue same medications' given in the preceding 48 hours Mrs Rendoth's usual medication was both given and withheld so it is unclear what 'continue same' now means. The absence of a thorough review, examination, assessment and management

plan as reflected in the briefness of this clinical record, unfortunately appears representative of the clinical care adopted by VACS, in particular Dr Kakkat and Dr Sharma for all COVID-19 residents.

46.41 At 4.10pm, Mrs Rendoth's clinical records at Newmarch House were accessed and reviewed by Nepean Hospital RN Sidney, who recorded the following case note: "*symptoms: patient good BP 111/76 temp36.6 sats98%RA RR 18 HR63".* At 6.45pm, Mrs Rendoth refused to eat all meals; staff continuously brought her cups of tea, but she refused these along with personal care assistance. At 9.00pm, no shortness of breath or coughing was noted. At 11.40pm, RN Gonzales noted that Mrs Rendoth was alert and conversant. She denied any pain or discomfort but had an on and off cough. Throughout the day, Mrs Rendoth was administered a majority of her medications.

24 April 2020

46.42 On 24 April 2020, Mrs Rendoth's observations were recorded four times. At 10.40am, SpO2 92% (BP 120/68, P 90, RR 18, Temp 36.7C), at 4.58pm, SpO2 92% RA (BP 112/77, Temp 36.7C), at 5.50pm, SpO2 97% (BP 117/66, P 101, RR 18, Temp 36.6C), and at 8.28pm, SpO2 92% (BP 115/75, P 85, RR 20, Temp 36.6C).

46.43 At 1.04am, an unknown RN noted that Mrs Rendoth refused dinner in the evening, and had informed her daughter that she had received no water all day despite bottled water and tea being provided to her. At 5.11am, Mrs Rendoth refused to be administered her antidepressant (Axit) medication. At 9.00am, Mrs Rendoth refused personal care and food. She appeared to be constantly physically agitated, socially isolated and withdrawn. At 10.43am, the VACS team including NP Carpen, Dr Sharma and a facility RN reviewed Mrs Rendoth and noted "*resting in bed Complaining of headache, Very upset Not breathless Plan Provide reassurance Panadol for headache Refer to chaplain for support*." Ms Finlay was informed of her condition.

46.44 Mrs Rendoth refused foods throughout the shift. Alternatives were offered, however, she continued to refuse. At 3.00pm, Mrs Rendoth was given 75mls of water to consume. At 4.25pm, Nepean Hospital RN Sidney noted that Mrs Rendoth was discharged from HITH, that VACS was aware and a second daily follow up was to occur. At 4.28pm, Mrs Rendoth was administered 20mls of Panamax Elixir for pain and a headache.

25 April 2020

46.45 On 25 April 2020, Mrs Rendoth's observations were recorded once at 8.15pm, SpO2 94% (BP 105/82, P 98, RR 18, Temp 36.9C).

46.46 At 1.41am, an unknown RN noted Mrs Rendoth's observations were within the standard adult general observations (SAGO) limits. She had no cough or shortness of breath. However, Panadol and cough syrup was administered as required. Mrs Rendoth refused fluids and food and stated she felt a bit dizzy. At 8.00am, an unknown RN noted that Mrs Rendoth complained of a headache. She refused to have her observations taken, she also refused regular medications, pain relief and personal care despite faecal incontinence. The RN attempted to contact Dr Rezk regarding Mrs

Rendoth's refusals. Ms Finlay was informed of her behaviour and agreed for the administration of morphine as required. At 10.43am, it was noted that Mrs Rendoth had a respiratory tract infection and that there was a "*change in respiratory, mental or functional status, new or increased dry or moist cough and Temperature greater than 38C"* and that Mrs Rendoth is "*currently having ongoing management of infection with VACs team Dr Kakkat and NP Haley Carpen. PHU/Dept Health aware of positive results."*

46.47 At 11.30am, Mrs Rendoth was administered Panamax. At 2.00pm, Mrs Rendoth refused to have her observations taken. At 4.30pm, Mrs Rendoth complained of a headache. At 5.15pm, it was noted that Mrs Rendoth was depressed about ANZAC Day coming up. Her observations were noted to be stable, and she refused to have her morning medications. At 9.00pm, Mrs Rendoth was given 100mls of water to consume.

26 April 2020

46.48 On 26 April 2020, Mrs Rendoth's observations were recorded three times. At 8.30am, SpO2 97% (BP 114/69, HR 89, RR 18, Temp 36.7C), at 12.10pm, SpO2 97% RA (BP 98/56, HR 96, RR 19, Temp 36.2C) at 8.20pm SpO2 98% (BP 102/97, P 94, RR 22, Temp 36.6C).

46.49 At 2.32am, an unknown RN noted that Mrs Rendoth was alert, orientated, afebrile and had no cough or shortness of breath. She refused her food, fluid, medications and stated she wanted to be alone. The RN noted that Mrs Rendoth covered her face with a blanket. At 7.46am and 8:13pm Mrs Rendoth was administered 10mls and 15mls of Panamax Elixir, for a headache.

27 April 2020

46.50 On 27 April 2020, Mrs Rendoth's observations were recorded once at 12:00pm SpO2 92% RA (BP 114/94, HR 90, Temp 36.5C).

46.51 At 3.51pm, the Nepean Hospital NUM noted that Mrs Rendoth continued to be followed up by the VACS team, and that the VACS team was to contact HITH or the Outreach Infectious Diseases (ID) team as required. At 5.58pm, Mrs Rendoth was administered 10mls of Panamax Elixir, for pain.

28 April 2020

46.52 On 28 April 2020, Mrs Rendoth's observations were recorded four times. At 1.00am, SpO2 93% RA (BP101/61, HR 71, RR 18, Temp 36.5C), at 6.00am, SpO2 91% RA (BP 104/56(11:00), HR 72, RR 17, Temp 36.6C), at 10.39am, Sp02 91% RA (BP 104/56, P 72, RR 17, Temp 36C), and at 4.00pm, SpO2 83% (BP 100/62, HR 80, RR 34, Temp 36.6C).

46.53 At 10.39am, a VACS videoconference occurred with NP Carpen, Dr Sharma, Dr Kakkat, Dr Kathiresan and Newmarch House RNs, which noted:

> Fay was alert, interactive, feisty
> Complaining of sore throat, no obvious thrush limited oral intake,
> Dry lips

Lower legs swollen
No complaints of pain
BP 104/56, P72, RR17, Sp0291% RA, T3!>.6 Plan
needs dietary requirements reviewed
regular oral care
push oral fluids

29 April 2020

46.54 On 29 April 2020, Mrs Rendoth's observations were recorded four times: at 5.00am, SpO2 95% RA (BP 100/60, HR 70, RR 30), at 11.00am, SpO2 93% (BP 106/61, HR 76, RR 19, Temp 36.8C), at 5.10pm, SpO2 93% (HR 90, RR 18, Temp 36.6C), and at 10.00pm, SpO2 93% RA (BP 118/62, HR 92, RR 18, Temp 37.2C).

46.55 At 5.51pm, Mrs Rendoth was administered Gastrogel Antacid oral liquid.

30 April 2020

46.56 On 30 April 2020, Mrs Rendoth's observations were recorded five times. At 5.15am, SpO2 94% RA (BP 95/58, HR 68, RR 18, Temp 36C), at 10.00am, SpO2 94% RA (BP 127/76, HR 92, RR 18, Temp 36.7C), at 11.56am, Sp02 94% (BP 127/76, Temp 36.7C, P 92, RR 18), at 3.00pm, SpO2 94% RA (BP 122/74, HR 75, RR 18, Temp 36.6C), and at 9.00pm, SpO2 97% (BP 125/75, HR 87, RR 18, Temp 36.6C).

46.57 At 12.01pm, a VACS videoconference occurred with NP Carpen, Dr Sharma, Dr Kakkat, Dr Kathiresan, Dr Sahil and Newmarch House RNs, which noted:

... Resting in bed
Agitated about being disturbed, Otherwise looks well
Poor appetite, drinking
Mouth dry
127/76, T36.7, Sp0294, P92, RR18 Plan
- Oral care
- encourage oral intake
- continue supportive care

1 May 2020

46.58 On 1 May 2020, Mrs Rendoth's observations were recorded twice. First at 10.00am, SpO2 97% RA (BP 134/84, HR 97, RR 22, Temp 36.5C), then at 3.00pm, SpO2 90% RA (BP 128/78, HR 96, RR 22, Temp 36.5C).

46.59 At 9.53am and 10.25am, Mrs Rendoth was administered morphine for the first time for terminal agitation. At 5.50pm, Mrs Rendoth was not administered with her usual medications.

2 May 2020

46.60 On 2 May 2020, Mrs Rendoth's observations were recorded three times. At 8.00am, SpO2 93% RA (BP 114/77, P 97, RR 24, Temp 36.6C), at 9.00am, SpO2 93% RA (BP 144/77, HR 97, RR 24, Temp 36.6C), and twelve hours later at 9.00pm, SpO2 90% (Temp 36.5C, P 85, RR 18, BP 108/67).

46.61 Mrs Rendoth was administered morphine throughout the day for agitation and/or pain at 9.53am, 10.25am, at 12.30pm, at 3.15pm, at 5.09pm, and midazolam at 5.10pm, due to agitation.

3 May 2020

46.62 On 3 May 2020, Mrs Rendoth's observations were recorded six times. At 8.00am, SpO2 71% RA (BP 105/67, P 91, Temp 35.6C), at 11.00am, SpO2 73% (Temp 36.6C, P 96, BP 92/62), at 1.00pm, SpO2 93% on 3L, at 1.30pm, SpO2 93% on 3L (Temp 36.3C, P 92, RR 17, BP 92/56), at 5.30pm, SpO2 97% on 2L (Temp 35.7C, P 109, RR 24, BP 90/62), and at 9.10pm, SpO2 96% (Temp 36.4C, P 33, RR 22, BP 92/54).

46.63 At 8.22pm, Dr Sharma noted: "*Spoken with Dr Kakkat Telephone call NM that Fay is deteriorating Family notified Not for transfer to the hospital not for CPR and not for intubation or ventilation.*"

46.64 Mrs Rendoth was administered 2.5mg morphine and 5mg midazolam for pain and agitation at 1.20am, 5.25am, 8.05am and 5.30pm. From 8.05pm onwards, Mrs Rendoth refused medications and was not given her usual medications as she was drowsy.

4 May 2020

46.65 On 4 May 2020, Mrs Rendoth's observations were not recorded.

46.66 At 10.13am, a VACS videoconference occurred with NP Carpen, Dr Sharma, Dr Kakkat, Dr Kathiresan and Newmarch House RN Monica, the following was noted:

> Covid +ve Day 17
> Resting in bed
> Conscious, covering her head as usual
> Refusing medications and observations
> Comfort foods being offered
> Nurses feel Fay may be in pain
> intermittent morphine being given
> Discussed risks and benefits of commencing Norspan patch Plan
> continue supportive care
> - offer meals as tolerated
> - commence Norspan Patch 1 Omcg - continue to monitor pain.

46.67 Mrs Rendoth was administered 2.5mg morphine and 5mg midazolam for pain and agitation at 9.45am, 1.20pm and 4.30pm.

5 May 2020

46.68 On 5 May 2020, Mrs Rendoth's observations were recorded twice. At 6.00am, SpO2 was not recorded (Temp refused, P 93, RR 20, BP 103/68), and at 9.00pm Temp 36.3C.

46.69 She was administered morphine at 6.49am, and 12:36pm for pain but not midazolam as it was out of stock.

6 May 2020

46.70 On 6 May 2020, Mrs Rendoth's observations were recorded once at 10.30am. Her temperature was 36.3C.

46.71 At 8.43am, Mrs Rendoth was administered Buprenorphine (SDZ) 10 mcg/hour patch (buprenorphine 10 mcg/hour patch). At 1.57pm, a VACS videoconference occurred with NP Carpen, Dr Sharma, Dr Kakkat, Dr Kathiresan and Newmarch House RN 'Monica', the following was recorded:

> Covid +ve Day 19 Medical History -IHD/AMI 2008 -HTN -GORD
> -OA
> - Parathyroidectomy
> - Breast Ca
> - Left THR
> - Right total elbow replacement
> Resting in bed, looks fatigued
> Groaning, struggling to get comfortable
> Once head covered stopped groaning
> Prefers a dark room
> Poor oral intake, small amounts of High protein drinks Dislikes having observations, refuses medications, T36.3
> Plan
> - monitor oral intake, encourage high protein supplements – Physio
> - continue supportive care

46.72 Mrs Rendoth was administered 2.5mg morphine at 11.00am, 3.30pm and 5mg midazolam at 1.00pm and 6.15pm.

7 May 2020

46.73 On 7 May 2020, Mrs Rendoth's observations were recorded six times. At 1.00am, SpO2 87% RA (Temp 36.3C, P 93, RR 23, BP 125/84), at 1.30am, SpO2 91% on 2L, at 3.00am, 90% on 2L, at 5.00am, SpO2 92% on 2L, at 2.30pm, SpO2 "unreadable" (Temp 35.7C, P 80, RR 17, BP 118/79), and at 8.00pm, 91% NP (Temp 35.7C, P 104, RR 12, BP 100/61).

46.74 Mrs Rendoth was administered 2.5mg morphine and 5mg midazolam for pain and agitation at 12.10am, 11.10am, 12.29pm(?), 6am and 2.40pm. Staff contacted Ms Finlay and provided her with an update on Mrs Rendoth's condition. It was noted that Mrs Rendoth was sleeping peacefully.

8 May 2020

46.75 On 8 May 2020, Mrs Rendoth's observations were recorded once at 12.26am, Sp02 94% (BP 100/60, RR 12).

46.76 At 5.41am, Mrs Rendoth was administered 2.5 mg of morphine. At 12.26pm, a VACS videoconference occurred with Dr Fox, Dr Kakkat, Dr Kathiresan, Aged Care NP Carpen and Newmarch House RN 'Monica', the following was noted:

> Covid +ve Day 20 Medical History
> …….Resting in bed
> Condition has deteriorated
> Now non responsive
> Daughter had a window visit
> BP100/60, RR12, Sp0294%
> Regular morphine- total dose 10mg in 24hrs
> Plan
> continue comfort care
> - Mouth care /eye care
> - Update family
> ADDIT: Dr Kathiresan contacted daughter Jayne Finlay to update Fay's deteriorating condition Daughter grateful for the call. Dr Kathiresan will review again tomorrow

46.77 At 8.15pm on 8 May 2020, staff attended Mrs Rendoth and found she was not breathing and had passed away. Dr Rezk was contacted and via WhatsApp viewed Mrs Rendoth. Ms Finlay was contacted shortly after. A note written on 9 May 2020 at 3.48pm by Dr Sharma records that Dr Branley had informed Ms Finlay that Mrs Rendoth in fact was COVID-19 negative when last tested.

MANNER AND CAUSE OF DEATH

46.78 **Cause of Death**: Associate Professor Kotsimbos and Professor Kurrle were of the opinion that the cause of death was COVID-19 pneumonia despite her testing negative for COVID-19 before she died. They opined that as the infection descends to the lungs, oral and nasal swabs may no longer have detected its presence. As there were clinical signs of chest involvement. Associate Professor Kotsimbos and Professor Kurrle were of the view that it was unlikely the infection had cleared. Professor French felt on balance it was more likely that her death related to her Ischaemic Heart Disease.

46.79 **Manner of Death**: A summary of Mrs Rendoth's COVID-19 progression is that she was relatively asymptomatic in the days after her positive COVID-19 test. Symptoms were limited to an ongoing cough between 17 April and 22 April 2020. On 27 April 2020, Mrs Rendoth complained of a headache, cough, sore throat and her appetite was reduced. From 28 April 2020 Mrs Rendoth became increasingly agitated and refused to eat or drink. Mrs Rendoth complained of back and neck pain and was increasingly agitated on 1 May 2020 when crisis medications (morphine and midazolam) were commenced. On 3 May 2020, Mrs Rendoth deteriorated further with tachypnoea, shortness of breath and hypoxia. On 4 May 2020 Mrs Rendoth refused treatment. Mrs Rendoth received approximately 22 doses of morphine (and 15 doses of midazolam) from 1 May 2020 to 8 May 2020

and died at 7.20pm that evening. The experts noted the extensive period between first experiencing symptoms on 17 April 2020 and her death on 8 May 2020, being just over 20 days. They also noted Mrs Rendoth suffered from pain in her neck and back and significant agitation during that time.

46.80 **Impact of any significant co-morbidities**: Ischaemic heart disease and cardiovascular disease generally, chronic obstructive lung disease, multiple falls and fractures all played a role. She also had a history of anxiety and depression which may have affected her ability to cope with the situation.

46.81 **Issues with care received**: Associate Professor Kotsimbos considered that Mrs Rendoth's respiratory symptoms were quite clear, even on 3 and 4 May 2020, with symptoms of tachypnoea and hypoxia suggesting that her COVID-19 infection was progressing down the respiratory path. It is not clear how much oxygen and fluid support she was given, but she was given antibiotics for her chest symptoms. The experts felt her end-of-life care was not well managed from an infection control perspective, and the family was concerned about lack of food and assistance. Professor Kurrle agreed with Associate Professor Kotsimbos' analysis of Mrs Rendoth's disease progression, and her management, and added that her anxiety and depression may have contributed in terms of her coping with her condition. Professor Kurrle noted that Mrs Rendoth had quite a bit of pain in her back and neck and significant agitation.

46.82 **Whether different action may have affected the outcome**: Possibly.

46.83 Associate Professor Kotsimbos noted that the medical records were not comprehensive and lacked detail as to how much oxygen Mrs Rendoth was receiving, there being only one or two records. Associate Professor Kotsimbos did not think that earlier intervention would have changed Mrs Rendoth's outcome, but noted that it was difficult to tell, given the lack of documentation about how much oxygen she was given and how much fluid support she received. Associate Professor Kotsimbos considered that Mrs Rendoth's care could have been better managed.

46.84 The limited documentation makes it difficult to ascertain the details of her care, so the experts speculated that she may have received more observation and supportive care in hospital. The Newmarch House progress notes record that Ms Finlay had expressed that she would like her mother to be transferred to hospital if there were insufficient nursing staff at Newmarch House to provide appropriate care to Mrs Rendoth. The sparsity of progress notes may reflect insufficient nursing staff, although that situation is said to have improved from the arrival of BaptistCare on 24 April 2020.

46.85 Professor Kurrle considered that Mrs Rendoth could have been managed better in a hospital setting from an observations and supportive care point of view. Professor French did not consider that Mrs Rendoth's death could have been prevented but agreed that if she was transferred to hospital, it would have improved aspects of the treatment provided. Associate Professor Kurrle felt that it was unclear whether earlier or different treatment would have changed her outcome given her significant co-morbidities and age of 92.

46.86 Associate Professor Kotsimbos considered that Mrs Rendoth was infected in the second wave given the timing of her positive COVID-19 test result on 17 April 2020. Professor MacIntyre was of the view that COVID-19 infections after 18 and 19 April 2020 were potentially preventable for the reasons

outlined previously. Given only one negative test prior to the positive test on 17 April 2020, Counsel Assisting submitted that Mrs Rendoth was likely infected during the first wave of the infection.

46.87 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Fay Rendoth.

Date of death

Mrs Rendoth died on 8 May 2020.

Place of death

Mrs Rendoth died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Rendoth's death was COVID-19 pneumonia with ischaemic heart disease, hypertension and chronic obstructive pulmonary disease being significant conditions which contributed to death.

Manner of death

Mrs Rendoth died of natural causes following diagnosis of COVID-19 infection. Due to the paucity of documentation, it is difficult to reliably assess the adequacy of Mrs Rendoth's management. Whilst transfer to hospital may have improved some aspects of Mrs Rendoth's management it probably would not have materially altered the eventual outcome although it is noted that Mrs Rendoth's family had requested that she be transferred to hospital if appropriate care could not be provided at Newmarch House due to staff shortages. Given the timing of Mrs Rendoth's COVID-19 diagnosis on 17 April 2020, her infection may have been prevented if a different model of care had been implemented.

47. Margaret Sullivan

HEALTH

Co-morbidities

47.1 Margaret Sullivan was 71 years old when she passed away on 11 May 2020 at Newmarch House during the COVID-19 Outbreak. She suffered from dementia (Lewy body), but was otherwise healthy. Mrs Sullivan required assistance with all activities of daily living, and she had minimal speech.

Background and events leading up to COVID-19 diagnosis

47.2 In 2014, Mrs Sullivan suffered a heart attack. In August 2016, she was diagnosed with Lewy Body Disease. Her illness became progressively worse. She suffered memory loss, confusion, anxiety and depression, decreased mobility and frailty. Mrs Sullivan was admitted to Newmarch House on 20 April 2018. By 2020, Mrs Sullivan was non-verbal and required assistance with all activities including toileting and eating. In late February 2020, she was noted to be eating less, and a food intake chart was commenced. At the beginning of the lockdown at Newmarch House, Mrs Sullivan's husband, Lloyd Sullivan, requested that he be able to move into the facility to care for his wife. This was not permitted, despite the fact that in Mr Sullivan's words "*She was a vegetable. She really was. She couldn't take care of herself in any way, shape or form*."

RELEVANT MEDICATIONS

47.3 Mrs Sullivan was prescribed a number of regular medications including Fortsip supplements, Senna CO Laxative, tinea cream, Cetirizine, sodium bicarbonate mouthwash and Systane eye drops.

PRN Medication - Midazolam and morphine

47.4 On 22 April 2020, Mrs Sullivan was prescribed midazolam 5mg/mL PRN and Robinul 200mcg/L. On 2 May 2020, Mrs Sullivan was prescribed Hydromorphone 2mg/mL PRN (as required). A nursing note at 3.00am records that Mrs Sullivan was in fact allergic to/had an adverse reaction to morphine. Dr Kakkat was contacted, who directed nurse staffing to continue with administration of morphine as "*morphine allergy is not well known and happened a long time ago*." In the handwritten progress notes, it records that morphine was administered on 2 May 2020 at 8.23am for pain. The progress notes state that morphine and midazolam were administered at midday, but this is not reflected in any medication charts. Morphine and midazolam were administered at 11.02pm and 9.30pm respectively on 2 May 2020. Handwritten medication charts record that 2.5 mg of morphine and 5mg midazolam in combination were administered at 6.00am, 10.30am, 3.45pm and 9.30pm.

47.5 Combining all entries in all records suggests that morphine was being administered on 2 May 2020 at 6.00am, 8.23am, 10.30am, 3.45pm, 9.30pm, and 11.02 pm. Whether this accurately reflects what was administered is difficult to say.

47.6 On 3 May 2020 morphine and midazolam were administered in combination at 1.20am, 5.30am and 1.15pm.

47.7 On 9 May 2020, midazolam was administered at 11.18am for agitation, and morphine for pain, and both again at 5.29pm. On 10 May 2020, morphine was administered for 'pain post PAC' [post-acute care] at 4.40pm and on 11 May 2020 at 2.05am both morphine and midazolam were administered as Mrs Sullivan appeared uncomfortable when staff were attending to her care needs.

COVID DIAGNOSIS

47.8 Mrs Sullivan undertook a combined nasal/throat swab for COVID-19 testing on 14 April 2020. That was reported to be negative on 15 April 2020. Mrs Sullivan undertook a further nose/throat swab on 17 April 2020. A preliminary report was available at 5.02pm on 17 April 2020. A final report was available at 8.26am on 18 April 2020, which confirmed that Mrs Sullivan was positive for COVID-19. This was reported to Newmarch House by the Public Health Unit around midday.

47.9 Lloyd Sullivan gave evidence that Dr Branley called him at 7.00am on the day of Mrs Sullivan's passing, 11 May 2020 (3 weeks after her positive test), to inform him that his wife was at that time COVID-19 negative based on test results from the previous evening. There is no corresponding pathology on file to confirm this. Mr Sullivan's memory is that Dr Branley informed him that her cause of death was Lewy Body disease.

ADVANCE CARE PLAN

47.10 An Anglicare Advance Care Plan (ACP) was prepared for Mrs Sullivan on 5 June 2019, which stated that she did want cardiopulmonary resuscitation (CPR), but did not want to be fed artificially. She did want to receive oral antibiotics and understood that intravenous antibiotics may require transfer to hospital. She wanted to be transferred to hospital if medically indicated.

Discussions around ACP

47.11 On 18 April 2020, GP Dr Graydon contacted Mr Sullivan and his son. His note of their discussion is as follows:

> GRAYDON: Margaret's usual GP is Dr. Anthony Park, but he was not contactable today. He will be contacted on Monday 20/04/20 to be given an update on her condition. I spoke to her husband Lloyd Sullivan and son Shaun at 1:45PM today after they were informed his wifes swab for Covid-19 was positive. We discussed updating her Advance Care Plan in the context of her Covid infection. I advised the residents at Newmarch were under the care of the Hospital in the Home Team. This includes access to oxygen, oral and injectable medications to provide comfort and relief of pain and breathing difficulties. It does not intubation or ventilation. The family declined the offer to make a final decision on the ACP details till they had a chance to have a whole family discussion. (emphasis added)

47.12 On 24 April 2020, Dr Sharma had a discussion with Mrs Sullivan's husband, Mr Sullivan about the ACP after Mrs Sullivan had tested positive for COVID-19. A note of that discussion records the following:

> Hailey Carpen Aged Care Nurse Practitioner VACS
> Advance Care Plan

> Dr Sharma has had a conversation today with Mrs Margaret Sullivans husband and son. Margaret is known to have dementia with Lewy Body, Osteoporosis. Dependent on all ADL's. Family had lots of questions. Dr Sharma explained to them about COVID and that there is no developed cure.
>
> Care that is provided is supportive care. Based on her underlying condition doctor Sharma has promoted for quality of Margaret's life. Dr Sharma has recommended to the family that she is best treated within the RACF. She is not for transfer to hospital and not for intubation and ventilation. Margaret is to have supportive care at the facility. If she deteriorates her husband and son want to be notified. (emphasis added)

47.13 This record does not reflect Mr Sullivan's understanding of the conversation, or what he believed would occur if his wife deteriorated. Although he had little recollection of the conversation surrounding his wife's ACP, he gave evidence that he wanted her to be transferred to hospital "*If it got to the stage where they couldn't care for her properly at Newmarch I wanted her to be transferred as per her ACP dated June 2019.*" He gave further evidence that he wanted her to be transferred out, as he could see there were many problems at Newmarch House, and in his opinion, the problems were beyond their scope and expertise.

47.14 In relation to being informed as to his wife's condition, Mr Sullivan gave evidence that communication between 23 March 2020 and the day his wife died was "*appallingly bad*" and that management *"couldn't get their act together."* He thought the video calls were a '…..*hell of a mess. There were problems with equipment, problems with carers knowing how to work the equipment, carers getting back to us and having video calls but I managed to have probably half a dozen video calls and I appreciated that. It was only 30 seconds but to see her, she couldn't talk, but just to look at h*er." He also received daily updates from a nurse, Gordon Andison, from 14 to 27 April 2020, described below.

47.15 Professor Kurrle's opined that Mrs Sullivan's ACP was not observed.

PROGRESSION OF ILLNESS

47.16 Electronic progress notes were made until 24 April 2020, when handwritten notes commenced. Nurse Gordon Andison made calls to Mr Sullivan to provide updates about Mrs Sullivan's care on at least a daily basis between 18 to 27 April 2020. From 29 April 2020, different staff members made calls to Mr Sullivan, and a log was kept of those calls.

18 April 2020

47.17 On 18 April 2020, Mrs Sullivan's observations were recorded three times. At 2.00pm, SpO2 97% (Temp 38C, BP 100/74, HR 70, RR 17), a 3.00pm, SpO2 97% (BP 100/70, P 60, RR 17), and at 10.45pm SpO2 97% (BP 100/67, P 84, RR 18, Temp 37.2C).

47.18 Other than blood pressure being slightly out of normal range, Mrs Sullivan's vital signs were within normal limits over the following days.

47.19 On 18 April 2020 at 2pm, Mrs Sullivan was admitted to Hospital in the Home (HITH). Mrs Sullivan was reportedly coughing intermittently that day, with no phlegm. A note recorded by RN Catherine Sidney that day states:

> Have been in contact with care manager Leanne Hinton in regards to updates on all positive covid19 residents. We required their observations, status and current condition but have so far been unable to obtain information. Was informed that the RN from each ward would contact us in regards to their current condition however no contact has been made at time of report. Have also had a call from public health to see if we had been able to contact nursing home as they are having the same sort of issues trying to obtain information. Will attempt to contact Newmarch House again tomorrow.

47.20 RN Sidney made further attempts to contact Newmarch House the following day, with no success. She recorded this note:

> If possible could we get a system in place where the RN from each ward where the residents are located call outreach and just give a quick update on each patient when that RN has time to do so, or even one person from the nursing home give outreach a call with an update on each patient.

47.21 Also on 18 April 2020, Dr Graydon contacted Mr Sullivan and his son to discuss the diagnosis and updating the ACP, the details of which are extracted in full earlier.

19 April 2020

47.22 On 19 April 2020, Mrs Sullivan's observations were recorded three times. At 11.00am, SpO2 97% (BP 100/73, P 68, Temp 37C), at 2.00pm, SpO2 97% (BP 115/70, P 72, RR 17, Temp 36.9C), and at 4.00pm, SpO2 97% (BP 100/70, P 70, Temp 37C).

47.23 Nursing staff attended upon Mrs Sullivan at around 1:38am and 4:04pm based on entries in the clinical records, with other entries appearing retrospective or summaries of what has occurred. It was noted that Mrs Sullivan stayed in bed all day and 'mostly understands directions with closed eyes' an entry which is difficult to reconcile with her husband's description of how Mrs Sullivan presented, raising doubts as to how a nurse could conclude that Mrs Sullivan "*mostly understands directions."*

20 April 2020

47.24 On 20 April 2020, Mrs Sullivan's observations were recorded four times. At 5.35am, SpO2 92% RA (Temp 36.9C) , at 11.00am, SpO2 was not recorded (BP 130/70, P 95, RR 16, Temp 37.2C), at 6.00pm, SpO2 was not recorded (BP 130, Temp 36.5C), and at 11.53pm (BP 125/81, P 76, Temp 36C).

47.25 Dr El Jamaly attached to HITH made a call to Newmarch House and informed staff of Mrs Sullivan's COVID- positive result, of the need for a single room and strict PPE and isolation. Dr El Jamaly recorded "*facility aware of the protocol for covid-19 +ve patients".*

47.26 NP Carpen conducted a remote review of Mrs Sullivan's notes and recorded that she could not make contact with Newmarch House. She further stated that on her review of the clinical records, no observations had been undertaken, although as noted, observations had been recorded that day.

21 April 2020

47.27 On 21 April 2020, Mrs Sullivan's observations were recorded twice at 1.00pm, SpO2 97% (BP 123/70, P 97, RR 20, Temp 36.4C), and six hours later at 7.00pm, SpO2 was not recorded (BP 119/67, P 72, RR 20, Temp 36.9C).

47.28 Nursing observations note that Mrs Sullivan was awake in bed, nil coughing shortness of breath (SOB), pain or signs of distress were observed.

22 April 2020

47.29 On 22 April 2020, Mrs Sullivan's observations were recorded five times. At 6.20am, SpO2 95% (BP 128/69 P 82, Temp 36.8C), at 10.45am, SpO2 was not recorded (BP 112/72, P 90, RR 19, Temp 36.3C), at 4.45pm, SpO2 95% (BP 105/67, P 92, RR 18, Temp 36.4C), at 7.29pm, SpO2 92% (BP 131/74, P 82, RR 19, Temp 36.4C), and at 11.15pm SpO2 94% (BP 117/66, P 85, RR 18, Temp 35.9C).

47.30 Nursing notes record that there were no issues or concerns, Mrs Sullivan's temperature was stable, nil coughing and nil SOB were observed, with fluids being encouraged.

47.31 On 22 April 2020, Mrs Sullivan was formally discharged from HITH. She was to be followed up VACS every second day. Dr Kakkat prescribed anticipatory medication and morphine was dispensed to the facility that day. Counsel Assisting noted that VACS did not follow up every second day.

23 April 2020

47.32 On 23 April 2020, Mrs Sullivan's observations were recorded five times. At 11.00am, SpO2 88% (BP 101/65, P 74, RR 12, Temp 36.1C), at 2.30pm, SpO2 91% (BP 104/66, RR 15, Temp 36.1C), at 4.23pm, SpO2 91% RA (BP 104/66, Temp 36.1C, RR 15. HR 74), at 6.00pm, SpO2 was not recorded (BP 101/73, P 82, RR 13, Temp 36.1C), and at 9.00pm, SpO2 97% (BP 127/68, P 18, RR 18, Temp 36.6C).

47.33 On 23 April 2020, Mrs Sullivan was reportedly unwell. She had developed pressure sores on her bottom and a skin tear on her foot, which were imaged and bandaged. Clinical records indicate that Mrs Sullivan was seen by Dr Kakkat for the first time. He recorded that she had vomited, was hemodynamically stable, 'chest clear' 'CVS' [current vital signs] normal and that the plan was PRN (as required) maxalone.

24 April 2020

47.34 On 24 April 2020, Mrs Sullivan's observations were recorded three times. At 8.00am, SpO2 92% (BP 103/75, P 84, RR 18, Temp 36.3C), at 12.22pm, SpO2 97% RA (BP 127/68, P 71, RR 18, Temp 36.6C), and at 5.00pm SpO2 93% (BP 104/67, P 75, RR 18, Temp 36.5C).

47.35 Dr Sharma spoke with Mr Sullivan and his son about an ACP, the record of which is extracted in full earlier.

25 April 2020

47.36 On 25 April 2020, Mrs Sullivan's observations were recorded four times. At 8.00am, SpO2 97% (BP 112/62, P 77, RR 18, Temp 35C), at 2.00pm, SpO2 95% (BP 117/68, P 72, RR 18, Temp 36.3C), at 9.00pm, SpO2 91% RA (BP 112/77, P 76, RR 18. Temp 36.2C), and at 10.30pm, SpO2 94% (BP 125/64, P 64, RR 18, Temp 36.2C).

47.37 Mrs Sullivan was coughing intermittently but did not appear to be in pain. A handwritten Vital Sign Chart was commenced on this day recording all observations until 8 May when observations were no longer recorded.

26 April 2020

47.38 On 26 April 2020, Mrs Sullivan's observations were recorded four times. At 3.51am, SpO2 91% RA (BP 122/77, P 76, RR 18, Temp 36.2C), at 8.30am, SpO2 93% RA (BP 147/83, P 76, R 18, Temp 36.2C), at 11.40am, SpO2 95% RA (BP 108/09, P 83, RR 20, Temp 36.4C), and at 9.00pm, SpO2 96% RA (BP 105/70, P 78, R 22, Temp 36.3C).

47.39 There are two entries in the progress notes the first of which records a Glasgow Coma Score of 12-13/15 and a request for monitoring, and second noting that all ADLs (assistance with daily living) were attended to.

27 April 2020

47.40 On 27 April 2020, Mrs Sullivan's observations were recorded three times. At 12.00am, SpO2 96% (BP 109/04, P 95, Temp 36.2C), at 11.40am, 94% RA (BP 99/66, P 77, R 16, Temp 36.7C), and at 4.44pm, SpO2 95% (BP 109/84, RR 22, Temp 36.2C, 96% RA).

47.41 A VACS teleconference with Dr Sharma, RN Carpen and TN Tracey Huegil took place. The handwritten note records that 'ACD completed,' although there is no ACD in existence and no new ACP was signed. The plan was to provide supported care, with anticipatory medications to be given as required and care to keep Mrs Sullivan comfortable, with twice-daily observations, which was the same recommendation made for other residents.

47.42 As noted above, Mrs Sullivan's observations were often taken more than twice per day. However, Mr Sullivan described his wife as being unable to "take care of herself in any way shape or form". This high degree of dependency suggests that Mrs Sullivan may have benefitted from a documented plan to take more than twice-daily observations, although it is accepted that this issue was not specifically explored in the evidence.

28 April 2020

47.43 On 28 April 2020, Mrs Sullivan's observations were recorded four times. At 1.:00am, SpO2 95% RA (BP 99/66), at 6.00am, SpO2 95% (BP 99/62, P 82, RR 16), at 4.00pm, SpO2 84% RA (BP 96/62, P 92, RR 36, Temp 36.2C), and at 11.00pm, SpO2 92% RA (BP 94/63, P 87, RR 22, Temp 36.5C).

47.44 At 1.00 am, Mrs Sullivan was noted to be slightly hypotensive (BP 99/62) but was saturating well (95% RA). However, she had limited response to pain stimuli.

47.45 At 10.25am, a VACS videoconference was held between Dr Sharma, Dr Kathiresan, NP Carpen and a nurse from Newmarch House. Mrs Sullivan looked comfortable and was engaging with staff, holding tightly onto the nurse's hand. She had minimal oral intake but was drinking small amounts. The plan was to continue supportive care and encourage oral intake.

47.46 At 12.10pm, Newmarch House manager Melinda Burns contacted Mr Sullivan to inform him that Mrs Sullivan was dying. Mr Sullivan and his two sons attended and were permitted to spend some time with Mrs Sullivan.

29 April 2020

47.47 On 29 April 2020, Mrs Sullivan's observations were recorded four times. At 5.10am, SpO2 94% RA (BP 102/58, P 98, RR 24, Temp 36.6C), at 10.15am, SpO2 95% RA (BP 101/69, P 80, RR 18, Temp 35.9C), at 4.50pm, SpO2 91% RA (BP 105/67, P 90, RR 18, Temp 36.8C), and at 10.15pm, SpO2 (BP 105/59, P 82, RR 18, Temp 36.4C).

47.48 Nursing entries indicate that all ADLs were attended to during the day and evening and Mrs Sullivan was comfortable during the shift. She was breathing spontaneously, repositioned regularly and had limited response other than to pain whilst moving. Her son had been to visit.

30 April 2020

47.49 On 30 April 2020, Mrs Sullivan's observations were recorded three times. At 5.45am, SpO2 90% RA (BP 91/[51?], P 80, RR 18, Temp 36.2C), at 10.10am, SpO2 94% RA (BP 108/70, P 83, RR 20, Temp 36C), and at 9.00pm, SpO2 95% RA (BP 116/67, P 76, RR 18, Temp 36.2C).

47.50 Nursing staff attended to Mrs Sullivan's ADLs at 3.35am, 9am, 8.30pm and 11.04pm. Her observations were reportedly stable and she was responding to verbal and touch stimuli. She drank half a cup of thickened water.

1 May 2020

47.51 On 1 May 2020, Mrs Sullivan's observations were recorded once at 10.00am, 90% RA (BP 114/78, P 90, RR 22, Temp 36.6C).

47.52 VACS palliative physician Dr Kathiresan and Clinical Nurse Consultant (CNC) Tucker (palliative care) attended on Mrs Sullivan. The notes do not state whether this was in person or as a video conference.

It was noted that Mrs Sullivan had "*deteriorated significantly*" but had "*nil symptoms*". Oxygen was in situ. The plan was recorded as follows:

> Terminal phase
> Ceased other meds
> Oral care/eye care
> PRNs if needed

47.53 Mrs Sullivan was administered 2.5 mg morphine and 5mg midazolam in combination at 2.30pm and 6.10pm. The plan to cease Mrs Sullivan's other medication was not communicated to the family until four days later, on 5 May 2020.

2 May 2020

47.54 On 2 May 2020, Mrs Sullivan's observations were recorded once at 9.00pm, SpO2 91% RA (BP 100/58, P 99, RR 22, Temp 36.4C).

47.55 Mrs Sullivan was given 2.5 mg of morphine and 5mg of midazolam in combination at 6.00am, 10.30am, 3.45pm and 9.30pm. Nurses noted that Mrs Sullivan was in fact allergic to/had an adverse reaction of morphine. Dr Kakkat was contacted at 3.00am who directed nurse staffing to continue with administration of morphine as "morphine allergy is not well known and happened a long time ago."

3 May 2020

47.56 On 3 May 2020, Mrs Sullivan's observations were recorded three times at 12.30am, SpO2 96% (BP 118/63, P 92, RR 19, Temp 36.3C), at 5.30pm SpO2 97% RA (BP 106/67, P 92, Temp 36.4C, RR 26), and at 9.10pm, SpO2 97% RA (BP 107/71, P 99, Temp 36.3C, RR 18).

47.57 At 1.20am and at 5.30am, Mrs Sullivan was administered morphine and midazolam in combination. The progress notes record Mrs Sullivan appeared comfortable after being administered both drugs and that pressure care was attended to with 2 hourly pad changes. She was saturating on room air at 91% but did not appear to be in respiratory distress.

4 May 2020

47.58 On 4 May 2020, Mrs Sullivan's observations were recorded three times. At 9.15am, SpO2 96% RA (BP 110/73, P 96, Temp 35.7C, RR 16), at 10.42am, SpO2 96% RA (Temp 35.7C), and at 4.30pm, SpO2 97% RA (BP 102/59, P 100, RR 18, Temp 36.3C).

47.59 A VACS videoconference was held with Dr Sharma, Dr Kakkat, Dr Kathiresan and CNC Monica Tucker from Newmarch House. Mrs Sullivan was noted to be resting in bed and looked comfortable. She had mild agitation, which was responsive to midazolam, but VACS planned to use haloperidol first. There is no record of haloperidol being administered. The plan otherwise remained as before.

5 May 2020

47.60 On 5 May 2020, Mrs Sullivan's observations were recorded five times. At 6.00am, SpO2 92% (BP 108/77, P 93, Temp 35.9C, RR 18), at 9.00am, SpO2 92% (BP 118/78, P 93, Temp 36.2C, RR 18), at 4.30pm, SpO2 94% (BP 112/76, P 94, Temp 36.9C, RR 18), at 9.00pm SpO2 96% RA (BP 104/74, P 97, Temp 36.2C, RR 17), and at 11.00pm, SpO2 95% RA.

47.61 By this stage, Mrs Sullivan was no longer responsive to voice, could no longer obey commands, could not swallow any oral fluids and could not move her arms and legs. Her care and treatment was clearly palliative only. A video call took place that afternoon, in which the family raised the query regarding the cessation of Mrs Sullivan's oral medication and who the doctor was who made this decision (namely Dr Kathiresan on 1 May 2020)

6 May 2020

47.62 On 6 May 2020, Mrs Sullivan's observations were recorded seven times. At 1.00am, 97% RA, at 3.00am, 96% RA, at 5.00am, SpO2 97%, at 10.30am, SpO2 95% RA (BP 93/67, P 94, Temp 36C, RR 14), at 5.30pm, SpO2 94% RA (BP 90/67, P 98, Temp 36.8C, RR 18), at 2.14pm, SpO2 92% (BP 93/67, P 92, Temp 36C), and at 8.00pm, SpO2 97% RA (Temp 36C, RR18).

47.63 On 6 May 2020 at 8:45am, Dr Branley reviewed Mrs Sullivan. There was a conference call with Dr Branley, Cameron Elliott and her husband Mr Sullivan. A note records the following:

> Dr Branley reviewed Margaret this morning and believes she is coming out the end of her COVID illness but she has been deconditioned. There is discussions w NSW Health about when to reswab COVID patients – this may start happening next week. Video call done with the RN on the floor for @ 0900 and next one due @ 1200.

47.64 Mr Sullivan had a window visit with Mrs Sullivan this day. She was unresponsive at this time, although Mr Sullivan used a phone to speak with her. It is difficult to understand on what basis Dr Branley opined that Mrs Sullivan was 'coming out the other end' of her illness as nothing in the clinical records supports a change in her condition.

47.65 There is no record of a further COVID-19 test being performed, although Mr Sullivan was informed by Dr Branley on the day of Mrs Sullivan's death that she had returned two negative results. There is a note in the records that a swab was conducted the day before on 5 May 2020.

47.66 On 6 May 2020 at 2.14 pm, a VACS videoconference was held with Dr Sharma, Dr Kakkat, Dr Kathiresan and CNC Monica Tucker from Newmarch House. Mrs Sullivan was sleeping and appeared comfortable. She continued to have poor oral intake. The plan remained as before. That plan was for end-of-life comfort care which again is at complete odds with Dr Branley's opinion that she was "*coming out the other end*" of her illness.

7 May 2020

47.67 On 7 May 2020, Mrs Sullivan's observations were recorded four times. At 1.00am, SpO2 96%, at 3.00am, SpO2 97%, at 5.00am, SpO2 96%, and at 8.00pm, SpO2 92% (BP 88/61, P 98, Temp 36.2C, RR 18).

47.68 On 7 May 2020, a palliative care nurse contacted Mr Sullivan. The notes record that Mr Sullivan was aware that Mrs Sullivan was dying and had started planning for a funeral. She remained unresponsive. Mr Sullivan asked nursing staff why his wife was not being given IV fluids/drip given she was not eating. It was explained to him that such interventions were not given at this stage and the aim was to keep Mrs Sullivan comfortable. He welcomed two phone calls and two video calls and planned to come for further window visits.

8 May 2020

47.69 On 8 May 2020, Mrs Sullivan's observations were recorded once at 4.30pm, SpO2 93% (P 106, Temp 36.3C, RR 20).

47.70 On 8 May 2020, a final VACS videoconference was held with Dr Sharma, Dr Kakkat, Dr Kathiresan, NP Carpen and CNC Monica Tucker from Newmarch House. Mrs Sullivan was noted to be "*COVID19 +ve Day 20*". She was resting in bed and appeared comfortable. Mr Sullivan was attending window visits. The plan remained as before. A pressure sore was noted on Mrs Sullivan's heels, and a 2-hour repositioning chart was commenced the following day. Progress notes record that Mr Sullivan was informed that his wife had tested negative for COVID-19.

47.71 A comfort care plan appears to have commenced on 8 May 2020 (or possibly earlier as some records are undated) and resulted in 2 hourly comfort care attendance for some parts of the remaining days of her life.

9 May 2020

47.72 On 9 May 2020, Mrs Sullivan was provided with morphine and midazolam in combination at 4.35pm. She remained unresponsive to verbal stimuli with minimal response to pain stimuli. That evening at 5.00pm, Mrs Sullivan was checked for pain and her heart rate was recorded at 106. At 8.00pm an assistant in nursing noticed she felt cold with laboured breathing.

10 May 2020

47.73 At 9.00am, a nurse called Mr Sullivan. A note recorded that Mrs Sullivan's breathing had changed over the past 24 hours, and she needed more morphine and midazolam, but she was comfortable and peaceful. Mr Sullivan had a window visit. That was the last time he saw his wife prior to her death. Mrs Sullivan was administered morphine and midazolam in combination at 11.00am and 5.00pm.

47.74 The notes record that staff continued to attend to Mrs Sullivan and reposition her, provided mouth care and personal care and provide fluids. How precisely fluids were provided is unknown given she

was largely non-responsive, she was in the terminal phase of her illness, and there is no fluid balance chart reflecting subcutaneous or IV fluid administration.

11 May 2020

47.75 At 1.00am on 11 May 2020, it was recorded that Mrs Sullivan's breathing was "raspy" and her chest appeared to be wet. At 2.25am, she was repositioned but appeared uncomfortable. Hydromorphone, midazolam and Robinul were administered. Staff attended on Mrs Sullivan at 3.15am and found her to be deceased. Following her death, Newmarch House contacted Shaun, Mrs Sullivan's son, and not Lloyd Sullivan, to advise him of her death. Shaun then informed Lloyd.

47.76 Of great distress to Mr Sullivan was that he was later contacted by an unknown person from Newmarch House at 9.00am on 11 May 2020, and offered at window visit, despite Mrs Sullivan's death earlier that morning. Mr Sullivan felt that this was indicative of Newmarch House's '*appalling'* communication and inability to manage the Outbreak well.

MANNER AND CAUSE OF DEATH

47.77 **Cause of Death**: Associate Professor Kotsimbos, Professor Kurrle and Professor French considered that Mrs Sullivan's cause of death was COVID-19 infection. The experts agreed that Mrs Sullivan's dementia (Lewy Body) was a significant contributor to her death. Professor French initially felt the dementia was the primary cause with COVID-19 a contributory factor, but was willing to reverse the emphasis, in line with the other experts. It was noted that in the days prior to her death, Mrs Sullivan tested negative for COVID-19 infection but continued to deteriorate before dying on 11 May 2020.

47.78 **Manner of Death**: The experts believed that Mrs Sullivan was fairly stable for two weeks after testing positive to COVID-19. She tested negative after 19 days so there was speculation that she had in fact recovered from COVID-19. Associate Professor Kotsimbos noted that there were mixed messages being received by the family which caused confusion. It was not clear what the focus of the managing team was and how that was relayed to Mrs Sullivan's family, which resulted in the family believing that COVID-19 was no longer in the picture and Mrs Sullivan was stabilising, particularly in light of a COVID-19 negative test result on 6 May 2020. He noted that Mrs Sullivan continued to decline after testing negative and it was not entirely clear why this was occurring. Associate Professor Kotsimbos considered that extra supportive care and monitoring as well as interventions may have been relevant to the outcome in this case.

47.79 **Impact of any significant co-morbidities**: Lewy body dementia.

47.80 **Issues with care received**: The experts noted that Mrs Sullivan did not have significant symptoms of COVID-19 infection until about 27 April 2020, when she became drowsy. She did not have respiratory symptoms and her oxygen levels were consistently above 90% and usually 95% until her observations were ceased on 8 May 2020. On 1 May 2020, Mrs Sullivan was reviewed by the Palliative Care Team and anticipatory medication were prescribed, which were first administered on 1 May 2020 (midazolam and morphine). On this date, fluids and regular medications were ceased. Associate Professor Kotsimbos noted that Mrs Sullivan did not require a lot of respiratory support until 8 May 2020.

47.81 **Whether different action may have affected the outcome**: Possibly.

47.82 Associate Professor Kotsimbos noted that Mrs Sullivan was diagnosed with COVID-19 on 17 April 2020 during the second wave of infections. This therefore raised the question of whether better infection control would have prevented her infection.

47.83 Professor MacIntyre was of the view that COVID-19 infections after 18 and 19 April 2020 were potentially preventable for the reasons previously. Given there was only one negative test prior to the positive test on 18 April 2020, Mrs Sullivan was likely infected during the first wave of the infection.

47.84 As outlined earlier, Associate Professor Kotsimbos considered that extra supportive care and monitoring as well as interventions may have been relevant to the outcome in this case. Associate Professor Kotsimbos considered that if Mrs Sullivan was transferred to hospital, it was a 50:50 call as to whether it would have changed her final outcome. She would have been more comfortable and more supported in hospital and would have had a better death. Had this occurred, her family would have been "*properly involved.*"

47.85 Professor Kurrle considered that if Mrs Sullivan was treated in hospital, her treatment course would have been different. She would have been kept hydrated and fed as much as possible and received treatment for her symptoms. Professor Kurrle noted that Mrs Sullivan did not receive fluids at Newmarch House and concluded that she would have received better care in hospital, and that she would have benefited from this care. Professor Kurrle's opinion was shared by Associate Professor Kotsimbos at the inquest.

47.86 It is noted that Mrs Sullivan was non-verbal and incapable of performing any daily activity unaided. Prior to the lockdown, Mr Sullivan was her full-time carer, attending the nursing home all day, every day. The evidence does not support a finding that the level of care she received after lockdown and after she contracted COVID-19 was equivalent to, or even close to the care and attention her husband provided. That is particularly evident in the first two weeks of the Outbreak when staff attendance was critically low on many days.

47.87 Lloyd Sullivan held great concerns from the outset that unless he was there and able to directly care for his wife, talking to her and feeding her, his wife would not be properly cared for by the staff at Newmarch House. It did not appear that his impression was based on any assessment of Newmarch House's good intentions, or even competence, but simply because caring for a high needs resident was incredibly time consuming, and the reality of the staff to resident ratio made proper care a physical and logistical impossibility.

47.88 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Margaret Sullivan.

Date of death

Mrs Sullivan died on 11 May 2020.

Place of death

Mrs Sullivan died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Sullivan's death was COVID-19 infection with Lewy Body dementia being a significant condition which contributed to death.

Manner of death

Mrs Sullivan died of natural causes following diagnosis of COVID-19 infection. Mrs Sullivan did not have significant symptoms of COVID-19 infection until about 27 April 2020 and she was provided with appropriate supportive care. Given the timing of Mrs Sullivan's COVID-19 diagnosis on 17 April 2020, her infection may have been prevented if a different model of care had been implemented. If Mrs Sullivan had been transferred to hospital, the level of care that she would have received, particularly in relation to fluids and nutrition, would have been greater. This may have materially altered the eventual outcome.

48. Alice Bacon

HEALTH

Co-morbidities

48.1 Alice Bacon was 93 years old when she passed away on 19 May 2020 at Newmarch House during the COVID-19 Outbreak. She suffered from a number of comorbidities including ischemic heart disease (IHD), hypertension (HT), asthma, chronic obstructive pulmonary disease (COPD), depression, frailty, osteoarthritis, and colonic carcinoma.

Background and events leading up to COVID-19 diagnosis

48.2 Mrs Bacon was admitted to Newmarch House on 2 February 2016. She was mentally alert, although she suffered from anxiety and depression at times. The Newmarch House records include some behavioural incidents and resistance to care. Mrs Bacon mobilised on a four-wheel walker but was able to walk around the Newmarch House facility.

48.3 Mrs Bacon was admitted to Nepean Hospital from 21 to 23 January 2020 for removal of gallstones and treatment with IV antibiotics. She was readmitted from 24 to 27 January 2020, following abdominal pain. On 19 February 2020, Mrs Bacon reported passing a black bowel motion, and subsequent faecal occult tests were positive. Colonic carcinoma was suspected, but further investigation or surgery was not recommended. The plan was to provide comfort care. Mrs Bacon was experiencing nausea, weight loss and dyspnoea.

48.4 Mary Watson described her mother as sharp, a woman who "*didn't miss a beat*" and was totally attuned to everything that was going on at Newmarch.

RELEVANT MEDICATIONS

48.5 Mrs Bacon was prescribed a number of regular medications including Maxolon, Systane eye drops, Ondansetron and mouth wash. She was also prescribed Diltiazem and GTN patch (IHD and HT) and Seretide inhaler and Spiriva (asthma and COPD).

PRN Medication - Midazolam and morphine

48.6 The progress notes record that Mrs Bacon was prescribed midazolam, morphine and Robinul for comfort on 6 May 2020. No corresponding prescription can be found in the clinical records or medication chart documents.

48.7 The PBS Records record the following. On 5 May 2020 Dr Feldman prescribed morphine (5 x 1ml ampoules), which was dispensed on 8 May 2020. On 6 May 2020 Dr Kakkat prescribed morphine (10 ampoules), which were dispensed the same day. On 7 May 2020 Dr Kakkat prescribed 5 ampoules, dispensed that same day. On 8 May 2020 Dr Kakkat prescribed 5 ampoules, as did Dr Feldman, and both were dispensed that day. On 9 May 2020 Dr Feldman prescribed 1 ampoule which was

dispensed that same day. On 18 May 2020 Dr Feldman prescribed 5 ampoules, dispensed that same day. In total, based on the PBS records, 41 ampoules of morphine were dispensed over this period.

48.8 On 7 May 2020 at 8.21pm Mrs Bacon was administered morphine. On 8 May 2020 she was administered morphine at 1.40am, 7.57am, 1.49pm and 8.22pm; and on 9 May 2020 at 7.55am.

48.9 On 14 May 2020 Dr Branley, in discussion with Dr Sharma, gave an order to cease morphine. However, on 15 May 2020 at 4.12pm Mrs Bacon was administered morphine when staff observed facial grimacing with noticeable pain. On 16 May 2020 the VACS team and palliative care nurse Monica Tucker were contacted, and records state that Mrs Bacon was commenced on a syringe driver for morphine and midazolam.

48.10 Prior to the commencement of the syringe driver on 16 May 2020, PBS dispensing records record 36 ampules of morphine being dispensed yet the clinical records and medication charts record only 6 occasions when Morphine was administered. This leaves 30 ampoules of morphine that were not used during that time.

48.11 It is difficult in the circumstances to know whether Mrs Bacon's pain and agitation was adequately managed, whether the morphine dispensed was in fact administered to her and if Morphine was administered, what 'handover' if any took place regarding dose, frequency and time and when and why it wasn't recorded in the clinical records or medication charts. Given this occurred over four weeks into the Outbreak, it implies that systems of communication and record keeping were still lacking, and clinical care was arguably still compromised at this late stage.

48.12 It is noted that on 14 May 2020 Mrs Bacon was administered haloperidol 5mg at 9.11pm for agitation. A quantity of 10 tablets of this medication had been prescribed by Dr Feldman on 9 May 2020. Further, and curiously, 30 tablets of Rosuvastatin (a statin to prevent cardiovascular disease), was prescribed and dispensed on 18 May 2020, the day prior to Mrs Bacon's death in circumstances where she had been deemed for 'end of life' care and placed on a syringe driver. As outlined, this appears to reflect the disjointed nature of the care being delivered as well as a breakdown in communication between treating clinicians. It is ultimately inconsistent with patient centred care.

COVID DIAGNOSIS

48.13 Mrs Bacon took combined nasal/throat swabs for COVID-19 testing on 14, 17 and 20 April 2020, which were all negative. She then undertook a fourth swab test on 23 April 2020, which was reported as positive on 24 April 2020. Dr Hydar El Jamaly notified Newmarch House of the result at about 6.30am.

48.14 Mrs Bacon's daughter, Mary Watson, was informed of the positive result that morning and a suggestion was made that she contracted COVID-19 as a result of visiting a COVID-positive resident, CA, at her door. Mrs Bacon undertook further tests on 9 May 2020 (negative), 10 May 2020 (positive), 11 May 2020 (positive), 12 May 2020 (positive), 13 May 2020 (positive), 15 May 2020 (negative), and finally on 16 May 2020 (negative). A culture taken after death was also confirmed to be negative on 20 May 2020. Professor French considered that it is possible that the result from the testing on 9 May 2020 was a false negative.

ADVANCE CARE PLAN

48.15 An Anglicare Advance Care Plan (ACP) was prepared for Mrs Bacon, the second page of which is missing, along with any signature or date. The ACP states that Mrs Bacon did not want cardiopulmonary resuscitation (CPR), or to be fed artificially. She wanted to receive oral antibiotics to promote comfort. She did not want to be transferred to hospital, except to maintain comfort, and preferred to remain in her place of residence following a palliative care plan, the priority being her comfort and dignity.

48.16 The ACP produced in the records of Alice Bacon appears to represent the ACP completed by her daughter Mary Watson in 2019. Mary gave evidence that she completed this form as her mother did not want any involvement, however, she knew that her mother did not want to be resuscitated. Although Mrs Bacon did not fill out her 2019 ACP, Mary gave evidence that she put down responses that she believed reflected her mother's thinking and wishes.

48.17 On 17 May 2020 CNC palliative care nurse Monica Tucker recorded that she updated the ACP. CNC Tucker recorded an entry at 1.05pm in Mrs Bacon's Accident and Incident Form under the heading "Advance Care Plan" which indicated, amongst other things, that in the event of acute illness, injury or advanced dementia, Mrs Bacon did not want: cardiopulmonary resuscitation if her heart and breathing ceased, to be kept alive by artificial feeding, or transfer to hospital except to maintain comfort (with a preference to remain in her place of residence following a palliative care plan). However, no updated and signed form is contained within the available records.

Discussions around ACP

48.18 Mary Watson stated that when her mother tested positive for COVID-19 a nurse informed her that an infectious disease physician from Nepean Hospital would ring to explain what was going to happen, what the symptoms were and what the treatment and management plan was. This did not occur until a week later, on 30 April 2020, and based on the records, the call she received was not from the infectious disease specialist, but rather Dr Kakkat.

48.19 On 30 April 2020, the first VACS video conference was held, between RN Nurse Practitioner (NP) Hailey Carpen, Dr Sharma, Dr Kakkat, Dr Kathiresan, Dr Sahli and nurses from Newmarch House. Mrs Bacon was described as "*medically stable*" and noted to be "*asymptomatic.*" The plan was for supportive care, to encourage oral intake and complete an Advance Care Directive.

48.20 Dr Kakkat subsequently spoke with Mary Watson at about 2.50pm. The note records:

> Discussed with Daughter after videoconferencing with nursing home. Mary Watson, about Alice Bacon. She is not an ideal candidate for intubation and ventilation. As a COVID 19 +ve case she may develop symptoms which will be managed with medicines and supportive therapy at nursing home. In case she deteriorates further she is for palliative care and not for transfer to hospital.

48.21 Mary Watson's recollection of her conversation with Dr Kakkat regarding her mother's ACP was that Dr Kakkat:

> Explained the disease of COVID and how it manifests and the, you know, signs as they move through treatment. He explained to me that in the elderly the mortality rate was about 50%. He said that there was only a 5-10% chance of recovery if mum ever needed to be ventilated, which would need to be done in hospital. So, I agreed with him that mum didn't want to be ventilated if that was the only course of action so definitely no hospital for ventilation. And of course he reinforced that everything that could be done for mum at Nepean would be done at Newmarch House apart from ventilation.

48.22 Mary gave evidence that her understanding after that conversation was that her mother would be provided with every treatment up to but not including mechanical ventilation at Newmarch House. She reiterated this belief whilst giving sworn evidence that short of mechanical ventilation in an Intensive Care Unit (ICU) her mother would receive care *equivalent to* that received at Nepean Hospital. Mary gave evidence that she understood that her mum's wishes were that she would be transferred to hospital if a higher standard of care was required. Dr Kakkat had no discussion with her in relation to oxygen, fluids or antibiotics.

48.23 Specifically in relation to the ACP and ticking the box "I *do not wish to be transferred to hospital except to maintain comfort,*" Mary gave evidence that her understanding of the effect of this tick box was:

> Mum did not want to be transferred to hospital in the event that it was an end of life event so if she had a stroke or was in a coma or had a cardiac arrest or some massive injury that, you know, there was no return. She wanted to stay at Newmarch and die in her own bed. That was what her wishes were.

48.24 On 6 May 2020, Dr Sharma contacted Mary. Dr Sharma noted that Mrs Bacon was deteriorating and that it was most likely due to COVID, not Asthma. Dr Sharma explained Mrs Bacon's management and supportive care. The note records "*Happy her mother receives supportive care at the RACF".*

48.25 In relation to the administration of Morphine, Mary gave evidence that she recalls in that phone call Dr Sharma mentioned Morphine and based on Mary's response or reaction Dr Sharma assured her that it wasn't "*what she was thinking*", namely that it was not a reference to the final moments or final stage. Dr Sharma said that they found that giving a small dose of Morphine actually helped with the breathing and lungs. Mary recalled Dr Sharma expressing in an opinion that COVID positive patients "*get sick for three days and then they wake up or they don't.*" Mary was told her mother would be given oxygen and they were going to start her on antibiotics to prevent any secondary infections.

48.26 On 7 May 2020 a further videoconference took place with Dr Kathiersan, Dr Kakkat, NP Carpen and Dr Michael Feldman, with Mary and her sister present. The notes record in part:

> Daughters felts mum is to be treated in the facility for COVID related concerns
> If Alice deteriorates from COVID point of view <u>daughters agree that</u>
> Not for transfer to hospital
> Not for CPR
> Not for intubation or ventilation
> Alice indicating she does not want to go to hospital
> Plan
> Continue Supportive care
> Morphine 2.5 mg tds for 24 hours and prn if required then review

Encourage oral intake
Oral/eye care as required

48.27 Mary Watson recalls the Nepean team discussing Hospital in the Home (HITH) and how "*absolutely everything that was required to keep mum well, healthy, treated could be done at Newmarch except for ventilation.*" Her memory is that leading the conversation was a doctor named Dr Michael [Feldman]. She recalls that she agreed to no transfer to hospital for ventilation but transfer to hospital *"for anything else,"* and that *"If Mum falls and breaks her hip, I want her to go to hospital."* Mary recalls being assured that absolutely everything that her mother required to survive would be provided at Newmarch House.

48.28 Mary Watson recalls that during that video conference "*they really pushed and kept talking about mum not going to hospital.*" Her memory is that they had the laptop out and kept saying "*so no hospital,*" and "*no hospital*". Mary gave evidence that in the end she just laughed and said, "*well if she falls and hurts herself or breaks her hip of course we want her to go to hospital*".

48.29 Dr Branley subsequently informed Mary that if her mother went to hospital she would be in a four bed ward and she would have to share a bathroom and family would be unable to visit. She felt they the medical team were "*virtually insisting*" that her mother remain at Newmarch, stating she would be more comfortable in her own bed, with her own bathroom and in a familiar environment.

48.30 Counsel Assisting submitted that what becomes clear when reviewing the clinical care and discussions on 14, 15 and 16 May 2020 (addressed in detail below under those dates), is that Mary Watson's express wishes and her mother's ACP were not honoured. The advice that Mary Watson received from all clinicians and reiterated during each discussion regarding Mrs Bacon's ACP, was that the model of care being delivered at Newmarch was *equivalent* to hospital care. This overstates the care that could be provided at Newmarch House, even in May 2020, as compared to the care that could be provided in hospital.

48.31 It was further submitted by Counsel Assisting that Mrs Bacon's care was disjointed, with conflicting opinions and directions to nurses being given regarding:

(a) whether she was being palliated or active treatment was required,
(b) the administration of morphine, and
(c) the provision of fluids.

PROGRESSION OF ILLNESS

22 April 2020

48.32 On 22 April 2020, Mrs Bacon's blood pressure was recorded as 92/55 at 12.37pm. Dr Graydon was contacted but was not available at that time. Her blood pressure had improved by 2.58pm to 110/57. She did not complain of dizziness or headache.

24 April 2020

48.33 On 24 April 2020, Mrs Bacon's observations were recorded twice. First at 11.46am, SpO2 99% (BP 153/72, P 99, Temp 37.4C), and over ten hours later at 10.10pm, SpO2 97% (BP 129/60, P 77).

48.34 At 10.30am, following her COVID-19 positive result, Mrs Bacon was admitted to HITH. Mrs Bacon was formally discharged from HITH later that day, with the plan that she be followed up as an outpatient. At 12.00pm, Mrs Bacon was informed of her COVID-19 positive result. She was upset and the attending nurse prayed with Mrs Bacon. Mrs Bacon's observations initially appeared normal, with no fever, cough or shortness of breath. Some issues about her care were raised by the family, including that Mrs Bacon needed a Ventolin spacer, that her Norspan patch needed replacing, and that her weight should be recorded, as she appeared to have lost weight.

25 *April 2020*

48.35 On 25 April 2020, Mrs Bacon's observations were recorded twice. Firstly at 8.53am, SpO2 93% (BP 128/64, P 83, RR 18), and secondly at 3.15pm, SpO2 93% (BP 114/60, P 86, Temp 36.6C).

26 A*pril 2020*

48.36 From 26 April 2020 to 6 May 2020, staff recorded progress notes on paper. From 27 April 2020, a food chart was commenced, which recorded oral intake on some, but not all days, until 16 May 2020. From 28 April 2020 to 5 May 2020, a Call Log records contact with the family. The family had a video call with Mrs Bacon using a donated mobile phone.

28 *April 2020*

48.37 On 28 April 2020, Mrs Bacon had no complaints and no flu like symptoms noted.

29 April 2020

48.38 On 29 April 2020, Mrs Bacon had no complaints and no flu like symptoms noted. She was escorted outside for sunlight therapy, at the direction of Dr Branley. She saw some family members who were outside the facility fence.

30 April 2020

48.39 On 30 April 2020, Mrs Bacon's observations were recorded once at 11.42am, SpO2 97% (BP 105/60, Temp 36.4C, RR 16).

48.40 The first VACS video conference was held, between RN Hailey Carpen, Dr Sharma, Dr Kakkat, Dr Kathiresan, Dr Sahil and nurses from Newmarch House. Mrs Bacon was described as "*medically stable"* and noted to be "*asymptomatic".* The plan was for supportive care, to encourage oral intake and complete an Advance Care Directive.

2 May 2020

48.41 On 2 May 2020, Mrs Bacon's observations were recorded twice. First at 6.00pm, SpO2 95% (P 87, RR 18), then at 8.40pm, SpO2 96% (P 72, RR 16, Temp 36C). Mrs Bacon had a visit with her family through the facility fencing.

3 May 2020

48.42 On 3 May 2020, Mrs Bacon's observations were recorded five times. At 5.35am, SpO2 94% (P 68, RR 16, Temp 34.5C), at 10.30am, SpO2 95% RA (P 85, BP 114/89, RR 20, Temp 35.3C), 5.30pm SpO2 95% RA (P 68, BP 110/69, RR 16, Temp 34.5C), at 8.35pm, SpO2 98% RA (P 76, RR 20, Temp 35.8C), and at 7.57pm, SpO296% (RR 20).

48.43 On 3 May 2020, VACS recorded that Mrs Bacon was "*more stable.*" The plan was to continue the same care. Also on 3 May 2020, the notes recorded that Mrs Bacon was "*dry coughing @ times*." Mrs Bacon was reviewed by a locum medical officer, who was not concerned and charted Vitamin D, SpO2 was to be monitored, and the doctor was to be informed if it fell below 94%. Mrs Bacon was moved from room C3 to room C30, which had been occupied by her friend CA who had passed away on 28 April 2020, less than a week earlier, a situation which upset her greatly. She also had a visit from her family (mode not recorded).

4 May 2020

48.44 On 4 May 2020, Mrs Bacon's observations were recorded seven times. At 5.50am, SpO2 93% RA (P 84, RR 18, Temp 36.4C), at 10.00am, SpO2 97% RA (P 98, BP 124/59, RR 21, Temp 36C), at 10.30am, SpO2 95% RA (P 95, BP 113/69, RR 24, Temp 36.5C), at 12.07pm, SpO2 96% RA (P 88, BP 111/56, RR 20), at 4.05pm, SpO2 96% RA (P 95, BP 107/75, RR 24, Temp 36.4C), at 7.15pm, SpO2 92% RA (P 95, RR 28, Temp 36C), and at 9.00pm, SpO2 92% RA (P 77, RR 27, Temp 35.7C).

48.45 Nurses observed Mrs Bacon to be in respiratory distress during the morning, although she was maintaining SpO2 of 95% on room air. No respiratory distress was observed in the afternoon. A second VACS teleconference was held between RN Carpen, Dr Kakkat and a nurse from Newmarch House. Mrs Bacon's medical history and COVID-positive status (Day 10) were noted. The clinical notes record that Mrs Bacon had been coughing that morning resulting in respiratory distress but had since settled. She was eating and drinking. The plan was to continue supportive care and add Rulide.

5 May 2020

48.46 On 5 May 2020, Mrs Bacon's observations were recorded five times. At 1.35am, SpO2 93% RA (P 80, RR 26, Temp 36.4C), at 5.00am, SpO2 94% RA (P 81, BP 133/60, RR 26, Temp 36.4C), at 10.10am, SpO2 96% RA (P 88, BP 132/55, RR 20, Temp 36.2C), at 4.30pm, SpO2 94% RA (P 90, BP 122/63, RR 18, Temp 36.4C), and at 8.45pm, SpO2 93% RA (P 84, BP 120/65, Temp 36.4C).

48.47 A VACS videoconference was held. Mrs Bacon appeared to be deteriorating and was unwell the previous night. The plan was to administer oxygen at 2L/min. She was also to be given Vitamin O, and Ventolin via a spacer.

6 May 2020

48.48 On 6 May 2020, Mrs Bacon's observations were recorded three times. At 8.00am, SpO2 95% RA (P 88, BP 112/42, RR 18, Temp 36.5C), at 4.40pm, SpO2 95% RA (P 90, BP 106/54, RR 26, Temp 36C), and at 8.00am, SpO2 95% RA (P 90, BP 110/60, RR 23, Temp 36C).

48.49 A further VACS videoconference was held between Dr Sharma, Dr Kakkat, Dr Feldman, Dr Kathiresan, RN Carpen and a nurse form Newmarch House. Mrs Bacon was described as "*tachypnoeic, breathless today"* and looked pale. Nurses had reported ongoing deconditioning. The plan included to add Morphine 2.5mg s/c and to document anticipatory medications.

48.50 Dr Sharma subsequently contacted Mary. Dr Sharma noted that Mrs Bacon was deteriorating and that it was most likely due to COVID, not Asthma. Dr Sharma explained Mrs Bacon's management and supportive care. The note records "*Happy her mother receives supportive care at the RACF".*

7 May 2020

48.51 On 7 May 2020, Mrs Bacon's observations were recorded five times. At 6.15am, SpO2 96% RA (P 86, RR 26, Temp 36.3C), at 10.00am, SpO2 94% (P 92, RR 24, Temp 36.7C), at 2.30pm, SpO2 94% RA (P 84, BP 103/64, RR 25, Temp 37C), at 5.00pm, SpO2 97% RA (P 95, BP 116/66, RR 18, Temp 36.7C), and at 8.30pm, SpO2 97% RA (P 97, RR 19, Temp 35.9C).

48.52 On 7 May 2020, staff noted a pressure sore on Mrs Bacon's right sacrum/buttock. The next day, a Comprehensive Skin Assessment was performed. A chart recording Mrs Bacon's positioning every 2 to 3 hours was completed from 7 to 15 May 2020.

48.53 At 10.00am, Mrs Bacon was commenced on oxygen via nasal prongs (2L/minute). At 8.21pm, Mrs Bacon was administered IV morphine.

8 May 2020

48.54 On 8 May 2020, Mrs Bacon's observations were recorded six times. At 5.41am, SpO2 91% (RA?) (P 97, RR 20, Temp 36.2C), at 10.03am, SpO2 99% (P 92, BP 102/53, RR 19, Temp 37.3C), at 12.00pm, SpO2 98% (P 91, BP 103/54), at 6.10pm, SpO2 97% (P 105, RR 17, Temp 36.1C, BP 105/61), at 7.50pm, SpO2 91% on 2L (P 96, RR 16, Temp 36.2C), at 11.00pm, SpO2 93% on 2L (P 96, RR 27, Temp 35.9C, BP 101/56).

48.55 The family was advised that their mother's health was deteriorating. Joyce (Mrs Bacon's daughter) and Mary attended Newmarch House for a visit, wearing PPE, and noted that she could not speak and she was in bed, unconscious.

48.56 A VACS videoconference was held between Dr Fox, Dr Kathireson, Dr Kakkat, RN Carpen and Monica Tucker from Newmarch House. Mrs Bacon was noted to be resting in bed and looked fatigued. She was breathless while talking. She was tolerating drinks. The plan was to continue supportive care.

9 May 2020

48.57 On 9 May 2020, Mrs Bacon's observations were recorded six time. At 03.10am SpO2 96% on 2L (P 86, RR 25, Temp 35.6C), at 5.35am, SpO2 98% on 2L (P 94, RR 14, Temp 35.7C), at 9.30am, SpO2 96% on 2L NP (P 98, RR 17, Temp 35.8C, BP 131/55), at 5.30pm, SpO2 94% on 2L NP (P 96, RR 17, Temp 31.1C, BP 120/69), at 7.25pm, SpO2 92% (P 104, RR 24, Temp 36.6C), and at 11.39pm, SpO2 95% (P 90, RR [illegible], Temp 36C).

48.58 Mrs Bacon was noted to be in respiratory distress and weak. A palliative care specialist was to contact Mary. Mary gave evidence that based on her window visit with her mother she felt that her mother had improved and she was awake and sitting in her chair.

10 May 2020

48.59 On 10 May 2020, Mrs Bacon's observations were recorded three times. At 6.00am, SpO2 97% (P 77, RR 16, Temp 36C, BP 114/53), at 5.26pm, SpO2 97% on 2L (P 80, RR 16, Temp 35.9C, BP 132/56), and at 7.35pm, SpO2 99% (P 83, RR 20, Temp 35.5C). The family were given a video call with Mrs Bacon.

11 May 2020

48.60 On 11 May 2020, Mrs Bacon's observations were recorded seven times. At 1.15am, SpO2 98% (Temp 35.8C, RR 32, P 84), at 06.00am, SpO2 98% (Temp 35.9C, RR 18, P 82), at 8.30am, SpO2 94% RA (Temp 35.1C, RR 18, P 86), at 9.30am, SpO2 98% RA, at 3.00pm, SpO2 98% on 2L NP, RR18, at 8.00pm, SpO2 97% on 2L NP (Temp 36.4C, RR 16, P 88, BP 134/71), at 9.00om, SpO2 97% on 2L NP (Temp 36C, RR 22, P 93, BP 150/68), and at 11.40pm, (Temp 36.8C, RR 18, P 84, BP 136/74).

48.61 A VACS videoconference was held between Dr Sharma, Dr Kathiresan, Dr Kakkat, RN Carpen, Monica Tucker from Newmarch House. Mrs Bacon was noted to be resting in bed and "*looks improved.*" Mrs Bacon stated that she felt better and was eating and drinking. The plan was to replace Ordine with a Norspan patch and to continue supportive care. Dr Kathiresan updated the family about this.

48.62 Mary Watson was called by Dr Sharma who informed her that her mother had 'turned a corner', and her condition had improved. Prior to that they had spoken to Dr Branley one day in the driveway who informed the family that he was 'looking after' their mother and that she was doing "pretty well." He described her as a "pretty strong nut".

12 May 2020

48.63 On 12 May 2020, Mrs Bacon's observations were recorded six times. At 1.00am, SpO2 98% RA (Temp 36.1C, RR 18, P 82), at 6.30am, SpO2 97% RA (Temp 36.8C, RR 14, P 84), at 10.30am, SpO2 94% RA (Temp 36.5C, BP 152/68, P 82), at 2.00pm, SpO2 97% RA (Temp 36C, BP 126/59, P 90), at 6.45pm, SpO2 94% (Temp 36C, BP 150/69, P 90), and at 8.45pm SpO2 95% (Temp 36.3, P 92).

48.64 Mary Watson describes her mother as appearing very sick on 12 May 2020, stating she had nausea, was lethargic, she was quite dry, she was saying she was licking her lips. When Mary asked "*are you thirsty?*", and "*do you want a drink?*", she said yes. Mary states that her mother was unable at this stage to get to the bathroom to collect water unassisted as she was too weak.

13 May 2020

48.65 On 13 May 2020, Mrs Bacon's observations were recorded three times. At 6.00am SpO2 93% (Temp 35C, BP 135/69, P 94), at 9.00am, SpO2 94% RA (Temp 36.1C, BP 150/69, P 95, RR 22), and at 5.50pm SpO2 95% RA (Temp 35.9C, BP 123/76, P 98, RR 20).

48.66 A VACS videoconference was held between Dr Fox, Dr Kathieresan, Dr Kakkat, NP Carpen, RB Acharya, and a nurse from Newmarch House. Mrs Bacon's poor oral intake was noted, as was Mrs Bacon's sacral pressure ulcer. The plan included adding fluids (500mls/24hr), to review the pressure ulcer and manage pain with PRN morphine. Dr Kathiresan updated the family about this.

48.67 Mary states that Dr Sharma informed her that she did not think Mrs Bacon had COVID. She requested that her mother be given fluids. Dr Sharma informed her that her mother could have fluids but that they weren't currently available. She understands that Dr Kathiresan cancelled those fluids the following day.

14 May 2020

48.68 On 14 May 2020, Mrs Bacon's observations were recorded five times. At 9.24am, SpO2 95% RA (Temp 39.5C, P 103, BP 119/62,), at 10.22am, SpO2 was not recorded (BP 98/65), at 10.45am, SpO2 was not recorded (P 101, BP 112/71), at 7.00pm, SpO2 97% RA (Temp 36C, RR 20, P 113), and at 10.00pm, SpO2 96% RA (Temp 35C, RR 16, P 88).

48.69 Dr Branley attended to Mrs Bacon. He recorded the following note:

> Worse deconditioning.
> Weak poor appetite.
> Not in Pain or discomfort.
> D/W [discussed with] Dr Sharma – cease morphine.
> IV/SC [intravenous/subcutaneous] fluid (Depending on availability) IV/oral Dexamethasone as charted (Depending on availability)

48.70 On 14 May 2020 at about 2.30pm Dr Kathiresan rang Mary to inform her that her mum had declined, and it was time to think about her comfort care given there was no effective treatment at this time. Nothing was said in relation to fluids.

48.71 Mary subsequently spoke with Dr Branley who said "*he hadn't given up on her mum and he said there were still a few things that he could do."* Mary asked him at this point whether or not her mother could have fluids and Dr Branley reassured Mary that there was a very good nurse on that evening and he would make sure that she really pushed fluids and took particularly good care of her mother. Dr Branley further said that he was going to give her Dexamethasone, a steroid that may help, as well

as fluids. His handwritten clinical note after the direction to administer Dexamathasone reads "*depending availability*".

48.72 Associate Professor Kotsimbos notes that it was unclear whether Dexamethasone was given for symptoms of COVID-19, or for Alice's pre-existing asthma.

15 May 2020

48.73 On 15 May 2020, Mrs Bacon's observations were recorded five times. At 12.30am, SpO2 97% on 1L (Temp 35C, RR 17, P 81), at 8.00am, SpO2 96% RA (Temp 35.5C, RR 20, P 102, BP 135/85), at 12.00pm, SpO2 95% RA (Temp 36.4C, RR 18, P 101, BP 117/67), at 5.30pm, SpO2 95% RA (Temp 36.2C, RR 18, P 103, BP 110/73), and at 8.00pm, SpO2 96% RA (BP 109/57, P 100, RR 20, Temp 35C).

48.74 A VACS videoconference was held at 10:23am with Dr Sharma, Dr Kathiersan, Dr Kakkat, NP Carpen, RN Acharya and CNC Monica Tucker from Newmarch House. The note records:

> Deteriorated yesterday
> ongoing nausea and dehydration
> seen by Dr Branley 14/5/2020
> given I/V fluids (250ml) and Dexamethasone (8mg IV) yesterday
> for oral steroids today
> today resting in bed looks "dry"
> having oral supplements
> seen by Dr Branley this morning
> ….cease haloperidol
> Plan
> add subcutaneous fluids (500mls/24hrs),
> add Ondansetron wafer 4mg
> Morphine subcutaneous if needed not oral

48.75 Dr Kathiresan recorded her conversation with Mary in the records as follows, "*[t]he daughter clearly expressed that the family and Alice wanted to remain comfortable and die with dignity. She also expressed distress over the fact that they could not see her mother in person and say their goodbye."* As a result, Dr Kathiresan contacted Newmarch House and facilitated a visit for the following day.

48.76 Mary Watson gave evidence that Dr Kathiresan apologised to her stating, "*she told me that Dr Branley, the medication that he ordered, that she was getting them, receiving them. She didn't think that they worked, would work, as the fluids and tubing wasn't available, we had lost the window of opportunity.*"

48.77 On this day Dr Branley called Mary at 6:40am and indicated to her that he was worried and he thought the fluids and the steroids had helped slightly but she was still critically unwell. This was a curious statement for Dr Branley to make given Alice Bacon was not administered Dexmathesone on 14 May 2020 or at any time until 4:14pm on 15 May 2020, 16 hours after Dr Branley's phone call. There is no evidence that fluids were administered, subcutaneous or otherwise, and Dr Kathiersan held a belief they were not even available.

48.78 Alice Bacon was given 5mg of haloperidol at 9.11pm for agitation. Dr Branley told Mary he would try and get some nourishment into Mrs Bacon as "*she was starving.*"

48.79 Mary Watson gave evidence that there were mixed messages in relation to the management plan in relation to her mother. Dr Kathiresan had cancelled all treatment at 10.30am on 14 May 2020, however, "*one doctor is telling me it's no good and the other is telling me that there's still hope so obviously they weren't communicating. That was my interpretation of that.*"

16 May 2020

48.80 On 16 May 2020, Mrs Bacon's observations were recorded six times. At 1.15am, SpO2 95% RA (P 99, RR 20, Temp 35.5C), at 3.30am, SpO2 95% RA (P 88, RR 16, Temp 35.4C), at 3.48am, SpO2 92-97% (P 86-104; RR 12) (irregular), at 4.00am, SpO2 92-97% (P 86-84, RR 12-13, Temp 35.4C), at 1.00pm, SpO2 97% (BP 132/75, P 90, RR 14, Temp 36C), and at 9.00pm, SpO2 96% RA (BP 124/64, P 84, RR 14, Temp 36C).

48.81 On 16 May 2020, Mary Watson and her sister, Joyce conducted an in-person visit with their mother, Alice Bacon. Mary gave this account as to how she presented:

> Well she opened her eyes, she smiled at us. We'd already asked if we were wearing gloves could we touch her and they said yes. So she was holding my hand, she was visibly thirsty, again licking her lips…. Again there was no water or straws in her room. I asked for her to be given a drink, to get a drink, I put it to her mouth. She gulped and gulped, so of course she's coughing and spluttering. Monica Tucker, the RN, was in the room with us, she said "would you like a cup of tea, Alice?" to which my mum said "yes please". .. All of a sudden my mother grabbed my hand, screamed at Jose, looked at Mark outside the window and was screaming at the top of her voice, Mark, Mark, get me out of here, get my shoes, take me home, get me out." And it was as you can tell very disturbing. … Her skinny little legs were doing this trying to get out of the bed. People were coming into the room and standing, like not forcibly holding her down, but you know, standing either side of the bed so she couldn't get out. She'd just "take me home Mark, take me home." She said "where's my shoes?" A doctor came into the room and mum was so upset they said they would give her something to calm her down which we were happy to do because she was so distressed. She could have done with some drugs at that point. At that point we were so distressed as well. I held my mum's hand while they were injecting her. She grabbed my hand, she flung it into the air and she said "get." I waited in the room until she was calm. We went outside. …
>
> We came back I think at around 12:30 or 1. We went to the window... the nurse turned on the light and said 'Alice, Alice your family is here.' Immediately my mum jumps up to get out, the legs were going frantically, let me out, let me out. I had Monica's mobile phone because she had recently rung me and I rang her and I said my mum is not comfortable... she is not settled you know. Help. … While this was going on I got a phone call from Dr J (Kathierisan) telling us that it was now telling us that it was now time to do the whole palliative care thing and her comfort must come first. She needed to be calmed and sedated and they would start the syringe driver with the morphine and the midazolam.

48.82 The clinical records record that Alice Bacon was "*very terminally distressed"* at 4.00pm. An untimed entry by an RN in the Observation Charts records "*Alice is now for comfort measures and no obs as per Dr's orders."*

48.83 A syringe driver was commenced with morphine and midazolam based on earlier instructions given by Dr Kathiresan. There is no evidence of midazolam (a schedule 4D drug) being prescribed or dispensed based on the pharmacy and medication records. It is unclear therefore whether in fact the syringe driver contained midazolam along with morphine and if so, who supplied it.

48.84 The evidence of CNC Tucker is of critical importance in relation to assessing the decision to commence with a morphine syringe driver based on an assessment that Mrs Bacon was nearing the end of her life and her behaviour, according to the clinicians, was one of terminal agitation. CNC Tucker gave the following evidence:

(a) Alice Bacon did not have terminal agitation in the days preceding 16 May 2020 when she saw her.'
(b) She recalls Alice Bacon's presentation on 16 May 2020 as being bed-bound, she was semi-conscious, she had moved through different stages of being alert, confused, and at times hypoxic (low Sat02 readings), and her assessment was she was nearing end of life.
(c) She viewed Alice Bacon's "*very distressed*" state and wishes to go home as 'terminal agitation.' She said there is an individuality to how a patient presents, namely there can be moments of great clarity and there is not one set way for somebody to die. She went on to say that patients can stand up, sit down, they can move from bed to chair, they can roll around, they can move from side to side and sometimes people are alert until they die.

48.85 CNC Tucker agreed that it is possible that Mrs Bacon's screams to her family "*Mark, Mark, get me out of here, get my shoes, take me home, get me out"* was Alice reacting to the circumstances she was in, in a quite rational way and that she was simply very upset. She further accepted that it was possible that in that moment, Mrs Bacon wasn't demonstrating terminal agitation, she was just very upset with what was going on.

48.86 In response to a question as to how one distinguishes between the two, namely whether it is terminal agitation or a rational response to what is going on, CNC Tucker gave evidence that "*the two of them can happen at the same time together. The terminal agitation isn't like a condition that lasts, you know, you can have terminal agitation, clarity, terminal agitation, clarity. So what you go on is the level of distress this is causing the person or the individual and you manage the symptoms."*

48.87 In response to a question with respect to how one distinguishes terminal agitation from simply distress CNC Tucker gave evidence that "*the restlessness becomes increasingly, out of the ordinary from normal restlessness" and "the person can become very, very, very agitated" so often one can find a cause and fix it but with terminal agitation it needs to be managed with medication to make the person comfortable*".

17 May 2020

48.88 Mrs Bacon was recorded as peaceful and comfortable. The family attended for a window visit and took photos of Mrs Bacon. Electronic progress notes record that the pain pump of midazolam and morphine was *in situ* and infusing correctly, and that Mrs Bacon was being observed at least every 30 minutes. As noted already, RN Cardwell gave evidence that it could take 25 to 30 minutes to don

PPE, enter a resident's room, administer medication, take a full set up observations, converse with a resident to ascertain any concerns or care needs and then doff PPE. Given this timeframe, which establishes that the movement of staff between residents' rooms and the taking of observations was a lengthier and more involved process than prior to the Outbreak, it is unclear what level of observation was actually occurring. The possibility arises that if observations were occurring at least every 30 minutes, as documented, then on occasions these observations may have been taken from the door of a resident's room.

18 May 2020

48.89 On 18 May 2020, a VACS videoconference was held between Dr Kathiresan, Dr Kakkat, Dr Feldman, NP Carpen, RN Westwood and CNC Tucker from Newmarch House. Mrs Bacon's condition had continued to deteriorate, although she was resting in bed and now looked comfortable. The plan was to continue comfort care and provide mouth and eye care. Electronic progress notes record that at approximately 11.45am the 'pump was empty' and Dr Michael [Feldman] was informed of this.

48.90 Mary attended Newmarch House for a visit. Mrs Bacon was unresponsive at that time. An electronic progress note at 4.15pm records that Mrs Bacon had laboured breathing, was reviewed by the doctor doing rounds, and that two RN's had administered a sure flow infuser [syringe driver]. At 8:55pm, a nurse recorded that Mrs Bacon was not responsive to verbal, touch or pain stimuli.

19 May 2020

48.91 Mrs Bacon was found unresponsive and not breathing at 12.15am. Mary was informed of Mrs Bacon's death at 12.41am.

MANNER AND CAUSE OF DEATH

48.92 **Cause of Death**: Associate Professor Kotsimbos, Professor Kurrle and Professor French considered that Mrs Bacon's cause of death was COVID-19 infection, significantly contributed to by Mrs Bacon's underlying Ischaemic Heart Disease. Professor French felt her underlying conditions were the primary cause and COVID was a contributory factor, but was willing to reverse the emphasis in line with the other experts.

48.93 **Manner of Death**: Alice Bacon experienced a late clinical deterioration after a period of confusion as to whether she had in fact recovered from COVID. It is noted that CNC Tucker's evidence was that Alice Bacon was "*quite physically fit*" and it could go "*either way*" as to whether she survived as a result. CNC Tucker gave evidence that Alice Bacon moved from being actively treated into end-of-life care but where the line was drawn in that regard was unclear given she had been very well and there was a possibility until very, very close to Alice's end of life that she may have recovered. Professor Kotsimbos opined that a syringe driver was used to escalate the speed of the morphine dose, suggestive of distress. However, there are no notations of distress in the clinical records from late afternoon 16 May 2020 until the time of Alice Bacon's death just after midnight on the morning of 19 May 2020. The evidence of distress appears limited to 16 May 2020 and the events that occurred during the family's visit.

48.94 **Impact of any significant co-morbidities:** Associate Professor Kotsimbos, Professor Kurrle and Professor French agreed that Ischaemic Heart Disease, asthma and chronic airways disease all had an impact.

48.95 **Issues with care received**: The experts noted that Mrs Bacon had three negative swabs in the days before she died and although she was medically assessed there was confusion about whether her symptoms and signs were due to ongoing COVID-19 or her underlying conditions.

48.96 The progress notes suggested that there was some confusion as to whether her respiratory symptoms were caused by her asthma or her respiratory infection. Associate Professor Kotsimbos noted that Mrs Bacon had "*crackles*" in the lungs which may have related to the respiratory infection but may also have related to fluids given her heart was not working well and she was given diuretics (Laxis) and therefore there were a whole lot of things "*pushing and pulling in different directions*". Her issues were complex, and she was treated for asthma and with diuretics for her heart, and the clinical records state fluids were started, stopped and started again by different specialists. However, it is noted that there is in fact no evidence that subcutaneous or IV fluids were ever administered, and oral intake appeared minimal. Associate Professor Kotsimbos remarked upon the confused messaging in communication with the next of kin regarding Alice Bacon's condition.

48.97 It is very difficult to determine now whether Alice Bacon was in fact terminally agitated on 16 May 2020, when her family came to visit, or whether in fact Mrs Bacon was rationally responding to the distress of being isolated in her room for over 5 weeks with reduced contact with family and residents. The decision to commence a syringe driver or to administer morphine in any form should not be taken lightly. As Professor McIntyre outlines in her first report, "*These drugs can reduce pain, distress and agitation, but can also depress respiration, contribute to respiratory failure and hasten death*."

48.98 At a minimum, given the competing explanations to Alice Bacon's presentation on 16 May 2020 when her family were present, a face-to-face consultation with a palliative care specialist should have occurred prior to the ordering of a morphine syringe driver.

48.99 **Whether different action may have affected the outcome**: Yes

48.100 Counsel Assisting submitted that the pertinent aspects of the evidence supporting a conclusion that different action may have affected the outcome, including transfer to hospital once Mrs Bacon tested positive to COVID-19 are as follows:

(a) Associate Professor Kotsimbos noted that Mrs Bacon's diagnosis was on 23 April 2020, being late in the Outbreak and she had several negative tests beforehand. As a result, Associate Professor Kotsimbos considered that Mrs Bacon's infection occurred well into the propagated second wave of infections and therefore her infection could have been prevented.
(b) Professor MacIntyre was of the view that COVID-19 infections occurring after 18 and 19 April 2020 were potentially preventable for the reasons described earlier. Given three negative tests on 14, 17 and 20 April 2020, more than one of those negatives was likely a true negative. As a result, if a different model of care had been adopted, involving in the initial period a transfer out of COVID-

19 positive residents until infection control measures were properly in place and sufficiently skilled staff were present, Mrs Bacon's death was likely preventable.

(c) In this regard the evidence of CNC Tucker is relevant, namely that prior to Alice Bacon testing positive for COVID-19, her morning routine was to move out of her room to make herself a cup of tea in the communal area. This increased the risk of Mrs Bacon contracting the virus. Associate Professor Kotsimbos and Professor MacIntrye opined that some infections amongst residents may have been prevented if a different strategy in relation to positive cases (namely moving them out) had been adopted, resulting in a reduction of the spread of COVID-19 at Newmarch House.

(d) Associate Professor Kotsimbos also considered that hospital transfer would have assisted Mrs Bacon as she would have received a fuller clinical assessment and more appropriate use of anticipatory medications being given at the right time.

(e) Professor Kurrle emphasised the confusion that was occurring within the medical team caring for Mrs Bacon. An example of this confusion was that Mrs Bacon was given a diuretic (Laxis) and then written up for subcutaneous fluids by Dr Sharna, which were then ceased by the palliative care physician and then restarted by Dr Branley.

(f) CNC Tucker's evidence was that prior to Alice Bacon testing positive to COVID-19 "*she certainly wasn't the palliative approach, she was mobile, she was walking independently, could converse*." Her good mobility appears to have favoured survival. In those circumstances, Alice Bacon would have benefited from hospital transfer.

(g) Counsel Assisting noted that between 7 and 9 May 2020, Mrs Bacon had increased shortness of breath, respiratory distress, and fatigue, but her condition fluctuated. Between 11 and 13 May 2020, there was evidence that Mrs Bacon was displaying signs of improvements and there were messages to the family that perhaps Mrs Bacon did not have COVID-19. The clinical records do not support a finding that subcutaneous fluids were ever in fact administered and the records disclose that they were in fact not available at Newmarch for the relevant period. Three days after signs of improvement, namely on 16 May 2020, anticipatory medications commenced via syringe driver for terminal agitation and Morphine and Midazolam were administered until the time of her death on 19 May 2020, roughly 56 hours after the syringe driver commenced. On one view, it showed Alice Bacon's tenacity to survive.

(h) Associate Professor Kotsimbos considered that medical staff were "*struggling,*" and that it was very hard to look after people when you are struggling.

(i) Professor Kurrle considered that transfer to hospital would likely have resulted in clearer management and Mrs Bacon may well have survived.

(j) Professor Kurrle acknowledged that transferring an elderly patient to hospital can be difficult but noted that Mrs Bacon had already been transferred between rooms at Newmarch House (having been placed in her deceased friend CA's room). She opined that if she was transferred to a hospital with a two-bed or four-bed ward, she would have received the level of care that may have made a difference.

(k) Associate Professor Kotsimbos and Professor French agreed that transfer to hospital would have provided better care, better management and better assessment.

(l) Lastly, transfer to hospital for better treatment, management, care and assessment were the express wishes of Mrs Bacon and her family. Mary Watson was clear in her evidence in this regard. The advice from the treating clinicians that Mrs Bacon would receive care at Newmarch House equivalent to hospital care is not borne out in the clinical records, or the expert opinion.

48.101 It was submitted on behalf of NSW Health and NBMLHD that multiple progress notes record that both Mrs Bacon and her daughter advised that she was not to be transferred to hospital in the event of deterioration. It was further submitted that because a number of significant advance care discussions relating to Mrs Bacon involved Dr Kathiresan, who also appears to have ordered the morphine syringe driver, and evidence was not called from Dr Kathiresan or any expert palliative care physician, that a finding that Mrs Bacon's ACP was not honoured cannot be made.

48.102 However, each of the experts noted that although Mrs Bacon's ACP stated that she was not for hospital transfer, an express discussion was required outlining that transfer to hospital does not only mean care in an ICU setting (which involved interventions such as intubation and ventilation, which Mrs Bacon did not want), but included other treatments, available in a general ward, could be provided to Mrs Bacon, with the effect of better management and assessment. As Professor Kotsimbos explained:

> Often the assumption, a lot of these Advance Care Plans are tick box exercises, do you want hospital transfer, and when the discussion is happening, hopefully there is a discussion, sometimes there isn't, it's in the setting of well, you don't want to go to hospital, you don't want to be transferred if there's nothing they can do. So that's how the informed consent gets played out, but sometimes there is something they can do, and so we've ticked a box that says, "not for hospital transfer", but we've left out that other nuancing qualifier, which is of course I don't want to be transferred if there's nothing that can be done. But if it was said to them that there is something that can be done, perhaps it would not be that box that was ticked.

48.103 Having regard to the opinions expressed by each of the experts who were called to give evidence, the absence of oral evidence from Dr Kathiresan or any expert palliative care physician does not preclude a finding being made that Mrs Bacon's ACP, properly understood in the terms described above, was not honoured.

48.104 Counsel Assisting further submitted that Mrs Bacon's death was preventable. If either different action had been taken to reduce the risk of her becoming infected, or she had been transferred to hospital for management when her condition deteriorated, she may have survived the illness.

48.105 The findings I make pursuant to section 81(1) of the Act are:

Identity

The person who died was Alice Bacon.

Date of death

Mrs Bacon died on 19 May 2020.

Place of death

Mrs Bacon died at Newmarch House, Kingswood NSW 2747.

Cause of death

The cause of Mrs Bacon's death was COVID-19 infection with ischaemic heart disease, asthma and chronic obstructive pulmonary disease being significant conditions which contributed to death.

Manner of death

Mrs Bacon died of natural causes following diagnosis of COVID-19 infection. Active supportive care for Mrs Bacon became confused when the treating team could not clearly determine whether Mrs Bacon had recovered from COVID-19 and whether her late clinical deterioration represented COVID-19 infection or her underlying co-morbidities. This changing medical treatment had consequences for Mrs Bacon and her family. In particular, uncertainty about whether Mrs Bacon's presentation on 16 May 2020 represented terminal agitation or a rational response to the distress of being isolated suggests that a face-to-face consultation with a palliative care specialist would have been of assistance prior to administration of a morphine syringe driver. Given the timing of Mrs Bacon's COVID-19 diagnosis on 24 April 2020, her infection may have been prevented if a different model of care had been implemented. If Mrs Bacon had been transferred to hospital a fuller clinical assessment would have been of assistance, appropriate anticipatory medications could have been given at the correct time, and Mrs Bacon would have received a level of care that may have made a material difference to the eventual outcome.

49. Acknowledgements

49.1 I warmly acknowledge and express my gratitude to Simon Buchen SC, Ragini Mathur SC and Jake Harris, Counsel Assisting, and their instructing solicitors, Kathleen McKinlay, Catherine Moore, and Ashleigh Heritage from the Department of Communities & Justice, Legal. The Assisting Team has provided exceptional assistance during the conduct of the coronial investigation and throughout the course of the inquest. I am extremely grateful for their commitment and tireless efforts, and the care and attention to detail they have shown in analysing and reviewing the evidence, particularly having regard to the scope of the coronial investigation and the complexity of issues involved. I am equally grateful for the empathy and compassion that they have shown during all stages of the coronial process. The coronial investigation and inquest simply could not have proceeded without their tremendous assistance.

49.2 The Registry and Court staff at the Coroners Court have also worked diligently to ensure that the logistical and administrative facets of the inquest proceeded as smoothly as possible. In addition, the staff has supported the family members involved in the inquest and kept them informed at each stage of the coronial process.

49.3 I also acknowledge the helpful, forthright and sensitive way each of the institutional sufficiently interested parties has engaged with the coronial process and inquest, and hope that this has been of assistance to the families involved.

49.4 I also thank Acting Inspector Steven Peroni, the New South Wales Police Force Officer-in-Charge, for his role in the police investigation and for compiling the initial brief of evidence.

49.5 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to the family members of CA, Alice Bacon, Blanche Billinghurst, Margaret Brocklehurst, Edith Brownlee, Leone Corrigan, Ann Fahey, Ronald Farrell, David Gee, Olive Grego, Maria James, Barry Jehan, Raymond Jennings, Fay Rendoth, Keith Smith, Victor Stone, Margaret Sullivan, Marko Vidakovic & Shirley Yates. Families involved in the coronial process often experience grief, distress, anxiety, uncertainty and helplessness, both as a result of the events which an inquest is examining and, regrettably, the inquest itself. In these cases, the emotional experiences of the families has no doubt been magnified by the broader challenges posed by the COVID-19 pandemic. The Coroners Court extends its deepest sympathies to each person who has lost a beloved partner, parent, grandparent, sibling, loved on and friend in such devastating and tragic circumstances.

49.6 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
24 January 2025
Coroners Court of New South Wales

Appendix A

Inquest into the deaths of CA, Alice Bacon, Blanche Billinghurst, Margaret Brocklehurst, Edith Brownlee, Leone Corrigan, Ann Fahey, Ronald Farrell, David Gee, Olive Grego, Maria James, Barry Jehan, Raymond Jennings, Fay Rendoth, Keith Smith, Victor Stone, Margaret Sullivan, Marko Vidakovic & Shirley Yates

Guidance available at the commencement of the Outbreak

CDNA Guidelines

1. On 13 March 2010, the Communicable diseases Network Australia (**CDNA**) published the first edition of the *National Guidelines for Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia*.

2. The CDNA Guidelines are adopted from those relating to the management of influenza outbreaks in RCFs with input from Commonwealth and State health agencies, relevant international organisation such as the WHO, the US Centre for Disease Control and Prevention, and the Canadian Public Health Agency.

3. The CDNA Guidelines set out the roles and responsibilities of the RCFs, the State/Territory Department of Health and Human Services and the ACQSC in responding to and managing an outbreak. Significantly, the CDNA guidelines identified that primary responsibility for managing outbreaks rests with aged care facilities and their providers.

4. The guidelines identified that primary responsibility for managing outbreaks rests with aged care facilities and their providers. It stated that the workforce management plan should be able to cover a staff absentee rate of 20 – 30%. Staff should be informed and supported to exclude themselves from work when they have any kind of respiratory illness and to notify the RCF once a COVID-19 diagnosis is confirmed.

5. As healthcare facilities may be impacted, the Guidelines foreshadowed that RCFs must be able to manage residents with COVID-19 while maintaining the level of care required for all other residents.

6. Transfer of residents to hospital should be facilitated "*only if their condition warrants*." The Guidelines state that "*in some circumstances, it may be feasible to transfer residents who are not symptomatic to other settings (e.g. family care) for the duration of the outbreak*."

Comment on the CDNA guidelines

7. Professor Ibrahim opined that the CDNA guidelines were well intentioned but did not consider the dynamic of the aged care sector or how it operated, or the fact that the sector was already in a dire situation prior to the pandemic, as had been found by the Royal Commission. The CDNA guidelines did not address the sector's core needs or provide the support and direction required. Consequently, many RACFs (including Newmarch House) felt they were well prepared but weren't. It was unreasonable, in his view, to expect RACFs to organise 20-30% of extra staff where they were already understaffed, or to have well-functioning infection control programs, and it was impractical to

suggest they should engage with infection control consultants or local health services to obtain advice.

8. Professor Ibrahim also opined that the CDNA guidelines were written with the underlying view that residents should generally not be taken to hospital. While in normal circumstances an individual could decide when to attend hospital, the decision to transfer them would generally be "*filtered*" by the RACF, who may liaise with the GP, paramedics and local Emergency Department, rather than being driven by what the resident wanted to do.

ASID Interim Guidelines

9. The *Interim Guidelines for the Clinical Management of COVID-19* from the Australian Society for Infectious Diseases Limited (**ASID**), to "*aid in the development of more detailed and specific local guidelines for your hospital.*" Their application is limited to the early stages of a pandemic where hospital resources are not yet significantly impacted.

10. The ASID Interim Guidelines outline the assessment for hospital admission, stating that where possible COVID-19 patients should be managed out of hospital in accordance with local policies.

11. Admission should be considered if patients are hemodynamically unstable, experiencing hypoxia (Sa02 on room air <94%), reduced platelet count, have comorbidities or if the home environment is unsuitable.

The Living Guidelines

12. With the support of the National Health and Medical Research (NHMRC), the National COVID-19 Clinical Evidence Taskforce was established to living guidelines for clinical care and treatment of people with suspected or confirmed COVID-19.

13. The Living Guidelines acknowledge that while most people will experience mild symptoms, "*older people and those with underlying diseases or medical conditions (such as cardiovascular disease, diabetes, chronic respiratory disease and cancer) are more likely to develop serious illness that require special care and treatment.*"

14. Version 2 of the Living Guidelines was published on 16 April 2020. It makes recommendations in relation to clinical care and treatment of patients with COVID-19.

CEC Guidelines

15. Interim Guidance entitled "*Infection Prevention and Control COVID-19 (SARS-CoV-2) – Residential & Aged Care Facilities*" was issued by the NSW Health Clinical Excellence Commission (CEC) on 12 March 2020.

16. The CEC Interim Guidance stated:

    There is evidence that the virus spreads through droplet and contact with contaminated fomites and surfaces.

    The virus is most likely spread through:

- *close contact with an infectious person*
- *contact with droplets from an infected person's cough or sneeze either directly or indirectly from used tissues or their hands*
- *touching objects or surfaces (like doorknobs or tables) that have cough or sneeze droplets from an infected person, and then touching your mouth or face*

17. The document cites 9 General Principles for Infection Prevention and Control to limit transmission:

    (1) Early recognition and containment,
    (2) Application of standard precautions at all times for all residents
    (3) Implementation of transmission-based precautions, including contact, droplet and airborne precautions.
    (4) Hand hygiene
    (5) Environmental cleaning
    (6) Cleaning of shared equipment
    (7) Alternative modes of visiting for families of residents
    (8) Respiratory hygiene, including cough etiquette and social distancing
    (9) Annual influenza vaccination of residents, healthcare workers and visitors.

18. The CEC Interim Guidance indicates that residents with COVID-19 or an influenza like illness should be cared for in a single room if possible and cease interaction with other residents.

19. In an instance of confirmed COVID-19, facility management should implement infection control measures, heighten surveillance, confirm influenza vaccination and provide information to residents, staff and visitors about restricting attendance and infection control.

20. Internal and external movement of residents and visitors should be limited and new admissions should be restricted.

21. There is also guidance visitor restriction and signage, environmental cleaning, patient transport, handing of linen, food service, waste management and management of deceased bodies.

WHO Interim guidelines

22. On 21 March 2020, the WHO issued "*Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19*."

23. The WHO Interim Guidelines stated:

    WHO recommends that COVID-19 patients be cared for in a health facility, in particular patients with risk factors for severe disease which include age over 60 and those with underlying co-morbidities (see Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected). A clinical assessment is required by a medical professional with respect to disease severity, for the potential patient transfer to an acute health facility. If this is not possible or indicated, confirmed patients can be isolated and cared for at the LTCF.

Australian Health Protection Principal Committee (AHPPC)

24. On 12 March 2020, the AHPPC issued a statement on COVID-19:

(a) recommending that anyone working in the health and aged care sectors with COVID-19 symptom be tested and not work whilst symptomatic; and
(b) specifying that those positive for COVID-19 must self-isolate for 14 days (as well as close contacts) until a negative test is returned.

25. On 17 March 2020, the AHPPC issued a further statement recommending, amongst other things, that:

(a) visitors and staff who had been overseas in the previous 14 days, close contacts and anyone with symptoms, should not be permitted into a residential aged care facility; and
(b) visits to residents should be limited to a maximum of two visitors at one time per day, that large gatherings and excursions be cancelled, and that visitors and staff should be instructed to stay away when unwell and should be screened for fever upon entry to a facility.

Public Health Orders

26. As a matter of public record, on 24 March 2020, the NSW Minister for Health and Medical Research made the *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020*, limiting persons that could enter aged care facilities. For example, the only families and friends of residents that could enter were those make a care and support visit, if it was the only care and support visit or the resident on the day, and those "providing end-of-life support".

27. On 26 March 2020, the *Public Health (COVID-19 Self-Isolating) Order 2020* was made requiring persons diagnosed with COVID-19 to reside at their residence until medically cleared.

Appendix B

Inquest into the deaths of CA, Alice Bacon, Blanche Billinghurst, Margaret Brocklehurst, Edith Brownlee, Leone Corrigan, Ann Fahey, Ronald Farrell, David Gee, Olive Grego, Maria James, Barry Jehan, Raymond Jennings, Fay Rendoth, Keith Smith, Victor Stone, Margaret Sullivan, Marko Vidakovic & Shirley Yates

Previous reviews of the Outbreak

NSW Health – Clinical Excellence Commission ('CEC'), Newmarch House Report

1. Infection Prevention and Control Practitioner and Senior manager at the Clinical Excellence Commission (NSW Health) Kathy Dempsey and a team of colleagues, attended Newmarch House on 11 occasions between 1 May and 3 June 2020. They were initially tasked with reviewing the infection control practices in place at the facility and provide support and advice, including by developing an infection control management plan.

2. Their review assessed compliance against 7 Principles of COVID-19 infection prevention and control, namely:

    a. Early recognition of patients with confirmed, probable or suspected COVID-19
    b. Physical distancing efforts
    c. Respiratory hygiene and cough etiquette
    d. Application of standard precautions for all patients
    e. Implement transmission-based precautions
    f. Hand hygiene
    g. Cleaning the environment and shared patient care equipment

3. The first report, released on 1 May 2020, made several recommendations:

    a. *Standard minimum infection prevention measures*

    The review could not assess the level of understanding and competence of all staff. It noted there was a lack of infection prevention and control expertise, which was significant where there were multiple agencies. The report stated:

    The overall governance to pull each of those agencies under one (1) reporting structure appeared lacking, clinical management/leadership models would also facilitate a consistent and controlled clinical environment.

    b. *PPE*

    There was a high use of PPE. However, the PPE varied widely and in some cases, inappropriate PPE was being used. For example, vinyl gloves were used, which did not fit well, were prone to breaking and permeable to viruses. These were therefore replaced with latex/nitrile gloves. At the time of the review, all staff were being required to successfully demonstrate donning/doffing PPE at the start of their first shift.

c. *Cleaning*

The review noted that there was a lot of clutter, which would impede infection control. There was a dedicated daily cleaning team. However, the level of waste management was excessive. All waste was being treated as clinical waste. This was to be reviewed at a later stage.

d. *Zoning of residents*

The facility had been separated into six teams, working in each of the units, and were further divided into those working with COVID-positive and COVID-negative patients.

However, issues with this approach were also noted:

- Apart from the logistics of moving an aged population, the challenges for infection control increase with the potential of moving and spreading disease to another site.
- The approach deviates from contain and control efforts recommended for outbreak management
- Possible shift of pathogen to other locations and increase in risk of spread, especially if personal belongings, patient care items and staff move.
- Some residents with negative screens have refused ongoing testing.

4. By the time the CEC's second report was released on 24 May 2020, Newmarch House had an educator inside, who had implemented training for hand hygiene and donning/doffing of PPE. Newmarch House was also exploring additional options to engage additional Infection Prevention and Control expertise, including identifying infection control champions. The second report recorded progress against an action list of infection prevention and control measures. All those measures had been implemented or were ongoing by the time of the second report.

5. The third and final report was issued after a final review of implemented infection control practices that took place on 3 June 2020. The findings of the report included:

a. *Education*

Newmarch House had arranged two dedicated educators for infection and control practices. A lead infection control nurse (Felicity Hill) had been identified, and infection control champions.

b. *Cleaning*

The entrance, dining areas and corridors to each wing were now visibly clean and not cluttered.

c. *Physical distancing*

This was occurring in the residents' dining area, although some staff were observed with limited physical distancing.

d. *PPE*

A PPE station was located at the entrance of each wing, and a smaller station outside each resident's room. There was clear zoning of clinical and non-clinical areas in place. Staff were observed on most occasions to be compliant with PPE, and non-compliance was resolved without conflict.

Some issues were identified with handling PPE stock. Isolation gowns had been left in the delivery dock for around 20 hours, which was located next to bags of waste disposal. New PPE stock in unopened cartons was also placed next to decanted stock. The report noted that staff responded to these issues promptly.

6. Overall, the report noted that there had been "*a commitment to ongoing training and education to establish a solid foundation for principles of infection prevention and control.*"

Healthcare Infection Control Management Resources (HICMR) – Review of COVID-19 Outbreak at Anglicare Newmarch House

7. The HICMR report, dated 13 June 2020, reviewed the events from an infection prevention and control perspective, to identify contributing factors and recommend strategies to address any issues, and to provide a documented report for use by the facility Executive. The report considered information, including policy and procedure material, supplied by Newmarch House and subsequent email discussions with James Zehnder and the NSW Health CEC.

8. The report focused on the preparedness of Newmarch House prior to the outbreak and considered how the outbreak was responded to and managed.

9. The report made several recommendations with regards to preparedness for an outbreak and outbreak management. These included:

    a. If an IPC professional had been approached in the planning and preparation phase, this may have resulted in the implementation of "*more robust evidence-based IPC processes at the facility*." Ongoing IPC input was recommended.
    b. Enhanced monitoring of residents' symptoms may have resulted in earlier recognition of resident infection and timelier implementation of appropriate IPC precautions.
    c. Temperature testing of people entering the facility was not implemented until after the commencement of the outbreak. This may have detected early onset of infection.
    d. Staff members worked at more than one facility and consequently were at risk of exposure to COVID-19.
    e. Confusion regarding the sequence of donning and doffing was reportedly a factor in relation to cross-contamination.
    f. There was a lack of familiarity with and adherence to standard, droplet, and contact precautions. Ongoing review and update of staff training and capability assessment tools to ensure inclusion of contemporary IPC requirements.

Anglicare Newmarch House Final Report by Andrew Kinkade, Independent Adviser

10. Andrew Kinkade was engaged as Independent Adviser following the Notice served on Anglicare on 6 May 2020 by the Aged Care Quality and Safety Commission (ACQSC). ACQSC alleged non-compliance with the following standards:

a. Standard 1 - Consumer Dignity and Choice.
b. Standard 2 - Ongoing Assessment and Planning with Consumers.
c. Standard 3 - Personal Care and Clinical Care.
d. Standard 8 - Organisational Governance.

11. Mr Kinkade attended Newmarch House, listened to staff and family members, sought feedback from clinicians, experts, suppliers, agencies, stakeholders and participated in webinars and frequent discussions with executive staff from Anglicare and Newmarch House. He prepared a report, dated 30 June 2020, considers all the advice that Mr Kinkade provided to Anglicare during this time, including advice that warrants consideration in the development of protocols regarding future COVID-19 outbreaks in aged care homes.

12. Mr Kinkade 's recommendations included the following:

a. Crisis management:
   - Governance for Anglicare was agreed and documented
   - Newmarch House's organisational structure was documented and implemented
b. Resident care
   - A 'single-view' of resident COVID-19 status and care needs was developed.
   - Improvements were made to the staff PCR testing regime, PPE stock management, visitor screening processes, and an infection control audit was performed.
   - A Resident Reconditioning and Reablement program was developed, with changes proposed to the physical environment.
   - An identified need for independent investigation of severe incidents and a review of incident management processes was undertaken.
c. Workforce
   - A workforce plan was developed and an approach to improve surge workforce uptake.
d. Communication, feedback and complaints
   - Establishment of the Family Support Program. Registered Nurses made daily calls to the families of every resident. The Family Support program received strong positive feedback from families, and reduced calls to Anglicare by 90%.
   - A focus on the complaints register by senior personnel, and improved responsiveness and sensitivity for handling these complaints. Open disclosure by staff encouraged.

13. The report also identified a need for the development of relevant protocols in the aged care sector, including implementing a staff swab testing regime, and staff wearing masks in homes and places where community transmission may occur.

Newmarch House COVID-19 Outbreak Independent Review – Final Report by Professor Lyn Gilbert AO, Adjunct Professor Alan Lilly

14. An Independent Review was commissioned by the Commonwealth Department of Health (DOH) to understand what occurred and what could be learned from the Outbreak at Newmarch House. The review was conducted by Professor Lyn Gilbert and Adjunct Professor Alan Lily and assessed the following issues:

a. Preparedness of the aged care facility for a COVID-19 outbreak
b. Infection and prevention control processes in the home

c. Leadership and governance during the outbreak
d. The outbreak experience for Newmarch residents and families
e. Support arrangements with the state and federal agencies

15. Over a 6-week period, reviewers met with the families of the victims and residents of Newmarch House, advocacy organisations, government agencies, GP's and other service providers, as well as reviewing written feedback and submissions from residents and families of those at Newmarch House.

16. The final report, dated 20 August 2020, acknowledged that the COVID-19 outbreak at Newmarch House was an unprecedented situation for any aged care facility in Australia.

17. The report made the following findings:

a. Emergency response
   - Anglicare executives and managers were confused by the hierarchy of different government agencies as they related to decision making, particularly the NBMLHD, NSW Health, the Commonwealth DOH and the ACQSC. Some of this confusion was clarified by the COVID-19 outbreak plan.
   - Problems with management need to be addressed as soon as possible after they are recognised. The immediate and repeated testing of all residents and staff should be implemented as soon as a single case is identified.

b. Leadership and management
   - Leadership at Anglicare and within Newmarch House seemed "invisible" to external parties interacting with them during this time. This was exacerbated by daily teleconference meetings where there were disagreements on how to proceed. This raised concerns in the ACQSC, which then appointed an Independent Adviser.

c. Communication
   - Regular meaningful contact with family members of residents was cited as a concern. Staff at Newmarch were too occupied to answer their calls given the many challenges they faced. Complaints were made to the ACQSC.
   - Access to advocacy services should be a priority.

d. Staffing
   - Staffing depleted due to infection and isolation due to COVID-19 infection, and the workload of the depleted staff increased exponentially. This could not have been reasonably anticipated during the planning phase as it greatly exceeded the planned surge capacity.
   - Approved providers should consider surge workforce capacity on the basis that at least 50% of its staff may be furloughed. The DOH should consider expanding its surge workforce providers.
   - Orientation for all new staff during the course of an outbreak is required and must include infection prevention and control training and a competency-based assessment of PPE donning and doffing.

e. Infection prevention and control (**IPAC**)
   - The original infection control policy did not detail how to practically apply IPAC principles in the setting of an infectious outbreak. Staff understandably erred on the

side of caution when considering staff infected with COVID-19, however this led to issues with incubation of the disease through PPE and staffing shortages.

- PPE was used in 'clean' areas of Newmarch House, but not changed when going into COVID-19 negative patients' rooms. It was difficult for staff to effectively physically distance. PPE stock was depleted and PPE that was not suitable (size and material) was used, which may have led to further infection.
- Following the CEC recommendations, BaptistCare assisted with zoning of COVID-19 infected residents and ensuring that some staff dealt with positive residents and others with negative residents.
- An IPAC champion was recommended.

f. Medical and clinical care

- The HITH program in consultation with the Virtual Aged Care Service (**VACS**) delivered clinical care. While this is advantageous to the elderly community, there was a lack of staff and support which hindered the quality-of-care residents received. It fell short of hospital-grade care. HITH may be valuable, but only on a smaller-case basis.
- There was an expectation of palliation after COVID-19 infection and a large order of end-of-life medication was ordered.
- Information needs to be repeated and/or provided in written form. Misunderstandings are likely to be amplified in the context of an outbreak crisis, particularly when they touch on end-of-life care.
- Decisions about the management of COVID-19 cases should be made by an expert panel, including experts in infectious diseases, infection control, geriatric medicine, clinical leadership from the approved provider and a local general practitioner, in consultation with the relevant government and health agencies. As soon as an outbreak is declared:
    1. The expert panel should be convened; and
    2. Residents should be transferred to hospital until the residential aged care facility is deemed safe and appropriate for residents to return. The implications of such decisions will need to be considered in light of individual resident's personal preferences.

g. Family experience

- There were several experiences of missed or delayed care, or poor-quality care for residents.

18. NSW Health's response to the report is within the brief.

Royal Commission into Aged Care Quality and Safety – Aged care and COVID-19: A Special Report

19. The Royal Commission into Aged Care Quality and Safety (the Royal Commission) was established by Letters Patent issued on 6 December 2018. The scope of the Special Report dated 30 September 2020, concerned COVID-19 outbreaks that had occurred in residential aged care facilities in NSW and Victoria, including Newmarch House.

20. The Special Report explored various topics, including:

a. Visitors and quality of life;
b. Allied health;

c. A national aged care advisory body and a COVID-19 plan;
d. Protocols between the Australian Government and the States and Territories;
e. Hospital transfers and Hospital in the Home (HITH);
f. Infection control expertise; and
g. PPE

21. The Special Report made six recommendations for the Australian Government to implement that will better prepare the sector, its staff, and its residents for future COVID-19 outbreaks. They were as follows:

a. *Recommendation 1:* The Australian Government should report to Parliament by no later than 1 December 2020 on the implementation of these recommendations.
b. *Recommendation 2:* The Australian Government should immediately fund providers that apply for funding to ensure there are adequate staff available to allow continued visits to people living in residential aged care by their family and friends.
c. *Recommendation 3:* The Australian Government should urgently create Medicare Benefits Schedule items to increase the provision of allied health services, including mental health services, to people in aged care during the pandemic.
d. *Recommendation 4:* The Australian Government should establish a national aged care plan for COVID-19 through National Cabinet in consultation with the aged care sector. The plan should:
    - Establish a national aged care advisory body
    - Establish protocols between the Australian Government and the States and Territories based on the NSW protocol but having regard to jurisdictional issues
    - Maximise the ability for people living in aged care homes to have visitors and to maintain their links with family, friends and the community
    - Establish a mechanism for consultation with the aged care sector about use of Hospital in the Home programs in residential aged care
    - Establish protocols on who will decide about transfers to hospital of COVID-19 positive residents, having regard to the protocol proposed by Aged and Community Services Australia
    - Ensure that significant outbreaks in facilities are investigated by an independent expert to identify lessons that can be learnt. The results of any such investigations should be promptly disseminated to the sector.
e. *Recommendation 5:* All residential aged care homes should have one or more trained infection control officers as a condition of accreditation. The training requirements for these officers should be set by the aged care advisory body we propose.
f. *Recommendation 6:* The Australian Government should arrange with States and Territories to deploy accredited infection prevention and control experts into residential aged care homes to provide training, assist with the preparation of outbreak management plans and assist with outbreaks.

22. Recommendations 2, 3, 4 and 5 were identified as areas for immediate action.

23. The Commonwealth Government's response to the report is within the brief.

NSW Health – COVID-19 Public Health Response Branch (PHEOC), Summary Report on Anglicare's Newmarch House, Kingswood

24. The NSW Ministry of Health Public Health Response Branch (formerly the Public Health Emergency Operations Centre) produced a report addressing the public health response to the COVID-19 Outbreak at Newmarch House. This response was managed by the Nepean Blue Mountains Public Health Unit (NBMPHU) and the NSW Health Public Health Emergency Operations Centre (PHEOC).

25. The report, dated 18 September 2020, particularly focussed on the OMT, cluster and case management, close contact management, source investigation, testing, infection prevention and control, resource support, and communication.

26. Key findings included the following:

    a. Co-ordinating the approach with multiple stakeholders
        - Outbreaks in residential aged care facilities (RACFs) demand time-critical and complex decision-making, which in turn requires clear understanding of roles and communication between the many stakeholders. The primary responsibility during an outbreak lies with the facility management.
        - The NBMPHU provided Outbreak Management Plans as a supplement to the NSW Health draft Incident Action Plan for RACFs, to clarify the roles and responsibilities of the various agencies and guide the public health response.
        - During the outbreak at Newmarch House, two key committees were formed:
            1. The Outbreak Management Team supported Anglicare to assume control of the outbreak; and
            2. A higher-level governance group was established to monitor the management of the outbreak by Anglicare and NBMPHU.
        - NBMPHU and the PHEOC agreed that as of 4 May 2020, the role of leading the coordination of the response should be transferred to the PHEOC, with ongoing strong support and partnership from the PHU. The focus of the outbreak management had largely shifted to improving coordination amongst multiple agencies, including the Commonwealth, and on strengthening infection control practices led by the CEC.
    b. A high scrutiny environment and potentially vulnerable workforce
        - Intense media scrutiny may have served as a disincentive for staff to seek testing. Industrial conditions such as a casualised workforce, inability to access sick leave and financial insecurity may have contributed to staff working while sick.
        - Many staff were engaged by temporary employment agencies and moved between different facilities, risking transfer of infection across facilities. This raised concerns within other facilities. This may have been further exacerbated by media coverage.
        - Aged care staff may be themselves a vulnerable group and may require tailored interventions to ensure effective training in IPAC practices. Aged care facility providers have an obligation to provide a safe workplace for staff as well as residents.
    c. Routine testing
        - Routine testing of Newmarch House staff only identified two new cases on the first day it was implemented. Repeated screening during an outbreak was recommended.
        - The intense nature of testing for residents and staff was acknowledged.
    d. Reinforcement and support of IPAC practices

- Newmarch House was having difficulty enacting advice around IPAC measures. From 1 May, there were NSW Health IPC practitioners on site.
- The final IPC report from the CEC demonstrates concerns regarding baseline IPC systems and practices. IPC practices and safe use of PPE requires ongoing reinforcement by an appropriately trained IPC supervisor.

27. The report notes that learnings from this Outbreak informed the review of the NSW Health *Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Facility*.