IN THE CORONERS COURT IN CANBERRA) CD 209 OF 2000
IN THE AUSTRALIAN CAPITAL TERRITORY)

Inquest into the manner and cause of death of Jamie Vincent Johnson

1. Jamie Vincent Johnson died at the Calvary Hospital on the 7th of September 2000 at approximately 3:45pm. Jamie had been admitted to the Hospital on Wednesday the 6th of September 2000 following a series of events which had occurred at his place of residence, [redacted] Ainslie, during the morning and early afternoon of that day.

2. A post-mortem was carried out on the body of Jamie by Doctor Jain and in Doctor Jain's opinion "death was caused by diffuse cerebral oedema caused by hyponatremia caused by excessive self-induced water drinking" (Ex 44).

3. The circumstances which led to Jamie's attendance at the Hospital are not in dispute.

4. Jamie had suffered from an intellectual disability from an early age and had been involved with various organisations and institutions during his life. He attended for a period, the Malkara Special School and the Mullala School in NSW. His conduct and general behaviour had been the cause of concern for a long period. He was dealt with in the ACT Children's Court and placed at the Quamby Juvenile Detention Centre for a period in 1987. Subsequent to his release he became a resident of Bruce Hostel.

5. Following his residence at Bruce Hostel he was in a number of residential environments including: time spent in the Melba Flats, a Group House at Conder, a Group House at Kambah and a period at the John Knight Hostel. He began residing at [redacted] about 1993/ 1994. He remained at [redacted] until his death.

6. His conduct was regarded as challenging by many of those professionals which whom he came into contact. He had substantial involvement with a number of agencies within the Australian Capital Territory, but it is not necessary in my view to attempt to extract from the various files and other records of the several agencies, a detailed history of his contact with those agencies. I am of the view that it is more appropriate to focus upon the months leading up to Jamie's death in order to ascertain what comments or recommendations might be made consequent upon his death.

7. There has been a very substantial delay in completing the inquest into Jamie's death. The taking of evidence began in February 2001 and for various reasons did not conclude until August 2004. There were a number of reasons for this protracted delay. The first was occasioned by the need to conduct additional inquiries following matters raised during the first period of hearing of the inquest. Subsequently criminal charges were laid against Debra Burnett and Annette Gilmore relating to evidence given by them during the course of the hearing. The proceedings against Ms Gilmore did not conclude until the 9th of July 2004.

THE FIRST SEIZURE

8. Jamie was admitted to Calvary Hospital on the 9th of June 2000 following a major convulsion. Upon admission he was found to have very low serum sodium. A report was prepared by Professor Herdson (Ex 45) who reviewed various available hospital and other records. He indicates, in relation to this first admission, as follows:

> It was thought initially that the low serum sodium (hyponatremia) was associated with inappropriate antidiuretic hormone secretion, but subsequently he was considered to be suffering from psychogenic polydipsia, in that he would drink 7 to 10 litres of water a day, associated with his obsessive compulsive behaviour.

Jamie was discharged from Calvary Hospital on the 13th of June 2000.

9. Evidence has been given by a number of workers involved with [redacted] of the difficulties which they experienced in obtaining any information from the Hospital in relation to this first admission in June 2000. It is clear that there was a reluctance, if not refusal, by the Hospital authorities to communicate usefully with those responsible for the care of Jamie. Information was obtained, at best, in an indirect way and this resulted in Sarai Mitchell (who then held the position of ASM at the residence), to begin the preparation of a new individual plan (IP) to cover the problem which had so starkly been exposed in relation to Jamie. This IP was ultimately prepared and became the document of guidance for the carers of Jamie. I shall return to the question of the individual plan in due course.

THE SECOND AND FATAL SEIZURE

10. Jamie was admitted to hospital on the 6th of September 2000 following his collapse at his residence at [redacted]. The carer responsible for Jamie during the course of the 6th of September was Shane Patrick Reardon.

11. Mr Reardon was at the time a DSO1 and a casual worker who had been employed casually for about three and a half years. He had spent this period with the ACT Government and prior to this he had worked with other organisations. He had no formal qualifications but was considerably experienced and had undergone six years study at the CIT towards a Diploma in Disability Services.

12. Mr Reardon indicated that when he first joined Disability Services he had completed an induction program, but had no other formal training with that organisation. The induction program had involved some 2 – 3 weeks of training.

13. He indicated that the induction program had not, to his memory, covered the use of IPs nor did he have any knowledge of ever been given any specific instruction concerning the use of IPs. Notwithstanding this evidence, it is clear however, that he understood that there was a need for him to be familiar with the IPs at least to a sufficient degree to allow him to properly carry out his work as a casual carer. He stated in his evidence that if he came to a particular house on a first occasion he would familiarise himself with an IP but that he would not necessarily do so if he had been engaged at a particular house on a number of previous occasions.

14. Mr Reardon in his evidence made a number of comments concerning the lack of communication which existed between casual workers and others employed by Disability Services. This would seem to be undesirable, although I understand that this situation may no longer prevail. The evidence of Mr Reardon clearly shows that if there remains an issue concerning the involvement of casuals in the chain of information within a residence and external to the residence, then this must be regarded as highly undesirable.

15. Mr Reardon indicated that he regarded himself as being familiar with the routines at the [redacted] house and with the clients who lived in that house as he had worked in that particular house on a significant number of occasions over the previous three and a half years.

16. Evidence was given by witnesses, other than Mr Reardon, which indicated that Jamie had a particular propensity to challenge unfamiliar workers. Mr Reardon accepted that he had this particular propensity and indeed gave some examples of circumstances in which Jamie tested not only Mr Reardon but others. This particular propensity would seem, on the evidence before me, to be significant, as the conduct of Jamie on the 6th of September is suggestive of an attempt by him to challenge Mr Reardon.

17. Mr Reardon gave evidence that he was aware of the issue of excessive water consumption and was aware of the practice, which had been adopted in the house of removing tap handles. I shall say more about the tap handles in due

course but merely indicate at this point in time, that the presence or absence of tap handles had no actual bearing on the events of 6th of September. The access of water which ultimately lead to the collapse and death of Jamie arose in the shower. There is no evidence that any of the taps in the shower were ever removed.

18. Mr Reardon conceded in his evidence that he had not read the IP when he came on for duty on the 6th of September 2000. He was however, aware that carers had a responsibility to monitor Jamie's drinking and in particular that he was "to be monitored", to use Mr Reardon's words, in the shower. The actual entry in the IP concerning supervision was in the following terms "Supervision: Ensure that James [sic] is not left unsupervised at any time and he should be monitored when he showers" [Ex 2].

19. Mr Reardon was shown the instruction and was asked the following question (T11):

Q: Do you agree that says James [sic] has a problem in recognising that he [sic] sufficient levels of drink?
A: Yes
Q: "Supervision: Ensure that James [sic] is not left unsupervised at any time"?
A: Yes
Q: …and he should be monitored when he showers?
A: That's correct.
Q: Did you read that instruction before 6 September last year?
A: I had – I'd seen that documentation. I've seen this documentation, yes.
Q: So that was before 6 September last year did you actually get to see that?
A: Not to my knowledge.
Q: So the first time you saw that was when Constable Braithwaite showed that to you?
A: Correct

There is no dispute however that Mr Reardon was generally aware of the requirement for supervision in the shower but did not comply with this requirement during the 6th of September 2000.

20. He accepts in his evidence that he was aware, following discussions with the staff at [redacted], that the excessive consumption of water presented a serious health risk to Jamie. He was aware of the actions which had been taken by the staff in order to attempt to limit Jamie's water intake. He was also aware of the first seizure of June 2000.

21. Mr Reardon indicated that he commenced work on the 6th of September between 6 and 7am. His recollection was that the handover on that morning was quick. He thought that on that morning there was only one tap handle removed and that was in the kitchen.

22. Mr Reardon states that from very early on in his shift Jamie began to soil his pants. Mr Reardon thought that it was some kind of "mind game" that Jamie was playing with him. Mr Reardon believed that between the first episode of pant soiling and the collapse of Jamie, Jamie had soiled his trousers on 13 occasions. On each occasion Mr Reardon requested Jamie to change his clothes and shower. He did not go into the bathroom with Jamie on any of these occasions. He indicated that the bathroom door was not fully closed and that there was some capacity for him to observe Jamie from outside the bathroom. He further indicated that there was a practical difficulty in supervising Jamie in the shower as there was another resident at [redacted] who also presented behavioural problems. Mr Reardon was of the view that the nature of the behavioural issues of the other resident reduced his capacity to be present in the bathroom supervising Jamie as he was required to do in accordance with the IP.

23. Mr Reardon created an incident report concerning these activities and this report shows that Jamie soiled himself 13 times between 7:20am and 12:40pm. The first incident occurred between 7am and 7:20am. Mr Reardon was asked the following question (T19):

Q: Have you ever supervised Jamie in the shower or the bathroom by watching him or standing outside the door and watching him?

A: I noticed Jamie in the shower, yes, but I would suggest to you privacy would exclude me from the bathroom area. I mean, he's an able adult.

Q: So it wasn't your practice to go into the bathroom with him or to watch him?

A: No.

Q: And actually stand there?

A: No. That's also an occupational health and safety problem as well.

Q: Okay?

A: Especially if he's covered in faeces at the time.

Q: And you didn't watch him this morning?

A: Pardon me?

Q: You didn't watch him this morning?

A: I didn't watch him on that morning, no.

24. Mr Reardon indicated that the number of incidents of soiling on the morning were unusual, although it was not unusual for soiling to occur.

25. There is other evidence particularly from Ms Mitchell of similar incidence of soiling in circumstance where Jamie was in contact with carers other than those with whom he was familiar at [redacted]. Ms Mitchell gave evidence of her contact with Jamie on the 8th of August, the occasion of the injury to Ms Andrews. Ms Mitchell was required to take over the hands on role as a carer in the absence of Ms Andrews and as a result of Ms Grayson being unable to obtain any relief for Ms Mitchell. Ms Mitchell indicates that on that occasion Jamie soiled himself and she sent him to the shower. She indicates that she left the door open and stood at the door singing in order to distract Jamie from any excess water drinking. She also indicates that she was informed by the staff at the Desaley House, which was the house being considered as a transfer residence for Jamie, that similar issues concerning toileting had arisen during his visits to that residence. This evidence would

clearly show that the experience of Mr Reardon was not unique but it also suggests that other carers were able to deal with the issue and still keep some degree of supervision in place.

26. Mr Reardon described how he became aware of Jamie being in distress as a result of Jamie calling for help. He went to Jamie's assistance and noted that he had vomited and that he had appeared delusional and had no concept of where he was. Mr Reardon moved Jamie from where he had found him and laid him on the hall carpet.

27. Mr Reardon then contacted Debra Burnett, who was the relevant on call officer, and obtained her permission to call an ambulance. He then returned to Jamie's assistance. Jamie had apparently managed to get from the hall into the kitchen. Mr Reardon observed that Jamie's balance was very poor. Mr Reardon then laid Jamie on the floor again. He then recontacted the ambulance. The ambulance arrived shortly after this second call.

28. He then passed over the care of Jamie to the ambulance officers and Jamie was transported to the hospital. Another worker called John arrived at the premises and subsequently Justin Watson also arrived. One of these workers went to the hospital with Jamie and Mr Reardon ended his shift and departed from the residence.

29. Mr Reardon was subsequently asked a number of questions concerning his failure to supervise Jamie in the shower as required by the IP. He seemed to be of the view that it was for practical purposes impossible to prevent Jamie from accessing water unless actual physical restraint was used. He did not believe that he necessarily had the legal power to use physical restraint in such circumstances. He again raised the issue of the need for him to be mindful of the activities of the other resident. It is also clear from the evidence of Mr Reardon that he had a substantial occupational health and safety concern about the appropriateness of being present in the bathroom with Jamie who had a history of inappropriate behaviours in relation to faeces. Mr Reardon regarded this history together with the regularity of the soiling on the 6th of September

as presenting to himself an unacceptable risk. There is no evidence before me to suggest that anybody in any responsible position had ever given proper consideration to the reality of Jamie's behavioural issues particularly in relation to faeces. It is clear on the evidence that his behaviour represented a genuine issue for carers but more particularly for casual carers. The evidence of Ms Andrews a long time carer of Jamie did not seem to indicate that there was a serious personal issue for her in relation to Jamie's behaviours.

30. I accept however that Mr Reardon clearly regarded the issue as one which related to and could adversely affect his personal situation. It is clear in those circumstances that he chose to disregard the direction concerning supervision. At best he allowed himself to be in a position where he engaged in, at most, cursory supervision in an indirect way. This failure of supervision clearly contributed to the death of Jamie Johnson.

31. The evidence is incontrovertible that it was during the numerous visits to the shower that Jamie consumed the excessive amounts of water which lead to his collapse and to his subsequent death.

32. Mr Reardon summed up his position concerning supervision of Jamie in the shower when he was asked the following question (T52):

> Q: What would you have done differently?
> A: The only thing I could have done your Worship, is get an apron, face mask, goggles; indeed, if it was accessible to me, full body armour, in effect, to prevent me from getting any faeces on me. All I could have done in real terms, your Worship, is stand there and watch him and perhaps give him directives, like, "Don't drink the water, Jamie," to which he would not listen. If anything he would drink it and smile at you.

33. I must say however that I have some sympathy with Mr Reardon's position. He was not properly equipped nor perhaps trained to be able to understand the real risk that Jamie represented in relation to the use of the shower. I say this

bearing in mind the lack of information which had been received by the carers from the Hospital concerning the seizure of June 2000, the lack of action on the part of Senior management to respond in a meaningful way to the clear implications which arose from the June incident and the absence of any proper procedures to include casual staff in the information loop at the residence. Ms Mitchell and Ms Andrews laboured personally to inquire into the situation exposed by the June incident and attempted to put together an IP which, at that time, did perhaps all that could be done to protect Jamie. Regrettably the condition from which Jamie suffered seemed to be so unusual as to create an environment of doubt in the mind of senior management, in particular Ms Gilmore, who were not able, in my view, to fully come to grips with the actual challenge that the condition represented concerning the care and more particularly the supervision necessary to ensure Jamie's well-being.

34. I will comment in due course further on the roles of these three persons as well as the roles of some other persons in relation to this particular inquiry but I would like to indicate at this early stage that no complaint can be made against the conduct of Ms Mitchell or Ms Andrews in relation to the death of Jamie Johnson. I was most impressed by both these individuals who clearly attempted to do all they could in the limited areas in which they had any input to understand and subsequently protect Jamie from harm.

35. Jamie was admitted to Calvary Hospital on the 6th of September. The report of Professor Herdson previously referred to indicates that Jamie was:

> "deeply unconscious and intubated and artificially ventilated. He was found to have marked cerebral oedema associated with low serum sodium (and other electrolytes including potassium and chloride). Life support was ceased and he was declared dead at 15:45 hours on 7/9/2000".

36. Some issues arose during the evidence as to whether there was any other possible explanation for the death of Jamie. I am satisfied on the evidence that Jamie died as a result of excessive consumption of water which led to the

presence of low serum sodium and other electrolytes. This it seems caused the severe injury to his brain which was found on autopsy. He died as a result of those injuries.

REMOVAL OF TAP HANDLES

37. Considerable evidence was given and extensive inquiries were conducted by the Australian Federal Police into the issue of removal of tap handles at [redacted]. I have already indicated that the issue of the removal or non-removal of tap handles does not in any way relate to the death of Jamie Johnson but it does in my view reflect a serious issue concerning the administration of the [redacted] Street premises as it existed in 2000. I accept that since the death of Jamie Johnson considerable changes have been made to the operations of what was then Disability Services and the comments that I make in this report relate only to the situation which existed as at the date of the death of Jamie Johnson.

38. The long delay which has occurred in relation to the conduct of the hearing into the death of Jamie Johnson has allowed for changes recommended in early reports by myself and more significantly as a result of the Inquiry conducted by Mr Justice Gallop, to be considered and implemented.

39. I have not read the report made by Mr Justice Gallop and it was not tendered in any proceedings before me but I accept as a matter of common knowledge that His Honour made various recommendations and that media reports indicate what action has been taken by the Government in relation to His Honour's recommendations. The submissions filed on behalf of the A.C.T have attached to them Reports relating to the implementation of Gallop J's report and to my recommendation in the Inquest into the death of Neil Summerell and Brett Ponting. For those reasons I do not believe that it is necessary for me to delve in any great detail into the issue of the taps other than to show how the history of the taps reflected the state of administration of the Campbell Street property as at September 2000.

40. Evidence was given by a number of witnesses including Ms Mitchell, Ms Andrews, Ms Burnett and Ms Gilmore as well as Mr Reardon concerning the history of action concerning the tap handles. Statements were provided by a number of other involved carers.

41. The evidence indicates that prior to June 2000, a concern existed amongst the carers at [redacted] Street in relation to excessive consumption of water by Jamie Johnston. While it is not precisely clear on the evidence I am content to accept that from a time much earlier than June 2000, various members of the staff at [redacted] Street had adopted a procedure of removing some of the tap handles in the residence so as to attempt to introduce a procedure whereby the consumption of water by Jamie might be more easily monitored. The record of interview of Darren Francis who was Jamie's key worker for some 6 months prior to June 2000 indicates that the tap handles were already removed when he first became involved with [redacted] Street some two years earlier. He also indicates that the then ASM Gayle Rose was aware of the practice but was apparently unhappy about the practice. There is nothing in any of the evidence to suggest that Ms Rose did anything about the practice. The rationale for this procedure, as I understand it, was that, by the removal of particular tap handles especially in the kitchen, the staff at the premises would be more easily able to detect attempts by Jamie to access water. When they became aware of these attempts they were then able to use distraction techniques in order to remove Jamie from the temptation of water. I am content to accept that at all times this process did not in any way impact upon the position of the other resident in the premises. The evidence from the relevant workers is clear that at all times that person's access to water was in no way restricted. The other resident indeed had his own water kept in the fridge and he was able to access this without limitation.

42. The evidence indicates in early 2000 an issue arose concerning the well being of the staff members of [redacted] Street. It is of interest to note the comments of Darren Francis, who was one of the workers affected by illness at [redacted] Street, that the issue of ill health relating to the carers at [redacted] Street arose

only after changes had been made to the water temperature in the premises. Significantly, he also indicates that prior to the change in the water temperature, which related to a lowering of the temperature, Jamie had never accessed the shower as a source of drinking water. It is unclear if anyone else knew of this changed habit. Mr Francis indicates that prior to the change in water temperature, a date about which I have no evidence, the taps in the shower were always left on but a majority of other taps in the residence had been removed. Mr Francis indicates that after the lowering of the temperature, Jamie began accessing the shower for the first time as a source of drinking water. A number of the workers had become ill and there was a genuine concern on the part of the workers and management as to the cause for a series of illnesses suffered by various workers. It was arranged that an inspection be carried out by the relevant health authority and during this inspection it become apparent that from time to time tap handles were removed. A report was provided by the Health Protection Service to Ms Gilmore dated the 4th of April 2000 (Ex 31). This report relates to an inspection by public health officers of the Disability Group homes at Burn Street Downer and [redacted] Street Ainslie which had taken place on the 31st of March 2000. This report makes the following observation at point 7:

> Hand washing should be done at the wash hand basins located in the toilets of the two homes; the removed tap handles of the wash hand basins in the toilet/ bathrooms in the Ainslie home to be refitted at once.

A direction was issued following this inspection, it would appear to have been made by Ms Gilmore, that the taps were to be replaced. It appears that as a result of this health inspection and the involvement of Ms Gilmore that a mistaken belief developed or is said to have developed, at least according to Ms Gilmore, that the taps had been removed as a result of contamination by faeces within the premises. The evidence from all of those who knew of the procedure relating to the taps clearly indicates that this was never the intention behind the removal of the tap handles.

43. Ms Mitchell indicates that within about a week or thereabouts of her taking up her appointment as acting ASM (May 2000) she became aware of the removal of the tap handles. She believed she mentioned this fact to Ms Gilmore. She states that Ms Gilmore gave a direction through her that the tap handles were to be replaced. Ms Mitchell had a discussion with the staff and the handles were replaced. She also indicated that when she first discovered the missing tap handles Jamie had shown her where the tap handle was kept and how to put it back on.

44. I find as a fact that the exercise in removing the tap handles was carried out by the various members of staff only with a desire to attempt to control the concerning excessive drinking habits of Jamie Johnson. Any other purported explanation is without foundation.

45. Subsequent to the Health Protection Service, an inspection was carried out by Ms Burnett and Ms Grayson in August 2000. This inspection was being carried out in relation to issues arising in [redacted] Street but did not relate to the issue of the taps. The evidence is contradictory concerning what occurred at the inspection but there is evidence that Ms Burnett, as a result of a direction she received from Ms Gilmore, instructed the relevant carers to replace the handles which apparently were off on the date of Ms Gilmore's inspection. The evidence of Ms Andrews is very firm in relation to this situation and I have no hesitation in accepting in her evidence and where it conflicts with the evidence of either Ms Burnett or Ms Gilmore rejecting their evidence.

46. It is perhaps appropriate at this point in time to make a comment concerning the evidence of Ms Gilmore and Ms Burnett. I have already indicated that both these persons were prosecuted as a result of the evidence that they gave to the inquest. Ms Burnett has pleaded guilty and Ms Gilmore had been found not guilty. I am of the view however that the nature of their evidence, particularly that of Ms Gilmore, is so unsatisfactory that I am not able to accept their evidence unless it is corroborated by some other witness.

47. I must also say that both Ms Mitchell and Ms Andrews impressed me with the evidence they gave and Ms Andrews in particular impressed me with her clear dedication to the well being of her residents and in particular her concern for the well being of Jamie Johnson. I have no hesitation in accepting their evidence.

48. Following the instruction given by Ms Burnett it appears that the taps were not always in position. It is difficult from the evidence to precisely determine whether this occurred on a frequent or infrequent basis but it is clear from time to time that the tap handles were removed.

49. Indeed the necessity to reopen the inquest and receive further evidence following the initial hearings in February 2001 and March 2001 were caused as a result of photographs which were taken after the event which showed the tap handles removed. According to the police evidence, this represented the state of the tap handles on the date of the death of Jamie Johnson.

50. The evidence shows that there was for a long period of time an ongoing concern on the part of the staff at [redacted] Street in relation to the excess water drinking habits of Jamie. It is unclear on the evidence as to how much of this concern ever came to the attention of people in the administration such as Ms Gilmore but it is clear that at least by April 2000 Ms Gilmore had become aware of the practice of removing the taps.

51. The issue in relation to the taps as I say relates more to administration than to the manner and cause of death of Jamie Johnson and indicates that there is a lack of communication between the workers at the residence level and the administration at the level of either Ms Gilmore or Ms Burnett.

52. The evidence in this inquest clearly shows that there must be a greater degree of communication between the various levels of personnel when decisions are being made which impact upon the well being and safety of a resident.

53. It would I think be unfair to make the above comments without making mention of the staffing issues which occurred at various levels of Disability Services during a particularly critical time. Ms Mitchell became involved as the support manager at [redacted] Street for a short period of time but was only ever acting in that position. Ms Andrews was on sick leave between August and September and Ms Burnett had only become the ASM in July 2000. Ms Gilmore was off work for considerable periods during the period June to September as her father was ill and subsequently passed away. The previous ASM Ms Gayle Rose appears on the evidence to have been ineffectual in the carrying out of her responsibilities. She left, as I understand the evidence, after long periods of sick leave, in about April 2000. One of the tragedies of the circumstances of the death of Jamie Johnson was this lack of continuity at a critical stage particularly after the first seizure of June 2000. Those that were at that time responsible for attempting to put together some type of program to cope with the then known risk of excessive water consumption were people with few exceptions who had little experience of Jamie and had to begin, in effect, at the beginning.

54. Ms Mitchell in her evidence indicates that she had to go back through all of the documentation that she could find relating to Jamie so as to attempt to understand his position while she was preparing, to some extent as a matter of urgency, a new IP to specifically cope with the new knowledge of his condition. During some of that time Ms Andrews assisted her but at other critical times as a result of injuries sustained in her employment she was absent on sick leave.

55. Ms Burnett came into the responsible role of ASM only in July and while she had some involvement during the period prior to the death of Jamie she clearly was at the time attempting to get on top of her responsibilities as the ASM for a number of residences. There is also a suggestion in the evidence that Ms Burnett was, in the beginning, more concerned about staffing issues than any issue relating to the residents, especially at [redacted] Street.

56. This lack of consistency and in particular the lack of somebody in a position of authority with an understanding of the history of Jamie Johnson no doubt complicated the task that needed to be done. It also perhaps lead to a degree of lack of proper concern on the part of those in management more directly responsible for the decisions which had to be made in relation to Jamie's care. Ms Mitchell and Ms Andrews in the preparation of the new IP clearly shouldered more than their fair share of the responsibility in the circumstances that prevailed.

57. The evidence indicates that there were at least 3 specific instances where directions were given by Ms Gilmore to the staff at [redacted] Street to replace the tap handles. The first was following the health inspection in April 2000, the second following the appointment of Ms Mitchell as acting ASM in about late May or early June 2000 and the third following the inspection by Ms Gilmore and Ms Burnett in August 2000. Notwithstanding these three specific directions there is no evidence that Ms Gilmore in her capacity as regional manager, ever caused any investigation to be made as to why the taps continued to remain off. The evidence of the police investigation suggest that even at the date of the death of Jamie the tap handles still remained off.

58. While as I have said it is clear that the taps in the shower were never the subject of removal and therefore the removal of the tap handles is not strictly connected to the death of Jamie, it is clear that there was a failure on the part of Ms Gilmore to ensure that her instructions whether they be right or wrong, were carried out. The continued failure of the carers between at least April and September 2000 to comply with the instructions given to them by Ms Gilmore, Ms Burnett and Ms Mitchell clearly raises an issue relating to the administration of Disability Services.

THE PREPARATION OF THE NEW INDIVIDUAL PLAN

59. Following the return of Jamie to [redacted] Street from the Hospital after his first seizure in June 2000, work was begun on the preparation of a new and more relevant IP. This work was commenced and carried out by Ms Mitchell with assistance from Ms Andrews.

60. The production of an IP relating to Jamie would have in the normal course of events been the responsibility of Darren Francis who was Jamie's key worker. Unfortunately at the time of the preparation of the new IP Mr Francis and indeed other permanent workers were off work on sick leave. Ms Andrews it seems had no personal experience of preparing an IP and so the responsibility for the preparation of the IP fell upon Ms Mitchell with the substantial assistance of Ms Andrews. Ms Andrews had become the relevant key worker during Mr Francis's absence.

61. Ms Mitchell held the designated position of a DSO 2 and had been with Disability Services since August 1998 at that level. She acted as the ASM from the 20th of May 2000 until the 7th of July 2000. Ms Mitchell was succeeded as the ASM of [redacted] Street on the 10th of July 2000 by Ms Burnett.

62. Ms Mitchell had no contact with the [redacted] Street residence before taking up the role as acting ASM.

63. Ms Mitchell was accordingly the acting ASM as at the 9th of June 2000 when Jamie was admitted with his first seizure. She became aware that Jamie had had a seizure when she returned to work the next morning. She was informed by Ms Gilmore who was the Regional Manger. Ms Mitchell indicates that she had a number of conversations with doctors at the hospital and she ultimately ascertained that Jamie's seizure had been caused as a result of a consumption of large quantities of water. She expressed concern at her inability to obtain accurate and detailed information from the hospital concerning Jamie's

situations. She comments that indeed she was told by the doctor at the hospital to stop ringing about Jamie's situation.

64. Ms Mitchell had had little contact with Jamie and his fellow resident prior to the 9th of June 2000. She was for practical purposes unaware of the issues relating to Jamie and his excessive consumption of water. She arranged through Ms Gilmore for the production and recovery of all files relating to Jamie and began what appears to have been a thorough investigation of his situation. Her inquiries failed to discover anything within the files and also the then current IP to indicate that Jamie had any difficulty in relation to the consumption of water.

65. Ms Mitchell gave some evidence, which had been referred to in other evidence, of a process which was then going on and had been going on for some time whereby a possible alternative placement for Jamie was being investigated. It is possible although there is no real evidence on this point, that this ongoing investigation may have caused Jamie to become anxious and this may have ultimately been a factor in the conduct which he exhibited towards Mr Reardon.

66. The preparation of the new IP involved Ms Mitchell, Ms Andrews, Mr Chandra who was a psychologist employed by Disability Services and another psychologist. A meeting was held involving these four persons during which the preparation of the IP was considered.

67. The new IP was ultimately completed and handed to Ms Gilmore. An issue arose as to the format of the IP and the evidence of Ms Andrews indicates that she recovered the original document and formatted it in such a way as to ensure that it was acceptable. On the evidence, the document was signed off by Ms Gilmore and became the official functioning IP.

68. The IP contained the following requirement for the management of Jamie:

> Ensure that James [sic] is not left unsupervised at any time and he should be monitored when he enters the bathroom.

At T66 of the transcript, Ms Mitchell was asked a number of questions concerning her expectations in relation to this requirement. She appears to accept that while she had written that requirement with the intention that it should be strictly observed, she did now accept based upon her personal experience in the house at [redacted] Street that it would be very hard to supervise Jamie constantly in the house bearing in mind his behaviours and those of the other resident. She is clear however that it was her intention at the time of writing the requirement in the IP that it meant what it said and that she expected those responsible for the care of Jamie to carry out the requirements of the IP.

69. Ms Mitchell gave some evidence concerning the process in which she engaged in the preparation of the IP. She indicated that she spoke with other staff regarding Jamie's behaviour and that there had been some difficulty developing the IP. She was content that Jamie had substantial respect for permanent staff but could present a problem in relation to casual staff.

70. Ms Mitchell also gave evidence about an incident in August 2000 when she suffered personal injury at [redacted] Street as a result of being attacked by another resident. She used this incident as part of the basis for her comments about the difficulty in practically implementing her recommendation concerning supervision of Jamie.

71. On the 29th of August 2000 Ms Andrews slipped while at work and injured her back. She was unable to continue at work and was taken away in an ambulance. Ms Mitchell was the acting DSO2 in relation to [redacted] Street on the date of Ms Andrew's injury. She became involved in the actual caring role at the house following Ms Andrews's injury. During the course of her shift she was assaulted by the other resident and injured. She had no involvement with [redacted] Street after that date.

72. She gave evidence however that notwithstanding what may have been a profound difficulty in properly carrying out the instruction concerning supervision, she did not receive any comment from any permanent or casual staff member, during the time she was acting ASM, relating to any difficulty in implementing the IP. She did however indicate that this plan, as with all IPs, would have been subject of a formal review every three months and it is likely that any real issues concerning the implementation of the new IP would have been raised at that time.

73. The evidence concerning IPs generally is that they are regarded in effect as a work in progress and something which is a live and vibrant document. They are not regarded as being set in concrete and there is clearly a process whereby all IPs are reviewed and that during this review there is input from various parties including where appropriate the individual resident and that resident's family. Regrettably in the circumstances of Jamie there was no possibility of such a review as he died on the 6th of September 2000.

74. IPs were capable of change even during the three-month period of review. Ms Mitchell appeared to indicate in her evidence that she would have no problem in adjusting the IP if such a request had been made by any staff member and she accepted that request.

75. None of the staff that she spoke with during the process of the preparation of the IP ever indicated to her that it would be impossible by reason of the behavioural issues of the two residents to introduce a regime whereby one resident would be supervised to the exclusion of another.

76. The evidence concerning the preparation of the new IP raises clearly a number of issues concerning the administration of Disability Services that existed in 2000. The failure of the medical authorities at the hospital to clearly communicate with those responsible for the care of Jamie lead to an inappropriate pressure being placed upon Ms Mitchell. The temporary nature of Ms Mitchell's attachment as acting ASM to [redacted] Street and the uncertain nature of the condition which had caused Jamie's hospitalisation in

June caused what would seem to be an unnecessary exercise which was carried out by Ms Mitchell to recover all relevant material relating to Jamie. I have engaged in a somewhat more limited activity in this inquest and I have found my attempts to trace the details of Jamie's life through the various files, which are now held by me, to be frustrating and frequently impossible. There would appear to be some need for some sort of master file to be kept in a central location on a permanent basis which contains all important and relevant information concerning an individual who is being cared for by Disability Services.

77. The IP was prepared with assistance from various other persons and clearly represented a genuine attempt by Ms Mitchell to ensure that Jamie was in receipt of proper supervision. Regrettably the reality of Jamie's situation would seem to have prevented the implementation at least at the relevant time of a system whereby he could be supervised appropriately in all circumstances.

78. The time between the first incident in June and Jamie's death in September, clearly on the evidence did not allow those involved in his care to apprise themselves properly of the reality of his condition and to create appropriate measures to deal with the realities of his situation. The combination of all of these, and indeed perhaps other factors including the ongoing discussions concerning Jamie's transfer to another residence and the issues concerning casual staff combined together to create a situation in which there was a very real risk to the wellbeing of Jamie Johnson, unfortunately those involved did not fully appreciate the risk.

ISSUES RELATING TO PRIVACY

79. Ms Mitchell and indeed other witnesses gave evidence concerning various documents which were created at the house and held either at the house or at regional offices. It appears from Ms Mitchell's evidence that the process of alerting a staff member, particularly a casual, to a potential problem with an

individual resident or some problem relating to the interrelationship with a number of residents is fraught with confusion and obscurity. The preparation of an incident report seems only to trigger a statistic keeping exercise while the use of the alert section referred to by Ms Mitchell seems to require consent from various interested parties before such an entry can be made. There seems to be a capacity at a properly conducted handover for information to be passed from one shift to the next. However, where there is no continuity between shifts then it is clear that significant and vital information relevant to the wellbeing of an individual resident may never come to the attention of another carer, particularly a casual carer.

80. An example of issues concerning non passing on of significant and relevant information to all involved in the care of a resident is exemplified by the evidence of Ms Mitchell concerning the toilet brush incident. Ms Mitchell observed Jamie to insert a toilet brush into his body. She did not create an incident report concerning this but directly passed on her knowledge to her then ASM and her regional director. This process would seem to create an insoluble problem for those carers who were not aware of such a significant issue. Ms Mitchell accepted that the process, she followed on that occasion, which would appear to be a standard process would not have drawn such a significant incident to the attention of somebody in Mr Reardon's position if he came on duty some days after the incident. The failure to record such an incident in an incident report appeared once again to raise the overwhelming issue of privacy and confidentiality. It seems extraordinary that a system is allowed to operate in which a resident can conduct himself in the way observed by Ms Mitchell and that such conduct is not capable of being drawn to the attention of all of those directly involved with the care of an individual resident. If rules relating to privacy operate to allow such a situation to exist, then in my view it is clear that these rules even if they are contained in legislation must be changed. The welfare of a disabled person must ultimately, in my view, be regarded as more significant than any theory relating to the privacy rights of that individual.

81. I have now completed three inquests into the death of men being cared for by Disability Services. All three deaths arose as a result of incidents occurring in the bathroom. The evidence in this inquest and the evidence in the other two inquests clearly indicate that there is a serious issue which must be considered by those responsible for the care of disabled people surrounding activities in the bathroom. The activity of bathing or showering starkly raises issues as to the privacy of the resident. Significantly, Ms Gilmore in her Record of interview [Ex 30] expressed the view that it would not be appropriate to supervise Jamie when he was in the shower [Q 84].

82. I do not dispute that a resident is entitled to appropriate privacy and in some ways the privacy of a resident in a disability house may be regarded as more sacred than the privacy of a normally abled person. However it is clear, based upon the evidence of the three inquests, that a disabled person is at greater risk of injury in the bathroom then they may be in any other activities in which they engage either in their home or outside. It is essential in my view that careful consideration is given to the issue of the competing challenges of care, safety and privacy. It may be that there is a need for additional procedures to be developed and training to be provided to carers, to ensure that where instructions, such as existed in this case, to monitor an individual are capable of being carried out without there being an unnecessary risk to the health and wellbeing of the individual carer and to the health and wellbeing of the individual resident.

DOCUMENTS AND DOCUMENTATION

83. A number of the carers including Ms Andrews and Mr Francis indicated in their evidence or statements that there had been, prior to Ms Mitchell taking over as acting ASM and Ms Andrews becoming a DSO 2 at [redacted] Street, a serious issue concerning the preparation and supervision of documentation at [redacted] Street. Mr Francis indeed suggests that from time to time that documentation of which he was aware, disappeared from the relevant files at [redacted] Street.

84. The evidence of Ms Andrews is that all of the documentation relating to Jamie disappeared presumably as a result of the activities of Ms Burnett either on the day of the death of Jamie or the next day.

85. Subsequently many months later material was discovered in an inappropriate place by Ms Mitchell which clearly related to Jamie. This material had not been produced in answer to the subpoenas directed at various agencies by myself.

86. In view of the prosecution and conviction of Ms Burnett it is not in my view necessary to attempt to form a concluded view as to the role of Ms Burnett in attempting to prevent this inquest from ascertaining the truth about the circumstances which lead to Jamie's death. This is particularly so in relation to the tap handle situation and more specifically in relation to the non production of the risk assessment carried out by Ms Burnett under instructions from Ms Grayson in August 2000. The non production of the risk assessment and the knowledge of the contents of this assessment by Ms Gilmore and Ms Grayson are issues which on the evidence I am not able to satisfactorily resolve. However, it is clear that an attempt was made by somebody to deliberately conceal documents from the court.

87. It is regrettable that Ms Burnett, as an officer employed by the ACT Government, should have considered it appropriate for whatever reason to undertake the activity in relation to which she was subsequently charged and found guilty.

88. I am not aware of the current status of Ms Burnett in relation to her employment with the ACT Government but I am of the view that her conduct was so reprehensible as to warrant serious consideration of her dismissal from the ACT Government Public Service.

89. Evidence also indicates that there was a failure on the part of those responsible for the care of Jamie particularly including the former ASM Ms Gail Rose and to some extent the other carers in the residence to ensure that proper

documentation was maintained within the house relating to the serious issues which required careful management concerning the conduct of both Jamie and the other resident.

90. The evidence however clearly indicates that in the 9 months prior to the death of Jamie that there was a considerable disruption in relation to the staffing and supervision of [redacted] Street. I accept that ultimately these upheavals were probably unavoidable, save the situation concerning Gail Rose, and that this disruption was clearly a factor in the situation which was ultimately disclosed following the death of Jamie Johnson.

91. It is clear however that the keeping of proper documentation is critical and there may be a need from time to time for Senior Management to reinforce by appropriate communication and training the need for care in the maintenance of proper records and histories. It may be appropriate that the risk managers be required as part of their responsibilities to conduct random inspections of all disability houses within the ACT to ensure that documentation is being properly maintained. This would be particularly relevant in houses where there are large numbers of casuals involved. The evidence clearly shows that the use of casuals raises specific issues relating to the communication of information.

ADVERSE COMMENTS / FINDINGS

92. I have given careful consideration to the appropriateness of making adverse findings in relation to the following persons:

    (1) Shane Reardon

    (2) Debra Burnett

    (3) Annette Gilmore

    (4) Janet Andrews

    (5) Sarai Mitchell

    (6) Lynette Grayson.

93. In relation to Mr Reardon I am satisfied that the evidence discloses that he failed to carry out the instructions contained in the IP. Indeed he had failed to familiarise himself with the contents of the IP and his failure to supervise Jamie Johnson in the shower clearly contributed to the death of Jamie Johnson.

94. I have taken into consideration however, the difficult reality of the recommendation concerning the nature of the supervision required of Jamie Johnson in the shower bearing in mind the reason for which Jamie was in the shower on the date he suffered his fatal seizure. I am satisfied in all of the circumstances that it is not appropriate to make an adverse finding against Mr Reardon. I believe that the prevailing circumstances in which he found himself were dealt with in a way which was not unreasonable.

95. In declining to make an adverse finding against Mr Reardon, I do not wish it to be considered that I am in any way approving of his conduct in not reading the IP as required nor supervising Jamie as required. Rather I am merely accepting that the circumstances which lead to Jamie consuming a fatal quantity of water were such that it may have occurred notwithstanding supervision in the bathroom. It is clear from the evidence that as at September 2000 the reality of the potential danger to Jamie caused by his consumption of water was not fully understood by any of those involved and perhaps not fully appreciated particularly by casual staff who were to a large extent, excluded from the information cycle at the residence. This exclusion was not the fault of Mr Reardon. In all of the circumstances as I have said I am not prepared to make an adverse finding against Mr Reardon.

96. In relation to Ms Burnett I am content to find that Ms Burnett deliberately misled the Coroner but in view of the fact that she had been prosecuted for this misleading conduct I am of the view that it is not appropriate to make any further adverse finding against her. Her conduct in misleading the Coroner did not in any way amount to contributing to the death of Jamie Johnson but merely was an attempt by Ms Burnett to prevent evidence concerning issues namely tap handles and the risk assessment of August 2000 from becoming public knowledge.

97. In relation to Ms Gilmore who was at relevant times the regional manager responsible directly for the ASM and the carers within [redacted] Street. Ms

Gilmore in my view failed to properly understand the reality of the situation in which Jamie Johnson had been placed following the first seizure in June and did not in my view respond appropriately to the efforts being made by Ms Mitchell and Ms Andrews to ensure insofar as was possible the safety of Jamie Johnson. Ms Gilmore has been prosecuted in relation to evidence given at the inquest and has been acquitted in relation to those prosecutions. I make no comment about that result but as I have indicated I am not prepared to accept her evidence unless it is supported by independent corroboration. I have given careful consideration to the need to make an adverse finding concerning Ms Gilmore but ultimately I am of the view that the circumstances prevailing particularly in relation to her being absent from her position for a long period of time at the relevant time and her distance from the actual operations at [redacted] Street preclude me from making any adverse findings against Ms Gilmore.

98. In relation to Ms Andrews, there may be some criticism of Ms Andrews failure to keep records as would have been appropriate at [redacted] Street but the same could be said for all of the other carers who were employed for much longer time than Ms Andrews. I am satisfied on the evidence before me that Ms Andrews made a genuine and heartfelt attempt to assist Jamie Johnson during her time at [redacted] Street and had the best interests of Jamie Johnson at heart. I am content that following the first seizure while she was at her place of work she attempted to the best of her ability and training to assist Ms Mitchell in the preparation of the new IP and did what she could to ensure that the IP was followed. In the circumstances there are no grounds upon which

any adverse finding could be made against Ms Andrews nor in my view against any of the other carers engaged at [redacted] Street at relevant times.

99. In relation to Sarai Mitchell I am satisfied that Ms Mitchell did all she could in most difficult circumstances to work with Ms Andrews in the preparation of an appropriate IP and that she was satisfied at the time of the preparation of the IP that the instructions contained therein were appropriate. She accepts as a result of her own personal experiences at [redacted] Street that there was a genuine difficulty if not impossibility in there being appropriate supervision of Jamie bearing in mind the behavioural difficulties of the other resident. Regrettably no time was ultimately available for those involved with the care and safety of Jamie to review the reality of his situation but this is not in my view a fault which may be laid at the door of Ms Mitchell. I am of the view in the circumstances that no adverse finding can be made or ought to be made against Ms Mitchell.

100. In relation to Lynette Grayson, Ms Grayson was at relevant times the head of Disability Services and had little, if any, real contact with the operations of [redacted] Street. While she as Director ultimately holds the responsibility for the actions of her staff I am not satisfied on the evidence before me that there is any good reason to make an adverse finding against Ms Grayson.

[REDACTED] STREET HOUSE

101. The evidence clearly indicates that the residence at [redacted] Street was an old style solid brick Government owned property. There was some evidence that repairs and maintenance had not been carried out for a long time and that there was an ongoing issue as to the suitability of the residence for its use as a home for disabled people.

102. The two residents Jamie and another male both presented particular behavioural problems but the evidence of the permanent carers seems to suggest that generally speaking they were able to be managed.

103. There were four permanent workers prior to September 2004 and it seems that the rostering arrangements which existed at the residence had been settled upon by those four permanent staff members. In addition to the four permanent carers there was frequent use made of casuals. The evidence indicates that there was a preferred list of casuals and that the composition of this list was the result, at least in part, of considerations applied by the four permanent staff members. Mr Reardon was one of the preferred casuals. It is clear that the four permanent staff members ran the staffing arrangements at [redacted] Street in such a way as to attract the disapproval of the Senior Management at Disability Services. The evidence however tends to suggest that the staffing arrangements led to the degree of continuity in care which was clearly vital and essential especially in relation to the wellbeing of Jamie Johnson.

104. There appears to have been ongoing discussions certainly involving Ms Gilmore, Ms Burnett and the permanent staff concerning the rostering arrangements.

105. A number of the permanent staff had been affected by the outbreak of illness which began in about April of 2000. So that as at the date of the death of Jamie Johnson there were no longer four permanent staff available for rostering and this had led it would seem to an increase in the number of casuals.

106. The evidence also indicates that prior to the elevation of Ms Andrews to DSO 2 and the appointment of Ms Mitchell as an acting ASM and the more permanent appointment of Ms Burnett as an ASM that there had been no proper supervision at the ASM level. The illnesses of the permanent workers had also caused a breakdown in the documentation of the management issues at [redacted] Street.

107. The situation concerning the relationship between the two residents and the circumstances of the house itself had led to investigations being conducted into the transfer of one or other of the residents to an alternative home. These activities had led, it would seem, to an increase in the unsettled situation prevailing in relation to at least Jamie. The evidence would tend to suggest that the residence at [redacted] Street was probably not a suitable and appropriate accommodation for the two residents.

108. The environment which had developed including the issue of the roster caused in my view an attitude to develop within the house whereby the staff at the house regarded themselves as being neglected and misunderstood by management. There appears to some extent, to have been a total breakdown in the relations and the contact between permanent staff members and the management especially during the period when Ms Gail Rose was the ASM. The permanent staff who had given evidence, especially Ms Andrews and others who have provided statements, all indicate that Ms Rose failed totally to carry out her appropriate responsibilities in relation to supervising the house. It is clear that there were significant management issues present for a long period of time at [redacted] Street which were never properly confronted by management but which were it seems beginning to be confronted by Ms Burnett and Ms Gilmore following the appointment of Ms Burnett to the role of ASM for [redacted] Street.

109. This dysfunctional situation may well have been a contributing factor to the failure on the part of management to fully appreciate the significance of the June seizure and the potential fatal consequences of the excessive water drinking habits which Jamie Johnson had exhibited for many years.

CORONERS ACT SECTION 58

110. Section 58 of the Coroners Act provides as follows:

(1) If, during the course of holding an inquest or inquiry, a Coroner has reasonable grounds for believing that, having regard to the evidence given at the inquest or inquiry, a person has committed an indictable offence, the Coroner –

(a) shall inform the director of public prosecutions; and

(b) shall not proceed further with the inquest or inquiry until the date ascertained in accordance with subsection 4.

111. Subsection 4 provides a timetable for the recommencement of the inquest or inquiry.

112. Notice was given to the Director in accordance with subsection 1 of section 59 in relation to Debra Burnett on the 30th of August 2002. Notice was given to the Director in relation to Annette Kay Gilmore on the 10th of September 2002.

113. The effect of these Notices was to cause the inquest to cease until such time as the requirements of subsection 4 were complied with. In view of the obvious delay which may occur as a result of the Notice being given to the Director, I wrote to the Chief Executive of the Department of Justice and Community Safety on the 3rd of September 2002 recommending that consideration be given to an amendment to section 58 to allow the inquest to

continue to a conclusion as the issues raised in the Notices did not have a direct bearing upon the manner and cause of the death of Jamie Johnson. The Chief Executive responded by letter dated the 5th of September 2002 and shortly thereafter discussions were held involving officers of the Department of Justice and Community Safety and myself, to discuss possible amendments to section 58. I am not aware that any amendment to section 58 following my correspondence with the Chief Executive.

114. The Director advised under cover of a letter dated the 3rd of February 2003 that charges were to be laid against Ms Gilmore and Ms Burnett consequent upon my notification pursuant to section 58.

115. A summons was issued to both Ms Burnett and Ms Gilmore on the 9th of April 2003 and both summonses were returnable in the ACT Magistrates Court on the 19th of June 2003. Ms Burnett entered a plea of guilty on the 10th of July and was sentenced on the 11th of July 2003. Ms Gilmore entered a plea of not guilty in relation to the charges laid against her and these were dismissed on the 9th of July 2004.

116. The Notices required to be issued under s58 therefore caused a delay of almost two years in relation to the finalisation of the inquest into the death of Jamie Johnson. I am of the view that such delays are not acceptable and I would strongly recommend to the Attorney-General that urgent consideration be given to an amendment to section58 so as to allow a Coroner a discretion as

to whether the inquest ought proceed to finality notwithstanding the issue of Notices pursuant to section 58(1).

117. There are no doubt many circumstances in which it would be in the interests of justice to continue with an inquest to finality but I do accept that there may be circumstances in which it is not in the interests of justice to so proceed. Such a decision ought be left to the presiding Coroner.

FINDINGS, RECOMMENDATIONS AND COMMENTS.

FINDINGS

118. I am required under s52 of the Coroner's Act 1997 to find, if possible,

(a) The identity of the deceased; and

(b) When and where the death occurred; and

(c) The manner and cause of death.

119. I, accordingly, make the following findings:

(i) The deceased was Jamie Vincent Johnson

(ii) The deceased died at the Calvary Hospital at approximately 3.45pm on the 7th of September 2000.

(iii) The deceased died as a result of a diffuse cerebral oedema caused by hyponatremia caused by excessive self-induced water drinking. This condition arose as a result of the deceased consuming excess

amounts of water in the shower at his place of residence 64 [redacted] Street Ainslie during the morning and early afternoon of the 6th of September 2000. I am of the view that the death was accidental.

RECOMMENDATIONS SECTION 57:

120. Section 57 of the Coroner's Act allows the Coroner to make recommendations to the Attorney General on any matter connected with an inquest including matters relating to public health and safety. Based upon the evidence put before me in the inquest I would make the following recommendations:

(1) I would recommend that a procedure be implemented at all houses managed by Disability Services to ensure that all staff especially casuals are required to read, prior to the commencement of a shift, the individual plan and other materials relating to individual residents. In making this recommendation I do not wish to indicate that the whole of an individual plan or the whole of the documentation available at a residence ought to be read on every single occasion at the commencement of a shift, but a procedure ought to be in place to ensure that all workers are sufficiently familiar with the contents of the documentation and the procedure must ensure that any material added since the worker was last engaged in a shift at the residence be read.

(2) I would recommend that there be further consideration given to the issue of communication between the carers casual and permanent at the house and the Senior Management of Disability Services, so as to ensure that decisions relating to the care and safety of residents are understood by all and are made in the full possession of all the facts.

(3) I would recommend that consideration be given to institute the commencement of proceedings against Ms Debra Burnett, if Ms Burnett remains a member of the ACT Government Public Service, to dismiss Ms Burnett from the Australian Capital Territory Public Service.

(4) I would recommend that a dedicated group of police officers be set up and trained to assist the Coronial process in the investigation of deaths in the Territory particularly deaths occurring while the deceased is subject to care provided or supervised by Government instrumentalities.

(5) I would recommend that there be a thorough ongoing review of the operation of the concept of privacy and confidentiality as exercised within Disability Services as at September 2000. It is clear from the evidence that the issue of privacy and confidentiality had become a dead hand in relation to the operation of houses by Disability Services and this dead hand prevented proper communication of relevant

information between staff members. This recommendation particularly relates to the use of incident reports and their clear need to be available as an information tool for all carers.

(6) I would recommend that a protocol be developed between Disability Services and all ACT Hospitals which allows and requires information relating to a person being cared for by Disability Services to be provided directly to that persons carers.

(7) I would recommend that procedures be developed which ensures that casuals be kept informed of all issues involving the care of residents. If this involves casuals being paid to attend meetings and similar activities then I would recommend that adequate funding be provided so as to ensure that casuals can contribute appropriately and become appraised appropriately in relation to the needs of the residents.

(8) I would recommend that there be a review of the record keeping and file keeping both at the house and also at regional offices in an attempt to limit the number of files that would seem to be kept in relation to each resident. It is clear from the evidence in this case that great difficulty was experienced not only by myself in attempting to work through the various files but also by Ms Mitchell in her attempt to understand the situation in relation to Jamie. It would in my view be desirable that there be only one file kept in relation to each individual and that this file contain all material relating to that individual. If it is

necessary to hold a file both at the residence and at the regional office or elsewhere then steps need to be taken to ensure that all relevant documentation is maintained at the house while main file is kept at the regional office.

(9) I would recommend that consideration be given to amending section 58 of the Coroners Act so as to allow a discretion in the Coroner to continue a hearing notwithstanding that a notice or notices have been issued pursuant to s58.

COMMENTS

Section 52 of the Coroner's Act allows a Coroner to comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice. Based upon the evidence before me during the inquest I would make the following comment:

(1) Some evidence was giving about the taking of minutes at meetings held between various levels of employees of Disability Services. The evidence indicates that for a considerable period of time, possibly as long as one year, in 2000, no record could be found of any minutes taken at various meetings during which discussions may have occurred relating to Jamie Johnson and other clients of Disability Services. Minutes of, perhaps, the only meeting that occurred between Ms Burnett and Ms Andrews likewise do not appear to have been recorded.

I am not able on the evidence to reach a concluded view concerning the absence of minutes. Two possibilities seem to exist, firstly that there was a complete breakdown of procedures at Disability Services during 2000 which led to a failure by the relevant officers to record minutes of the various meetings held during that time. Secondly an inference might be drawn that the minutes were taken but have been withheld from the inquest. It seems strange, in the circumstances, that during a time of considerable crisis within Disability Services, following three deaths, that minutes were not kept of the discussions which must have inevitably occurred consequent upon those deaths.

There can be no dispute however that it is essential that accurate minutes be taken and maintained of meetings at which issues relating to the care and safety of clients of Disability Services are discussed. There can be no doubt that it is essential that the minutes, where relevant to staff not present at such meetings, must be circulated and communicated to the relevant staff members.

These minutes ought to be maintained in a central location either at the residence if meetings are held there or the regional or central office if meetings are held at that place but the maintenance of the minutes must be subject to the communication of those minutes. If no such requirement exists then it is clear that a direction ought be issued by the

Director or relevant senior officer to require the keeping of minutes and the maintenance of these recorded minutes.

SUBMISSIONS

121. Submissions have been received from Counsel Assisting, from the Australian Capital Territory Government Solicitor, from the Community Advocate, and on behalf of Ms Grayson. I am grateful for the assistance these submissions provided and each contains matters of importance. I have accordingly attached copies of the submissions to my report.

Dated this 8th day of June 2005.

M A Somes
Coroner