

## CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

**Case Title:** AN INQUEST INTO THE DEATH OF  
CHARLES ROWAN McCULLOCH

**Citation:** [2016] ACTCD 5

**Date of Findings:** 10 August 2016

**Before:** Coroner P.G. Dingwall

**Legislation Cited:** *Coroners Act 1997 (ACT)*  
*Aged Care Act 1997 (Cth)*

**Cases Cited:** *R v Coroner Maria Doogan; ex parte Lucas-Smith*  
[2005] ACTSC 74; 158 ACTR 1  
*Harmsworth v The State Coroner* [1989] VR 989

**File Number:** CD 20 of 2012

IN THE CORONERS COURT )  
AT CANBERRA IN THE ) CD 20 of 2012  
AUSTRALIAN CAPITAL TERRITORY )

INQUEST INTO THE DEATH OF  
CHARLES ROWAN McCULLOCH

**Reasons for Findings of Coroner Dingwall**

**Published on the 10<sup>th</sup> day of August 2016**

1. On 21 January 2012, the death of Mr Charles Rowan McCulloch (“Mr McCulloch”), aged 94 years, was reported to me. It was reported that early in the morning of 21 January 2012 he had been found deceased in Room 43, Casuarina Ward, Jindalee Aged Care Residence (“Jindalee”), Goyder Street, Narrabundah in the Australian Capital Territory and that his life had been declared extinct at 9.45 am that day. Upon receipt of the report, being satisfied as to my jurisdiction, I commenced an inquest into Mr McCulloch’s death and ordered that a post-mortem examination of his body be carried out.

**Jurisdiction**

2. Section 13 of the Coroners Act 1997 (“the Act”) sets out the circumstances in which a coroner must hold an inquest into a person’s death. The relevant parts of the section are as follows:

**“13 Coroner’s jurisdiction in relation to deaths**

- (1) A coroner must hold an inquest into the manner and cause of death of a person who—
  - (a) dies violently, or unnaturally, in unknown circumstances; or
  - (b) dies under suspicious circumstances; or . . .”

3. It was clear at an early stage that on 21<sup>st</sup> January 2012 Mr McCulloch had sustained significant injury inflicted by another person whilst a resident of Jindalee and that he had died as a result of these injuries. It is therefore clear that I had jurisdiction to conduct an inquest by virtue of sub-paragraphs 13(1) (a) and (b) of the Act.

### **Applicable Law**

4. Section 52 of Act sets out what a coroner is required to find and may comment upon as a result of holding an inquest. The relevant parts of the section provide as follows:

#### **“52 Coroner’s findings**

- (1) A coroner holding an inquest must find, if possible—
  - (a) the identity of the deceased; and
  - (b) when and where the death happened; and
  - (c) the manner and cause of death; and
  - (d) in the case of the suspected death of a person—that the person has died.
- . . .
- (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner’s findings in writing.
- (4) The coroner, in the coroner’s findings—
  - (a) must—
    - (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
    - (ii) if a matter of public safety is found to arise—comment on the matter; and
  - (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.”

5. Quite separate from the obligation to make the formal findings required by s 52, the objects of the Act articulated in s 3BA allow a coroner to make recommendations based on the coroner’s findings about a number of matters, should it be considered appropriate. Those matters include those contained within s 3BA (1)(d):

- “(i) the prevention of deaths;\
- (ii) the promotion of general public health and safety including occupational health and safety;
- (iii) the administration of justice;
- (iv) the need for a matter to be investigated or reviewed by an entity”.

6. However, a coroner's power to make comments is subject to s.55 of the Act. It provides as follows:

**55 Adverse comment in findings or reports**

- (1) A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless the coroner has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—
  - (a) make a submission to the coroner in relation to the proposed comment; or
  - (b) give to the coroner a written statement in relation to it.
- (2) The coroner may extend, by not more than 28 days, the period of time specified in a notice under subsection (1).
- (3) If the person so requests, the coroner must include in the report the statement given under subsection (1) (b) or a fair summary of it.”

7. The limits of a coroner's inquiry and powers have received judicial consideration. In *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 (5 August 2005) the Full Court of the ACT Supreme Court comprising Higgins CJ, Crispin and Bennett JJ stated at [12] :

“The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant section of the Coroners Act 1997 (“the Act”) and make, if possible, the required findings and any comments that may be appropriate.”

At [15] the Court stated:

“The Act is generally concerned with the resolution of relatively straightforward questions such as ‘what was the cause of this death?’ or ‘what caused this fire?’ It does not provide a general mechanism for an open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the

death or fire occurred. Specific provisions of the Act confer jurisdiction on coroners to enquire into stipulated questions, require them to make certain findings, and empower them to make comments.”

8. Further in *Harmsworth v The State Coroner* [1989] VR 989 at 997 Nathan J discussed the ambit of the Coroner’s power and said:

“The power to comment arises as a consequence of the obligation to make findings...It is not free ranging. It must be comment ‘on any matter connected with the death.’ The powers to comment and also to make recommendations ....are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner’s prime function that is to make ‘findings’.”

9. In my view, in light of the above authorities, it is not the function of a coroner to ascribe blame to any person or institution. Comments that a coroner makes, even if adverse to a person or institution, are made for the purpose of identifying matters concerning the death being investigated which should be improved or changed so as to avoid similar deaths in the future.

### **Post Mortem Examination**

10. At my direction, Dr Parsons, Forensic Pathologist, performed a post mortem examination of Mr McCulloch’s body. She reported that the Mr McCulloch died as a result of blunt head and neck trauma. The neck trauma included a fracture through both left and right horns of the thyroid cartilage and a fracture through the left greater horn of the hyoid bone, both with associated haemorrhage. Her report details significant injuries to his face, head and neck area. During the post mortem examination, pieces of what appeared to be a bloodstained napkin were observed in his mouth and airways. Dr Parsons reported that the significance of the foreign bodies in the upper airway and the multiple areas of bruising to the neck and hyoid were difficult to explain and a degree of neck compression/upper airway obstruction in a man with emphysema could not be

excluded as contributing to his death. She further stated that there were areas of haemorrhage in multiple planes, consistent with multiple impacts of blunt force trauma.

11. Dr David Griffiths, Consultant Forensic Odontologist, also examined Mr McCulloch's body during the post mortem examination. He found that Mr McCulloch had sustained significant traumatic injuries to the dentition area, with associated soft tissue injuries, which appeared to have occurred peri – mortem and were consistent with a blow to the left side of the Mr McCulloch's face.

### **Inquest hearing**

12. I conducted a public hearing for the purposes of the inquest into Mr McCulloch's death. Ms Amanda Tonkin appeared as Counsel Assisting, Mr Wayne Sharwood appeared on behalf of Johnson Village Services Pty Ltd (the company which operates Jindalee) and Ms Lesli Strong of Strong Law appeared on behalf of Mr McCulloch's family.
13. The hearing was held over seven days. It commenced on 4 May 2015 and ran for two days, it continued on 24, 25 and 29 September 2015 and was finalised over two days on 20 and 21 April 2016.
14. On the morning of 4<sup>th</sup> May 2015, I, Counsel Assisting, Counsel for Jindalee and Counsel for Mr McCulloch's family participated in a view of the Casuarina Ward at Jindalee. During the view, we were accompanied, and assisted, by Sergeant Sarah Casey and Constable Tristan Thexton of the Australian Federal Police. Sergeant Casey was the officer who had been in charge of the investigation carried out at my direction. She and Constable Thexton and other members of Australian Federal Police conducted a thorough investigation into the circumstances surrounding Mr McCulloch's death, as well as suspected assaults upon two other residents of the Jindalee which took place on the morning of 21<sup>st</sup> January 2012.
15. During the hearing videoed re-enactments of events were played to the Court. 155 exhibits were tendered and 15 witnesses were called to give evidence, including a representative of the McCulloch family.

16. At the commencement of the hearing, I made a non-publication order with respect to residents of Jindalee who were known dementia patients and who were suspects in relation to Mr McCulloch's injury and subsequent death.

### **Circumstances Surrounding Mr McCulloch's death**

17. It is clear that Mr McCulloch died in Bed A, Room 43 of the Casuarina Ward at Jindalee on the morning of 21 January 2012 after another person had inflicted blows to his head and neck regions.

18. The exact time that Mr McCulloch sustained his injuries cannot be determined but it is clear that it occurred at some point between 7.05 am and 7.58 am. After a very thorough and meticulous investigation carried out by the members of the Australian Federal Police, it is clear that the injuries sustained by Mr McCulloch were sustained while he was lying on his bed and that they were inflicted by another resident who also lived in Room 43.

19. Throughout these reasons I shall refer to that other resident as VH, consistent with the non-publication order I have made, and because he was not charged with any offence before his death, which occurred prior to the inquest hearing, it being unclear that he could have ever been found guilty of an offence in light of his dementia. In these circumstances, I consider it inappropriate to name him when neither he nor his family have been given an opportunity to be heard in respect to the matters alleged about him.

20. The Casuarina Ward is a secure ward in which patients suffering from dementia are accommodated. Both Mr McCulloch and VH suffered from dementia.

### **The evidence of the witnesses**

21. As noted above, 15 witnesses were called to give evidence. Their testimony was long and detailed.

22. Counsel Assisting has painstakingly prepared an accurate summary of the important aspects of the evidence of each witness. In view of this, it is unnecessary for me to carry out the same exercise in writing these reasons. Instead, I have edited the summary prepared by Counsel Assisting, to the extent I consider appropriate, including ensuring

that all references to the person who caused Mr McCulloch's injuries are to "VH", and I have attached it as **Annexure A** to these reasons.

### **Summary of Events**

23. Sergeant Casey prepared an extremely useful timeline of the events leading up to and after Mr McCulloch's death. The timeline was prepared with a high level of precision and sourced from actual records, which were subsequently tendered at the hearing. In her submissions, Counsel Assisting set out a summary of the material facts surrounding Mr McCulloch's death, which was drawn the timeline. The summary, together with italicised comments made by Counsel Assisting, referable to the evidence before the Court, is as follows (I have amended the summary so that all references to the person who inflicted Mr McCulloch's injuries are to VH):

#### Prior to 20<sup>th</sup> January 2012

- Prior to 9<sup>th</sup> August 2011 Mr McCulloch had lived independently. Following a fall on 9<sup>th</sup> August 2011 he was conveyed to Manning Base Hospital. Following concerns during his admission he was transferred to Kularoo Gardens on 1<sup>st</sup> September 2011 where the staff raised concerns about his tendency to wander and other behavioural issues. On 19<sup>th</sup> September 2011 Mr McCulloch was transferred to Riverview Lodge in Wingham to address his problematic behaviours. On 31<sup>st</sup> October 2011 it was determined that there was no longer any need to house Mr McCulloch in Riverview Lodge and he was discharged back to Kularoo Gardens on 3<sup>rd</sup> November 2011. On his return his behaviour deteriorated and it was determined he would be transferred back to Riverview Lodge on 18<sup>th</sup> November 2011 with a long term plan for appropriate accommodation in Canberra. He was formally discharged from Kularoo Gardens on 20<sup>th</sup> December 2011 and returned to Riverview Lodge. On 20<sup>th</sup> January 2012 he was transported from Wingham NSW by air ambulance to Canberra Airport where he was conveyed to Jindalee Aged Care Residence on the afternoon of 20<sup>th</sup> January 2012.

#### 20<sup>th</sup> January 2012

- 1420 hours on 20<sup>th</sup> January 2012 Charles McCulloch was admitted as a new resident to Jindalee. He was allocated Room 43 Bed A. It was noted on his admission records he was at risk of falls;

- Other residents in Room 43 included Frank Noble Bed B, VH Bed C and John Durr Bed D.

21<sup>st</sup> January 2012

- 0650 hours on 21<sup>st</sup> January 2012 Mr McCulloch was awake during the night. Staff put him back to bed;
- 0700 hours Tim Yappa (Assistant in Nursing) started his shift. He entered the nurses station and noted that he was allocated to area 3 which included Room 43;
- 0700 hours Bobby Joseph (Assistant in Nursing) started his shift. He entered the nurses station and noted that he was allocated to area 1;
- 0705 hours Tim Yappa checked the residents in Room 43 Beds C and D. He also checked Room 44, Room 45 Bed A and B and Room 47;
- 0705 hours Bobby Joseph received a handover from Mouhammad Awali. He observed Frank Noble (allocated to Room 43 Bed B) in the dining room. Mr Joseph and Mr Awali entered Room 43. Mr Joseph noted that a “*male from Bed A was standing in the ensuite*”. This was later confirmed as Mr McCulloch. Mr Joseph assisted Mr McCulloch back to bed. He observed VH was in Bed and John Durr was in Bed.
- 0705 Mr Yappa reported that he observed Mr McCulloch asleep in Room 43 Bed A. [*The timing of the observations made by Bobby Joseph and Tim Yappa is inconsistent – it may be that Mr Joseph put Mr McCulloch back to bed before he was observed by Mr Yappa given that Mr Awali (night shift staff member was still present for a handover)*]
- 0705 hours Tafa Tichivangana (Assistant in Nursing) started her shift. She entered the nurses’ station and noted that she was allocated area 4. She was partnered with Tim Yappa;
- 0705 VH was observed by Tim Yappa asleep in Bed Room 43 [*This evidence is consistent with Mr Joseph’s evidence*];
- 0705 John Durr was observed by Tim Yappa asleep in Bed Room 43 [*This evidence is consistent with Mr Joseph’s evidence*];
- 0710 Mr Joseph did a “*head check*” of residents in Room 39, Room 40 and Room 41 in allocation areas 1 and 2;
- 0710 Mr Yappa assisted Lilly O’Brien with a shower;

- 0710 Mimi Endo (Registered Nurse) started her shift and received a handover from Sheeba Matthews;
- 0715 to 0720 Ms Endo and Ms Matthews (Registered Nurse) walk to the Jindalee Pharmacy together to collect medication;
- 0725 Mr Yappa assists other residents within allocation area 3 with washing, changing and dressing;
- 0725 Mr Joseph returned to the nurses station to check the allocation folder. He showered, shaved and dressed KB in Room 40 Bed C;
- 0725 Sunil Varughese (Assistant in Nursing) started his shift late. He entered the nurses' station and noted he was allocated to area 2. He was partnered with Mr Joseph. He assisted Mr Joseph with resident DP in the bathroom and washed and changed him;
- 0725 Ms Tichivangana went to the dining room to check on residents. She observed Frank Noble seated in the dining room. She did a "head check" of residents in Room 45 Beds A and B and Room 46. She observed Tim Yappa in the corridor with another resident. She saw Mr Yappa proceed to the dining room while she continued to check on residents in Rooms 47, 48 and 49.
- 0725 Ms Tichivangana checked on Maureen Magliulo in Room 46. She observed her door alarm was not in use. She observed Magliulo was asleep in her bed. She did not observe any injuries on her;
- 0730 Mr Joseph escorted resident KB to the lounge room. He observed Mr Varughese in the lounge room and Ms Endo preparing medication on the medication trolley;
- 0730 Ms Tichivangana checked residents in Room 48. She observed resident EW was asleep. Resident Mary Faulkner was also asleep. She did not observe any injuries on Ms Faulkner;
- 0730 Mr Yappa commenced preparing breakfast for residents in the dining room with Mr Varughese;
- 0735 Mr Joseph hears someone yelling "*help me help me*" from Room 43. Mr Joseph and Mr Varughese enter Room 43 and observe John Durr bleeding from his face. VH was standing in Room 43. Mr Joseph informed Ms Endo about the incident. Ms Endo entered Room 43 and told staff to separate Mr Durr and VH. Mr Yappa also enters Room 43. VH walks out of Room 43

holding his neck with both hands. Mr Yappa takes John Durr to the lounge room to clean his face;

- 0740 Mr Varughese assists Mr Joseph in changing resident RS in Room 39. Mr Varughese leaves Room 39 where Mr Joseph remains;
- 0740 Ms Endo goes to Wing C with the medication trolley and starts preparing and administering medication to residents in the dining room;
- 0740 Ms Tichivangana goes to Room 47 and assists resident BO with a wash and changes her clothes;
- 0745 Mr Yappa says he hears shouting in Room 43. He enters Room 43 with Mr Varughese. He observes VH and John Durr facing up to each other. Mr Yappa observes blood on John Durr's cheek. Mr Yappa claims he noticed Mr McCulloch "*out of the corner of his eye*" still asleep in his bed and he did not notice anything unusual; [*This timing 0745 is likely to be more accurate rather than 0735 as asserted by Mr Joseph. Mr Varughese did not start his shift until 0730. He and Mr Yappa had started to prepare breakfast when they went to Room 43 following the shouting*]
- 0746 Ms Endo hears John Durr yelling "*that man again*". Ms Endo enters Room 43 and observes Mr Joseph and Mr Varughese with John Durr. She observes Mr Durr is bleeding and VH standing in the room watching John Durr. Ms Endo directs Mr Joseph and Mr Varughese to separate VH and Mr Durr;
- 0746 Mr Yappa in Room 43 gets between VH and Mr Durr to separate them. Mr Varughese takes John Durr to the lounge room while Mr Yappa takes VH to the dining room;
- 0746 Mr Varughese walks to the dining room to start preparing breakfast with Mr Yappa. He had a conversation with Mr Joseph about the breakfast [*This timing is inconsistent with Mr Joseph's timing that the alleged shouting by John Durr occurred around 0735. It was probably later and closer to the time given by Ms Endo at about 0746*];
- 0746 Mr Joseph and Mr Varughese take resident MMVIC to Room 40 to shower and change him. Mr Varughese left the room and Mr Joseph took MMVIC to the lounge room and seated him next to resident KB [*This timing is inconsistent with Mr Joseph's timing that the alleged shouting by John*

*Durr occurred around 0735. It was probably later and closer to the time given by Ms Endo at about 0746];*

- 0746 Mr Yappa takes VH to the dining room and gives him breakfast;
- 0750 Ms Endo takes VH to the dining room and asks Mr Yappa to clean the blood off John Durr's face. Ms Endo continues her medication round [*The evidence as to who took VH from Room 43 after the incident with John Durr is inconsistent and varies between Mr Yappa and Ms Endo*];  
Ms Endo and Mr Yappa continually tell VH to sit down and eat breakfast. VH eats some breakfast and then says he wants to return to his room;
- 0750 Ms Endo administers medication to Maureen Magliulo. She did not observe any injuries on her at that time;
- 0750 Mr Varughese was in the dining room when he heard "help me" coming from Room 43. He and Mr Yappa and Mr Joseph went to Room 43 and observed Mr Durr sitting on his bed crying with blood on his face. He and Mr Joseph took Mr Durr to the lounge room and Mr Yappa cleaned Mr Durr's face;
- 0751 Mr Joseph is assisting Mr Varughese and Ms Tichivangana to prepare breakfast. Mr Yappa is also assisting with breakfast;
- 0754 Ms Tichivangana takes breakfast to residents in Rooms 46, 47 and 48;
- 0757 Ms Endo walks VH back to the entrance of Room 43 and returns to medication duties;
- 0757 Ms Tichivangana feeds Maureen Magliulo her breakfast. She does not observe any injuries on Ms Magliulo at the time;
- 0757 Ms Tichivangana takes breakfast to Mary Faulkner who refuses to get up. She leaves her breakfast on a side table;
- 0758 Mr Yappa and Mr Varughese assist residents in the dining room and lounge room with breakfast. Mr Joseph and Ms Tichivangana are attending to serving breakfast to residents in their rooms;
- 0758 Mr Joseph asks Mr Yappa about breakfast for Mr McCulloch. Mr Joseph takes Mr McCulloch breakfast to Room 43. He observes something under the covers but was unsure whether there was a person underneath. Mr Joseph lifted the covers and observed blood coming from Mr McCulloch's

nose and mouth. He left the room and called out to Ms Endo to come to Room 43;

- 0758 Mr Joseph said he called out to Ms Endo to “*come and check*” in Room 43. Ms Endo enters Room 43 and Mr Joseph points to Mr McCulloch. Ms Endo observes Mr McCulloch and sees blood on the wall. She pulled the quilt back. She said she believed Mr McCulloch was dead. She did not check his vital signs for signs of life;
- 0759 Mr Joseph recalls Ms Endo entered Room 43 with him and he lifted the quilt back and showed Ms Endo Mr McCulloch. Ms Endo screamed and left the room. Mr Joseph covered Mr McCulloch with the quilt and left the room. He did not recall if any other person was in the room when he found Mr McCulloch;
- 0759 Mr Yappa recalled that Mr Joseph organised to take breakfast to Mr McCulloch;
- 0800 Ms Endo recalled that Mr Yappa was in the dining room and she yelled out to Mr Yappa to “*come*” to Room 43. She said they entered Room 43 together and Ms Endo showed Mr Yappa Mr McCulloch;
- 0800 Mr Yappa recalled that he was in the dining room and he heard Mr Joseph call out to Ms Endo who was at the medication trolley. He observed her go to Room 43. Ms Endo then called to him to “*come*” and they entered Room 43 together. Mr Yappa observed blood on the wall and pillow around Mr McCulloch’s bed and formed the view he was deceased. He recalled that Mr Durr was at that time seated in the lounge room;
- 0800 Mr Varughese observed Ms Endo, Mr Joseph and Mr Yappa coming out of Room 43. Mr Joseph told him “*someone has hit Charles and he has blood on his face, he is not sure if Charles has died.*” Mr Varughese observed that Mr Durr was seated in the lounge room at that time;
- 0801 Ms Endo walked around to reception to phone management. She looked through the staff phone book in an attempt to phone Jo Costuna (a Director of Nursing);
- 0801 Ms Tichivangana was told by Mr Yappa that a resident had been found deceased and another resident, VH, had killed him;

- 0802 Mr Varughese went to Room 43 and looked through the space between the door and saw someone who appeared to be sleeping in Room 43 Bed A. He did not observe any other residents in that room. Mr Durr was still seated in the lounge room;
- 0802 Ms Endo phones Jo Costuna on a landline and tells her she has found Mr McCulloch dead. The call lasted 2 seconds;
- 0804 Ms Endo phones Jo Costuna on a mobile number. The call lasted 368 seconds;
- 0810 Ms Endo phones CALMS. The call lasted 92 seconds;
- 0813 Ms Endo phones SS on a landline. The call lasted 95 seconds;
- 0814 Ms Tichivangana observes Mr Varughese standing outside Room 43 and they discuss Mr McCulloch. Ms Tichivangana enters Room 43 and at Bed A observes Mr McCulloch lying underneath a quilt covered from head to toe. No other person was observed in the room however Ms Tichivangana did not know if a person was in the toilet. Ms Tichivangana left Room 43 and spoke to Mr Varughese as she left;
- 0816 Ms Endo phones Mr Anthony McCulloch (son of the deceased) on a landline. The call lasted 0 seconds;
- 0818 Ms Endo phones Mr Anthony McCulloch on a mobile number. She left a message lasting 28 seconds;
- 0818 Mr Yappa left Room 43 and returned to breakfast duties;
- 0820 Ms Endo receives a phone call from Jo Costuna's landline number. The call lasted 203 seconds;
- 0821 Ms Tichivangana resumes her duties. She enters Room 48 Bed C and observes Mary Faulkner has red spots on her check. Ms Faulkner tells her "*I want to get out of this place. A man has hit me.*" Ms Tichivangana took Ms Faulkner to Bed A (a vacant bed) to change her and then took her to the dining room. She observed Mr Yappa in the dining room;
- 0822 Ms Endo receives a phone call from Anthony McCulloch. The call lasted 150 seconds;
- 0823 Ms Endo recalls Ms Costuna phoned her from a landline. The call was 0 seconds;

- 0824 Ms Endo received a phone call from Sheba Matthews in H wing. Ms Endo advises her she has found a resident deceased;
- 0824 Mr Varughese observes a doctor enter Room 43;
- 0826 Ms Endo observed Ms Matthews enter C Wing to check if Ms Endo was okay;
- 0827 Ms Endo observed Ms Matthews return to H Wing;
- 0828 Ms Endo enters H Wing and discussed Mr McCulloch's circumstances with Dr Weber;
- 0830 Mr Joseph says he left Room 43 to resume other duties;
- 0830 Ms Endo and Dr Weber return to C Wing and enter Room 43;
- 0831 Ms Endo receives a phone call from CALMS. Duration 0 seconds;
- 0832 Ms Endo and Dr Weber enter Room 43 and observe Bed A and notice that Mr McCulloch is covered with a quilt. Under the quilt is a pillow covering his face. VH was present in the room seated on a chair. Dr Weber and Ms Endo notice VH has blood on his hands;
- 0835 Ms Endo spoke to Mr Yappa, Mr Joseph and told them not to enter Room 43 and not to clean John Durr or VH's hands;
- 0837 Ms Endo and Dr Weber return to H Wing;
- 0839 Ms Endo receives a phone call from CALMS. The call lasted 366 seconds;
- 0847 Ms Endo receives a phone call from Cheryl Hart (a Director of Nursing). The call lasted 49 seconds;
- 0850 Ms Endo receives a phone call from Cheryl Hart. The call lasted 66 seconds;
- 0851 Ms Endo returns to C Wing nurses office to obtain Mr McCulloch's details;
- 0853 Ms Endo phones police. The call lasted 220 seconds;
- 0856 Ms Endo receives a phone call from ACT Ambulance Service. The call lasted 66 seconds;
- 0857 Ms Endo receives a phone call from police. The call lasted 63 seconds;
- 0906 Ms Endo escorts ACT Ambulance officers to Room 43. VH is sitting on a chair in Room 43 when they arrive;
- 0907 Cheryl Hart and Jo Costuna arrive at Jindalee;

- 0910 Sue Scott arrives at Jindalee;
- 0910 ACT Police arrive at Jindalee (Acting Sergeant Dean Chichi, Constable Robert Barron, Constable Nicholas Eliades and Stephen Gamara);
- 0911 Mr Howden is observed in the dining room with Mr Yappa;
- 0911 Ms Endo, Ms Costuna and two ACT Ambulance officers informed police of ACT Ambulance findings;
- 0911 in Room 43, Mr Arnemann ACT Ambulance officer shone a torch in the deceased's mouth and found foreign material in his throat which was then observed by Constable Gamara. All police then left the room;
- Acting Sergeant Chichi makes arrangements for AFP forensics and members of the criminal investigation team to attend Jindalee;
- 0913 or 0920 Ms Tichivangana enters Mrs Magliulo's room 46 and observes a doona cover pulled up to her head. She uncovers the doona and observes Mrs Magliulo has a pillow covering her face and blood coming from her nose. Ms Tichivangana leaves the room and advises Sue Scott of her observations and asks her to come and see what has happened;
- 0914 Ms Tichivangana and Sue Scott enter Room 46 and observe Mrs Magliulo. Ms Scott leaves to get Cheryl Hart;
- 0915 Ms Tichivangana observes Cheryl Hart, Sue Scott and police enter Room 46 and observe Mrs Magliulo's injuries;
- 0915 Ms Endo is told by Cheryl Hart that Mrs Magliulo was found to be bleeding with a pillow covering her face;
- 0926 Acting Sergeant Chichi conveyed information to ACT police that a deceased male at Jindalee appeared to have a wound to the back of the head and material in his mouth;
- 0938 to 0940 phone calls made in an attempt to contact a VMO;
- 0939 to 1500 Ms Tichivangana remains with Mrs Magliulo until the end of her shift;
- 0949 Ms Endo says that a VMO contacted Sue Scott who then returned the phone call advising that Mrs Magliulo had been found with blood on her nose and that he needed to come to Jindalee;

- Between 0930 and 1000 Ms Endo enters Room 48 and observes Mary Faulkner's face is bruised (Transcript, 4 May 2015, pp 49 – 50). She notifies Cheryl Hart and Sue Scott;
- 1200 Ms Endo records in the Progress notes that Mr Howden was aggressive in the morning and was seen to be involved in a quarrel between one of the residents in the wing. The other resident complained of being hit by Mr Howden. An incident report was also completed;
- 1330 Ms Endo records in the Progress notes that Mr McCulloch was located with blood on his face. She altered a reference to Mr McCulloch being found with a blanket covering him and changed the entry to a "*pillow and blanket*;"
- An entry was made by Jo Costuna advising staff not to say anything.

### **Issues Arising**

24. After having considered the brief of evidence prepared by Sergeant Casey, it was clear that I had sufficient basis to make the findings required by s 52 of the Act. The primary purpose to be served by the public hearing was to ascertain what, if any, systemic issues were present at Jindalee which enabled a resident of the dementia ward to physically attack three other residents, one of whom died as a result, without him being seen to attack them, and not being prevented from doing so.

25. The issues that were explored in the hearing included the following -

- Whether supervision arrangements for residents of Jindalee, particularly Mr McCulloch, were adequate and/or appropriate, having regard to the fact that three residents sustained physical injury and it is probable that Mr McCulloch was killed by one of the residents, in that facility on 21 January 2012 ("the safekeeping of all residents and supervision issue");
- Whether changes (if any) to supervision arrangements, the treatment and care for residents (including the ratio of staff to residents in Jindalee are sufficient to prevent the physical injury and/or death of any resident in the future ("the changes to supervision issue");
- Whether there is a need for CCTV monitoring of residents with severe dementia ("the CCTV issue");

- Whether there is a need to implement interim care plans for residents before a new resident's assessment is complete and before a new resident's final care plan is undertaken ("the interim care plan issue"); and
- Whether the Jindalee protocols for responding to suspicious deaths, reporting reportable deaths to the coroner and reporting assaults as required by the *Aged Care Act 1997* (Cth) are appropriate ("the reporting issue").

### **Submissions**

26. Counsel Assisting and Counsel for Jindalee have provided me with detailed and comprehensive submissions. Counsel for Mr McCulloch's family has also provided me with written submissions, mainly directed at suggested recommendations. I do not propose to discuss the submissions and counter submissions in detail. It is sufficient for me to say that I have read them, considered them carefully and found them to be most helpful.

### **Comments in respect of the issues**

27. In making comments, I have kept in mind the functions of a coroner discussed in paragraphs 7 to 9 above and I have particularly avoided ascribing blame to any individual or Jindalee. The comments I make are based on the facts disclosed by the evidence and are assisted, to some extent, by hindsight.

### **The safekeeping of all residents and supervision issue**

28. I am not satisfied that there was generally a lack of supervision of residents by the staff of Jindalee working in the Casuarina Wing. The evidence of Dr Jones, Ms Neale, Ms Costuna and Ms Hart, as well as the feedback report from the Department of Health and Aging, following that Department's review consequent upon the report to it of Mr McCulloch's death, satisfy me that the Casuarina Ward was generally well run, and that the staff employed in it were experienced, caring and dedicated to their respective roles, in a difficult environment due to the unfortunate physical and mental condition of the residents.

29. While there were some issues in relation to the recording of resident monitoring and the administration of drugs, I do not consider that these had any relevance to the death of

Mr McCulloch. However, such matters are undesirable. I am satisfied that Jindalee has been alerted to these matters as result of this inquest and will address them.

30. Whilst I am satisfied that, once Mr McCulloch was found injured in his bed, things in the ward became somewhat chaotic, I am not satisfied that they had been so prior to that time. The evidence suggests that, until that time, it had been a fairly usual morning, even allowing for the incident between VH and Mr Durr. The chaos which followed the discovery of Mr McCulloch injured in his bed flowed from the very nature of the discovery by staff members, who although experienced and having been exposed to death regularly, were shocked by the nature of Mr McCulloch's injuries, they having never before experienced such an event.
  
31. I am also satisfied that, notwithstanding what Counsel Assisting and Counsel for Mr McCulloch's family have submitted, there was no reason for the staff of Jindalee to anticipate that VH would assault other residents in the way that Mr McCulloch, Ms Faulkner and Ms Magliulo were assaulted. Clearly, they were aware of an issue between Mr Durr and VH, but nothing in VH's records or staff observations of him after his admission to Jindalee suggested he would engage in the degree of violence to which Mr McCulloch and Ms Faulkner were subjected. In this regard, I am mindful not to judge things with the benefit of hindsight.
  
32. In my view, two significant issues are that, following the quite violent altercation between VH and Mr Durr on the morning of 21 January 2012, which occurred in Room 43 and which resulted in Mr Durr bleeding quite profusely, and in view of the fact that the staff were aware of a complaint made by Mr Durr three days before that VH had assaulted him,
  - the staff did not check the welfare of the other residents of Room 43, particularly Mr McCulloch; and
  - VH was only monitored by staff for a relatively short period after the incident and then permitted to return to his room unaccompanied and unsupervised with the possibility that other residents were then in the room.

33. In my view, knowing about Mr Durr's previous complaint, and then intervening in the incident between him and VH in Room 43 that morning, it was incumbent upon the staff who intervened to not only separate and distract VH and Mr Durr, but to also check the welfare of other residents in the room. Although the altercation seemed to be limited to between Mr Durr and VH, the staff had no basis for concluding that the violence apparently engaged in by VH had been limited to Mr Durr. In these circumstances, it is entirely possible that VH had attacked Mr McCulloch before his altercation with Mr Durr, and even that Mr Durr had intervened to stop the attack. If this were the case, immediate attention to Mr McCulloch, who may have still been alive, may have had a significant effect on the outcome.
34. Similarly, with the knowledge to which I have referred, and the knowledge that VH was very territorial, it is my view that the staff should have placed VH under much closer supervision than he was following the altercation with Mr Durr. In particular, I do not consider it appropriate that he was allowed to return to Room 43, unsupervised and unaccompanied, without a check of the welfare of the other residents of that room having been conducted, and without staff having checked who was going to be present in the room when he returned to it. Given VH's territorial nature and the fact that the altercation with Mr Durr occurred in VH's room, Room 43, it seems to me that it would have been prudent, in ensuring the safety of other residents of Room 43, for a staff member to have accompanied VH to his room and an assessment carried out as to whether he should remain there, unsupervised, with other occupant's of the room. Although, VH had seemed to settle down after the altercation, and indeed appeared quite calm when the staff intervened between him and Mr Durr, and was not exhibiting any aggression, bearing in mind Dr Jones's evidence as to the nature of dementia and the unpredictability of conduct by sufferers and the fact that the aggression towards Mr Durr had been repeated, it should have been anticipated by staff that VH may again become territorial and aggressive to someone he found in his room. Had VH been accompanied back to his room, and Mr McCulloch was found there, the staff would have been in a better position to ensure Mr McCulloch's safety, particularly being aware, as they should have become upon reviewing the documentation that accompanied him, that he had a tendency to wander. If he was then alive, the staff could have ensured that he moved to a communal area, or that VH be returned to a communal area until at least the busy part of the morning was over. If that had

occurred, the outcome for Mr McCulloch, if he had not been attacked by that stage, may have been very different.

35. A third significant issue is that Mr McCulloch was left to his own devices and unattended to from 7:05am to 7:58am. He was a resident who had been admitted the previous evening and whose bags remained unpacked at the time of his death. The documents which accompanied him indicated that he had a tendency to wander. In these circumstances, it is my view, that there should have been a much greater focus placed on introducing him into the facility and to its routines to ensure that he settled in well and to observe this process. Given that it was, or should have been, known by the staff that VH was very territorial, the fact that Mr McCulloch had a tendency to wander and suffered from severe dementia should have alerted the staff to the need to closely manage his introduction to an environment and people that were foreign to him.
36. The fact that Mr McCulloch was not closely supervised and assisted was largely due to a staff scheduling arrangement which permitted the person assigned to care for him that morning not arriving until 7:30am. The result of this was that another already busy staff member was responsible for the care of Mr McCulloch until the assigned member arrived.
37. Had the degree of supervision of Mr McCulloch been provided, as I have suggested, the outcome for Mr McCulloch may have been quite different.
38. A fourth issue is that, following the examination of Mr McCulloch's body by Dr Weber at 8:32am, VH was permitted to remain in room 43 with Mr McCulloch's body until 9:06am when ambulance officers arrived. Although, by this stage, Mr McCulloch was clearly deceased, it was, or should have been, apparent to the staff that Mr McCulloch had been interfered with between the time RN Endo left the room until she returned with Dr Webber. In these circumstances, it was inappropriate to leave VH in the room, on his own and unsupervised, for a period of up to 34 minutes. Whilst, Mr McCulloch was then not at risk of further harm, it was important, given the fact that Mr McCulloch had clearly been assaulted, and not simply fallen out of bed or otherwise fallen over as one witness suggested might have occurred, to ensure that the person, who was by that stage suspected of causing the injuries to Mr McCulloch, be removed

from the scene and monitored, for his own sake and safety, as well as to assist the obvious police investigation to come.

39. A fifth issue is the failure of the nurse in charge of the ward to check Mr McCulloch's vital signs immediately upon him being found injured in his bed. I accept her evidence, as an experienced nurse, that he was obviously deceased when she first saw him. I also understand her shocked reaction to what she saw. However, in my view, in the context of an aged care facility, death should not be determined by a mere viewing of the person, regardless of the nature of any injuries sustained, nor should the arrival of a doctor be awaited to confirm death.
40. Although, I am satisfied that Mr McCulloch was deceased when he was seen by the nurse in charge, there may be cases where a person is assumed to be dead but later found to be still alive. In such cases, the failure to check vital signs could be disastrous.
41. To the extent that the five matters to which I have referred may have resulted from inadequate training, inadequate protocols and a too ready acceptance of the fact that those with dementia can become uncharacteristically aggressive, I consider that training of staff in nursing homes and associated protocols be reviewed so as to introduce relevant changes guided by the events surrounding Mr McCulloch's death.

#### **The changes to supervision issue**

42. The question as to what changes to supervision arrangements and the treatment and care of residents (including the ratio of staff to residents) are sufficient to prevent physical injury and/or death of any resident in the future is a problematic one. This is so for a number of reasons, including the difficulty in managing residents suffering severe dementia, cost and regulation by a Federal Department.
43. The evidence leaves me with the impression that Jindalee is generally a well run and managed aged care facility. This appears to be a view shared by the Federal Department responsible for providing funding and accreditation to the facility.

44. On the evidence before me the staff to resident ratio appears to be appropriate, given the funding provided and the ratio in other similar institutions which are also accredited by the Federal Department.
45. One comment I make in respect of this issue is the one expressed above. That is that a greater focus should be placed on new residents to ensure that their admission and orientation is managed and closely monitored, bearing in mind what is known about them and other residents with whom they will be interacting.
46. A further comment is that, given the unpredictability of dementia patients who exhibit aggression and violence, the Director of Nursing and the Registered Nurse should be encouraged to call for additional support from another area of the facility when the need arises, particularly at busy times of the day, following an incident of aggression and violence between residents. If this means the engagement of more staff to enable this to occur when needed, that should be considered.
47. In this matter, had a staff member been called in from another ward to monitor and supervise both VH and Mr Durr after their altercation, until at least the busy morning activities of the ward staff were over, the outcome for Mr McCulloch may have been different.
48. Similarly, had such a staff member from another ward been called in to supervise VH after the discovery of Mr McCulloch injured in his bed, the outcome for Mrs Faulkner and Mrs Magliulio may also have been different.
49. I note that, subsequent to Mr McCulloch's death, significant changes have been made at Jindalee. An additional staff member is now rostered on each shift on C Wing, including nightshifts. A Director of Nursing is now rostered on duty each Saturday and Sunday (at the time of Mr McCulloch's death these senior managers were not required to be on duty on weekends). Six CCTV cameras have been installed in C Wing and monitor the main traffic and communal areas, with the surveillance monitor being located in the nurses' station. New policies are in place such that a doctor is to be

called every time there is a physical altercation between residents that is either witnessed by staff or where there is an allegation made by a resident.

50. Additionally, Jindalee has done the following:
  - introduced a policy of not accepting residents with a history of significant physical aggression without a known medical cause;
  - recently, and subsequent to the hearing, further developed this policy to plan for only taking female dementia patients and separating male dementia patients with tenure from female patients;
  - continued to develop policies for dealing with suspicious deaths as a result of issues identified during the inquest.
  
51. These and further changes that have been made, or are proposed, at Jindalee are detailed in a letter addressed to my office from Mr Johnson, Managing Director, dated 11 July 2016. It is **Annexure B** to these reasons. The changes and proposed changes have been formulated with the recommendations urged by Counsel Assisting in her written submissions in mind and with a view to adopting them.
  
52. I commend Mr Johnson and Jindalee for proactively introducing these changes.

### **The CCTV issue**

53. A coronal recommendation has previously been made in an inquest relating to the death of a resident of Jindalee, following an incident there involving two residents in January 2007, concerning the installation of CCTV in the dementia unit of Jindalee, including the residents' rooms. This recommendation has never been implemented.
  
54. On the evidence before me, particularly that of Mr Jones, I am not satisfied that the installation of CCTV in residents' rooms would be appropriate, or of much utility in increasing the safety of residents, let alone economically viable.
  
55. One of the issues concerning the introduction of CCTV surveillance is the invasion of the privacy of residents. Dr Jones said a surveys of residents in other aged care facilities revealed that more than half of residents would object to the invasion of their

privacy. Whilst the right to privacy may at some point, and in some circumstances, be regarded as being, on balance, of lesser importance when weighed against personal safety, I am not satisfied that is the case in aged care facilities.

56. In my view, it would be well nigh impossible for an aged care facility to place sufficient cameras in every room of a dementia facility in order to monitor the movement and activities of every resident. Even if it could be achieved, it would require the constant observation of an array of monitors by one or more persons. Also, given the number of cameras and monitors that would be required, there would be every chance that an incident appearing to put the safety of a resident in jeopardy might occur without it being seen and, even if seen, the response may be too late to prevent violence occurring.
57. Additionally, given that one of the purposes for installing CCTV is the deterrent effect on those under surveillance, it seems to me that residents suffering dementia are unlikely to be continually, or at all, aware of the presence of CCTV cameras. Thus the desired deterrent effect would not be achieved.

#### **The interim care plan issue**

58. Counsel assisting drew attention to the report of Miss Neale in relation to the need for interim care plans.
59. Ms Neale stated that interim care plans are a very important part of the admission documentation for a new resident of a dementia unit. They are required by staff to enable them to begin caring for the resident appropriately and safely. She expressed the view that interim care plans should be completed within 24 – 36 hours after admission of a resident, pending more detailed assessments to be completed over the next four to six weeks as part of the comprehensive care plan, and should be updated or changed as new information becomes known. She listed a number of categories of information that she considered an interim care plan should contain, and specifically noted the need for information about challenging behaviours and the likelihood of displays of physical aggression. She noted that she had not been given any documentation of behaviour assessment or monitoring of VH, notwithstanding that he had a documented history of

domestic violence and challenging behaviour which escalated following his admission to the Casuarina Ward at Jindalee.

60. Counsel for Jindalee submitted that when a resident is admitted, and as part of the admission process, an interim care plan is commenced but is not completed until approximately four to six weeks after the resident's admission. This allows the resident to settle in to enable the resident's behaviour, continence, blood pressure, mental health and cognitive function to be observed and assessed. In the interim, the lifestyle summary sheet, which is formulated on admission, provides staff with a snapshot of basic care needs and is available to all staff. If staff require further information, and whilst the care plan is being prepared and completed, the care plan is made available to all staff on computer. It was for this reason that neither Mr McCulloch's nor VH's interim care plans were completed as they were both still in the early stages of observation and preparation.
61. Dr Jones gave evidence that observation of the person needs to last at least three weeks in order to gain a preliminary understanding of the resident. Dr Jones said the care plans start with information provided by family or other sources but it is only after settling in and observing the resident that an appropriate care plan can be completed. Dr Jones recommended that, in dealing with residents with dementia, the carer should have a good understanding of the person, which can assist the carer in making decisions when the person shows aggressive behaviour. Completion of the care plans take time to ensure that they used to their optimum. Once complete, and although taken to be complete, because the resident's behaviour and, as a result their needs, are constantly changing, and because new information about the new resident becomes known and the various assessments are finalised, the care plans are documents that are constantly updated and can be regularly changed.
62. I note that Mr McCulloch had only been admitted the night before his death. In these circumstances, no criticism can be levelled at Jindalee from not having an interim care plan drawn up for him.

63. In relation to VH, I note that he had been at Jindalee for nine days prior to Mr McCulloch's death. In this regard, Dr Jones expressed the opinion, that, because VH had only been a resident for that short time, his full needs and behavioural aspects could not be sufficiently determined to enable a care plan to be completed.
64. It is clear that, in the short time that the VH had been a resident of Jindalee, the staff had developed some information about his absconding behaviour and an observation regime was put in place until a decision was made that it was no longer required.
65. The known incidents of violence and aggression in which he was involved had occurred on 18 January 2012, between him and Mr Durr, and on the day of Mr McCulloch's death, again between him and Mr Durr. The incidents were appropriately dealt with by staff at the time that they occurred. However, given that short time span, on the basis of Dr Jones's evidence, there had not been sufficient opportunity to properly observe his behaviours for the purposes of formulating an interim care plan.
66. Accordingly, I make no comment concerning the lack of interim care plans for Mr McCulloch and VH.

### **The reporting issue**

67. During the hearing, the adequacy of Jindalee's protocols and procedures relating to the response by staff to suspicious deaths, reporting such deaths to the coroner and reporting assaults as required by the *Aged Care Act 1997 (Cth)* were examined.
68. Jindalee's compliance with its obligations under the *Aged Care Act 1997 (Cth)* to report assaults was examined by representatives of the Department of Health and Aging following Mr McCulloch's death. It was found that Jindalee was complying, save that it was not recording the occasions when an available discretion not to report an assault was exercised. This issue has now been resolved by Jindalee.
69. The staff response upon finding Mr McCulloch injured in his bed was, as I have said above, chaotic. It resulted in Mr McCulloch's vital signs not being checked until Dr Weber's arrival – 34 minutes after Mr McCulloch had been found in his bed. It resulted in the Police not being called to the scene until 8.53am – 55 minutes after Mr

McCulloch had been found in his bed. It also resulted in VH (suspected at the time by some staff to be the person who had injured Mr McCulloch) being left unsupervised and able to enter, and remain in, the room with Mr McCulloch after he was found, and quite likely to enter the rooms of Mrs Faulkner and Mrs Magliulio and harm them, and enabled someone (probably VH) to place a pillow over Mr McCulloch's face at some time between 8.00am and 8.32am.

70. It was not a satisfactory response. It is partly explained by the shock and distress of the staff caused by the discovery of Mr McCulloch and partly by the uniqueness of the event in the experience of the relevant staff. However, it was also explained by the lack of an appropriate protocol for dealing with such events.
71. I am satisfied that the proposed protocol drafted by Constable Tristan Thexton, which is **Attachment C**, addresses all the issues concerning the appropriate response to an event such as the one involving Mr McCulloch.

### **Formal Findings**

72. As required by s 52 of the Act, I make the following findings –

- The deceased was Charles Rowan McCulloch, born on 4 February 1917;
- he died in Room 43, Casuarina Ward, Jindalee Aged Care Residence, Goyder Street, Narrabundah in the Australian Capital Territory at some time between 7.05am and 7.35am on 21 January 2012; and
- he died as a result of blunt head and neck trauma inflicted upon him by another resident of Jindalee Aged Care Residence.

I found no matter of public safety arising in connection with the inquest into Mr McCulloch's death.

### **Recommendations**

73. I propose to make a number of recommendations. In making them, it is not to be implied that I have found general, or any specific fault, with the running and management of Jindalee beyond the matters on which I have commented. Many inquests result in matters surrounding the death being investigated and issues identified which, although they did not play a part in causing, or hastening, the death, appear as matters which

might prevent similar deaths in the future, matters which will improve coronial investigations into such matters in the future or benefit the system of justice generally

74. I make the following recommendations –

- (a) The policy recommended by Constable Tristan Thexton in relation to suspicious deaths and matters to be referred to the Coroner, which is **Annexure C** to these reasons, be adopted and implemented by Jindalee and all other aged care facilities in the Australian Capital Territory;
- (b) Staffing requirements of aged care facilities be reviewed and a minimum staffing requirement be set for dementia specific units of aged care facilities such as C Wing at Jindalee. I note that a T – BASIS unit has a maximum of 16 residents at any one time, each housed in individual rooms. There is a registered nurse on duty at all times, with an additional three staff until 9 pm, and then an additional staff member until the commencement of day shift. In addition, a nurse manager is rostered on during the day. This should be the minimum staffing requirement for residents who suffer from dementia.
- (c) Compulsory mandatory minimum training be implemented for staff employed in aged care facilities who are required to care for and deal with residents who have been diagnosed with dementia;
- (d) To ensure the safety of both residents and staff of Jindalee, and all other aged care facilities with dementia specific units, with the assistance of an external provider with expertise in aged care, undertake a review and/or implementation of policies and procedures including but not limited to:
  - behavioural management strategies for staff for the management of residents with dementia and specifically with those who have a tendency to be aggressive;
  - mandatory reporting, and recording, of all incidents of violence of any level between residents, between a resident and a staff member or between staff members;
  - procedures for dealing with deceased residents; and

- development and implementation of an efficient record keeping system, preferably electronic;
- (e) To ensure the safety of both residents and staff, Jindalee and all other aged care facilities undertake, with the assistance of an external expert provider in aged care, training or updating in Compliance with Elder Abuse reporting and maintenance of a register in accordance with the requirements of the *Aged Care Act 1997* (Cth.).
- (f) Jindalee undertake a review of the staff structure within the facility so as to ensure that management fulfil their requirement to supervise and monitor staff and ensure task compliance.
- (g) That the discretion reposing in the management of aged care facilities to determine whether an assault is a “*reportable assault*” under the *Aged Care Act 1997* (Cth.), where a resident has a cognitive impairment, be removed and that there be a requirement for mandatory reporting of all assaults in aged care facilities.

75. Mr McCulloch’s family has requested, through their Counsel, that I make a recommendation which, if adopted, will allow families who are considering placing their aged relative in an aged care facility to make an informed decision as to whether a placement poses an unacceptable risk to the safety of their relative, and whether the relative has capacity to cope in the environment of the facility.

76. The feasibility of adopting the recommendation was not canvassed during the hearing. I have no basis for knowing whether or not it could be implemented. However, it seems to me that it may be capable of being implemented and, if necessary and appropriate, imposed. Accordingly, I make the following recommendation –

- (h) that all aged care facilities with a dementia unit be required to disclose to families of prospective residents of the unit, prior to their admission, the following:
- the level of risk of violence for potential residents (taking into account their particular circumstances); and

- the established protocols for protecting residents from witnessing and/or experiencing regular violent events; and
- the protocol for advising relatives of violent incidents as they occur, such that the relatives are able to reassess circumstances from time to time.

77. In making these recommendations, I share the view of Counsel Assisting that all aged care facilities have an obligation to ensure the safety of residents. All residents are entitled to be treated with dignity and respect, which no doubt they have earned as being past contributing members of a community, financially and practically and at one time loving and respectful parents, relatives and/or friends.

### **Concluding remarks**

78. This has been a long and thorough inquest in which I have been greatly assisted by the efforts of Counsel Assisting, Ms Amanda Tonkin, Counsel for Jindalee, Mr Wayne Sharwood, and Counsel for the McCulloch family, Ms Lesli Strong. I thank them for this assistance.

79. I also thank Sgt Sarah Casey of the Australian Federal Police for the thorough and detailed investigation carried out by her and her fellow officers. Their work has been thoroughly professional and painstaking, and the results of the investigation presented in a way which greatly assisted me in making my findings and recommendations.

80. Finally, I offer my condolences to Mr McCulloch's family for the loss of their loved one in such tragic circumstances. I hope that this inquest has enabled them to obtain a full understanding of what happened to him.

P.G. Dingwall  
Coroner

**EVIDENCE OF THE WITNESSES**

**Evidence of Sergeant Sarah Casey**

1. Sergeant Casey was in charge of the coronial investigation. She provided an extremely comprehensive statement outlining the very thorough investigation undertaken by the Police (Exhibit 140) including a criminal investigation (Operation Penna) in relation to Mr McCulloch's death and the assault of three other residents on the morning of 21<sup>st</sup> January 2012. In addition she gave evidence in the proceedings. Her evidence can be summarised as follows:
  
2. Mr McCulloch was a resident of C Wing, a secure facility within Jindalee, providing care for residents suffering from severe dementia. At the time of the incident there were 31 residents in C Wing. The day shift on C Wing consisted of one registered nurse Ms Niho (Mimi) Endo and four Assistants in Nursing ("AINs") Bobby Joseph, Timothy Yappa, Sunil Varughese and Tafadzwa (Fuzzy) Tichivangana. The registered nurse was regarded as the team leader with AINs attending to the residents' activities of daily living. All staff were required to sign on at the commencement of a shift in the Duty Book and consult a Diary located in the nurse's office to ascertain the designated area they had been assigned to ("members' allocation). In addition, staff were required to review the Director of Nursing book (DON'S book) which contained a summary of incidents that staff needed to be aware of such as falls by residents, residents leave or other matters of significance.
  
3. The members' allocations for 21<sup>st</sup> January 2012 were as follows:  
Allocation 1: Rooms 39 and 40 (all residents): Mr Bobby Joseph;  
  
Allocation 2: Rooms 41 and 42 (all residents) and Room 43 Beds A and B: Mr Sunil Varughese (he commenced his shift late at 0730)  
  
Allocation 3: Rooms 44, 45 and 46 (all residents) and Room 43 Beds C and D and Room 47 Beds A and B: Mr Timothy Yappa;  
  
Allocation 4: Rooms 48 and 49 (all residents) and Room 47 Beds C and D: Ms Tafa Tichivangana

Staff designated to Allocation 1 and 2 were required to work together. Staff designated to Allocation 3 and 4 were required to work together. Night staff provided a handover to day staff at approximately 0700 hours prior to the night staff shift ending. On 21<sup>st</sup> January 2012 Mr Varughese was allocated responsibility for Mr McCulloch, who was a resident allocated to Room 43 Bed A (closest to the front door on the left hand side as you enter the room). Mr Frank Noble was a resident allocated Room 43 Bed B (closest to the bathroom at the rear of the room), VH was a resident allocated to Room 43 Bed C (near the bathroom at the rear of the room) and Mr John Durr was a resident allocated to Room 43 Bed D (closest to the front door on the right hand side as you enter the room). A map of Room 43 was tendered (Exhibit 2). A further map was tendered through Counsel for Jindalee (Exhibit 3). Mr Yappa had been allocated responsibility for VH and Mr Durr. In addition Mr Yappa had been allocated responsibility for Mrs Maureen Magliulo in Room 46 and Mary Faulkner in Room 48.

4. Mr Awali provided a handover to Mr Joseph on the morning of 21<sup>st</sup> January 2012. Mr Varughese did not attend a handover as his shift did not commence until 0730 in accordance with an arrangement he had with management. Mr Joseph had observed Mr Noble to be dressed and in the main dining area when Mr Joseph commenced his shift. Mr Yappa commenced a handover with Mr Rajesh Shahi at 0700 hours. Ms Tichivangana was not present for the handover as she was running late. Mr Shahi said that during handover at about 0700 on 21<sup>st</sup> January 2012 he observed VH was in the hallway and VH asked where the toilet was. He was then shown to the toilet. He observed VH was still in his pyjamas. He said Mr Yappa was with him at the time. This evidence does not accord with Mr Yappa's evidence who said he observed VH and Mr Durr both asleep in their beds during handover. Mr Yappa's evidence is that he visited Mrs Magliulo at 0705 in Room 46 and she was in bed and appeared happy. Shortly after observing Mrs Magliulo he entered Room 48 and observed Mary Faulkner. He did not observe anything unusual. At around 0735 Ms Tichivangana observed Mrs Magliulo sleeping in her bed and did not observe any injuries. She continued to check on residents and observed Mary Faulkner at about 0730. She was sleeping and saw nothing out of place at the time.<sup>1</sup> Following his arrival at about 0730, Mr Varughese accompanied Mr Joseph in Room 40 and 39, assisting to shower and change those residents.
5. Ms Endo, Registered Nurse, arrived and checked the roster and received a handover from Sheba Matthews, Registered Nurse, in the corridor whilst the pair walked to the Jindalee Pharmacy. Ms Matthew's indicated that the evening had been uneventful. Ms Endo's duties were to provide care for residents in H Wing, D Wing, J Wing and C Wing which meant she

---

<sup>1</sup> Transcript 4<sup>th</sup> May 2015 at p.19

had responsibility for 60 residents. Ms Endo then attended to distributing medication in C Wing, between the main dining room and the nurses station, at about 0730.

### **Altercation between VH and John Durr**

6. *“At about 0730 . . . Ms Endo observed numerous residents eating breakfast in the main dining area, including Mr Noble of room 43. Ms Endo distinctly recalled that Mrs Faulkner was not in the main dining area at this time because Mrs Faulkner was usually in a bad mood before breakfast and hence Ms Endo remembered she wasn't there at that time. Between about 7.40 and 7.45 am, Ms Endo was standing in the main dining area in the nurse's station dispensing medication. Mr Joseph was standing nearby in the sitting room adjacent to the nurse's station when they both heard yelling coming from the direction of room 43. Mr Varghese and Mr Yappa were assisting the breakfast service in the main dining area by serving residents seated in that area and also heard yelling coming from the direction. Mr Haprett Shamar was also in the vicinity of room 43 and heard yelling. Ms Endo recalled Mr Durr saying, "That man again." Mr Joseph recalled a man yelling, "Help me. Help me." Mr Varghese recalled a man say, "Help. Help." Mr Yappa could hear two people shouting at each other but he couldn't decipher any specific words. Mr Shamar recalled Mr Durr repeatedly yelling, "Help me. He's hitting me again." Mr Joseph, Mr Yappa, Mr Shamar and Mr Varghese immediately attended room 43 and were followed by Ms Endo a short time later. Upon entering the room they observed (VH) and Mr Durr facing up to one another in the central walkway of the room. At this time Mr Yappa observed that Mr Durr had what appeared to be scratch marks on his cheeks. The staff members separated (VH) and Mr Durr. They moved Mr Durr to his bed and sat him down. One staff member recalled that Mr Durr appeared to be crying. Mr Durr was also holding a hand over his left cheek which was bleeding. Mr Joseph recalled hearing Mr Durr say, "Help me. Help me. He's trying to hurt me." Ms Endo recalled hearing Mr Durr say, "That man. He hit my face again." Mr Varghese recalled hearing Mr Durr say, "Someone hit me." Mr Varghese asked Mr Durr who had hit him, and Mr Durr replied, "I don't know." Mr Yappa formed the opinion that Mr Durr was quite angry at that time and thought he said words to the effect of, "You bloody bastard." Ms Endo thought (VH) was watching what was going on in the room but was not aggressive in his demeanour. Mr Durr didn't indicate which man had hit him, however at the time she only saw Mr Durr and (VH) in the room. None of the staff members present could recall (VH) saying anything at this time.*

*“Ms Endo didn’t see the deceased at this time as she remained standing in the doorway to the room throughout the incident. Mr Joseph didn’t see the deceased at the time but stated he didn’t look into the deceased’s living area because he was focused on the situation between (VH) and Mr Durr. Mr Varughese didn’t see the deceased at the time and thought this may have been due to the curtain around the deceased’s living area being shut. Mr Yappa recalled seeing the deceased lying on his back at that time and having no visible injuries. Mr Yappa did not observe any blood on the wall near the deceased’s bed.”* (Transcript 4<sup>th</sup> May 2015 pp.20 – 21) Sergeant Casey noted *“given the location of each of the staff members in the room at the time of the altercation it was most plausible that Mr Yappa would have the best view of the deceased’s living area. None of the Jindalee members observed anyone else in the room at the time.”*<sup>2</sup>

7. Sergeant Casey noted that Ms Endo formed the impression that Mr Durr indicated VH had hit him. She based this on the fact that VH was in the room watching what was going on and incidents had previously occurred between VH and Mr Durr. Ms Endo decided it was necessary to separate them and to organise to have Mr Durr’s wound cleaned. Ms Endo and Mr Yappa escorted VH from Room 43 and then seated VH at the rear of the main dining area, closest to the door that opens out onto the courtyard. The courtyard leads to a glass sliding entrance to Mrs Magliulo’s room which is usually kept closed and locked.<sup>3</sup> Once VH was seated Mr Yappa got him breakfast. Mr Joseph noticed that as VH exited Room 43 he was holding both his hands around his throat in a choking motion. Mr Durr was escorted from Room 43 by Mr Varughese to the sitting room adjacent to the nurse’s station and Mr Yappa cleaned Mr Durr’s wound. Mr Yappa observed scratch marks to both sides of Mr Durr’s face. Mr Durr said at the time *“I’m going to get that bloody bastard.”*
  
8. Following the altercation, Ms Endo returned to dispensing medication and saw VH continually attempt to get up from the table where he was seated. She and Mr Yappa encouraged him to remain seated. Eventually he ate some cereal and then stood up and began to walk away from the table in the direction of Room 43. Ms Endo approached VH inviting him to stay seated. He refused insisting he wanted to go back to his bed. Ms Endo in response to his inquiry *“What room should I go to?”* said to him *“your room number is 43. I’ll show you”* and escorted VH back to his room. She then returned to dispensing medication. Ms Endo was of the view that VH would not have had the opportunity to leave the dining room because she was watching him and did not see him leave and return. She

---

<sup>2</sup> Transcript 4<sup>th</sup> May 2015 at p.21

<sup>3</sup> Transcript 4<sup>th</sup> May 2015 at p.23

said she did not observe any blood on VH at this time. She administered medication to Mrs Magliulo at 0750 and did not observe any injuries to her face at that time.

### **Discovery of Mr McCulloch**

9. Mr Joseph began assisting staff members and distributing breakfast to residents in their rooms shortly before 0800 hours. He prepared some porridge and went to Room 43. *“As he entered the room, he noticed the door was partially open. He went to Bed A and noticed the curtains around Mr McCulloch’s living area were partially closed. He saw the shape of a person lying on the bed with a doona cover pulled up over their head so it reached the bedhead. Mr Joseph observed two feet sticking out covered by a sheet at the end of the bed. He pulled back the top of the doona cover and saw the deceased lying on the bed. He observed a lot of blood covering the deceased’s face and also blood coming from his nose and mouth. The deceased was not moving. He placed the doona back over the deceased’s face and left the room for assistance. Mr Joseph left Room 43 and walked towards Ms Endo requesting she “come.” Ms Endo followed Mr Joseph into Room 43. Ms Endo observed the curtains surrounding the deceased’s bed were pulled partway across at the end of the bed. Ms Endo observed a latte covered doona on the bed was pulled all the way up over the pillow at the head of the bed. She observed a smear of blood on the wall behind the bed and approached the bed. Mr Joseph pulled back the top of the doona cover from the area near the head of the bed so that Ms Endo could see Mr McCulloch. She immediately formed the opinion that the deceased was dead as he was observed to be no breathing. She considered that given his facial injuries it was very unlikely he was alive. She moved away from the bed towards the middle of the room and screamed. She immediately thought someone had killed Mr McCulloch and was concerned for other residents in the room. Ms Endo observed (VH) in the room seated on a chair within his living area. (VH) didn’t say anything. Mr Joseph again placed the doona back over the deceased’s face.”*<sup>4</sup>
10. Ms Endo and Mr Joseph exited Room 43 and walked towards the main dining area. *“Ms Endo summonsed Mr Yappa and they returned to Room 43 together. Ms Endo pulled back the doona to show Mr Yappa the deceased. Mr Yappa observed that the deceased was lying on his back in bed with his head resting on the pillow and with the sheets pulled up over his chest area. Mr Yappa was of the opinion that the deceased had been bashed badly and noticed his nose had been smashed inward. He also observed blood on the pillow, bedhead*

---

<sup>4</sup> Transcript 4<sup>th</sup> May 2015 at p.26

*and on the walls around the deceased's bed. Mr Yappa formed the view that the deceased was no longer alive but did not witness any staff member check for signs of life.”<sup>5</sup>*

11. Both Ms Endo and Mr Yappa left Room 43 after Ms Endo shut the surrounding curtains. Ms Endo went to H Wing reception area. No attempt was made to check the deceased for signs of life. No attempt was made to ensure the deceased had some privacy. Nothing was done to protect any potential crime scene. No supervisor was allocated to watch over VH, notwithstanding that both Ms Endo and Mr Yappa had formed the view that VH had been the assailant.

12. Sergeant Casey noted:

*“Mr Joseph informed Mr Varughese that Mr McCulloch had sustained serious injury and stated he was unsure if the deceased was still alive. Mr Varughese went to the doorway of Room 43 and looked through the door jamb into the deceased's living area. He observed the curtain around the deceased's living area was open and saw the shape of a person on the deceased's bed underneath a doona cover. He did not notice any part of the person protruding from the bed covers, did not see blood on the wall near the deceased's bed and did not observe any other person in the room.”<sup>6</sup>*

13. At about 0802 or 0804 Ms Endo contacted Jo Costuna Director of Nursing for Jindalee and informed her she had located the deceased. She advised Ms Costuna she believed VH was responsible for Mr McCulloch's death. Ms Endo advised Ms Costuna she intended to call the Police. Ms Costuna said that as *“no one had observed what had happened to the deceased Ms Endo should contact a doctor instead.”* Ms Endo discussed with Ms Costuna the difficulties obtaining a doctor as Mr McCulloch had not yet been seen by an ACT doctor. They agreed Ms Endo would contact CALMS to have Dr Arguetta attend. Ms Endo then returned to C Wing to obtain information about the deceased. When she returned she observed that the door to Room 43 was open. Ms Endo contacted CALMS in an attempt to have a doctor attend upon the deceased. She also contacted the deceased's next of kin Anthony McCulloch and at about 0816 she contacted Sue Scott, Registered Nurse, who was the weekend supervisor and requested she attend Jindalee.

#### **Staff view the deceased**

14. Shortly before 0800 hours Ms Tichivangana gave Mrs Magliulo her breakfast. At this time she did not observe her to have any injuries. At about 0816 hours *“Mr Yappa informed Ms*

---

<sup>5</sup> Transcript 4<sup>th</sup> May 2015 at p.30

<sup>6</sup> Transcript 4<sup>th</sup> May 2015 at p.31

*Tichivangana that Mr McCulloch had been killed by another resident. “<sup>7</sup> After hearing of the deceased’s death Ms Tichivangana sought out Mr Varughese and asked him if she could look at the deceased. “He replied she could enter the room but not to touch anything. She entered the room and observed that the curtain was pulled half way across the length of the curtain railing. She observed the deceased but did not observe any other person in the room at the time. She left Room 43 and asked Mr Varughese who he considered responsible for Mr McCulloch’s death. He replied in his view (VH) was responsible for the death, due to his previous aggressive behaviour.”<sup>8</sup>*

15. No staff had been allocated to supervise Mr McCulloch or VH. *“At about 8.20am, Ms Endo returned to her medication trolley and wheeled it down the corridor outside room 43 whilst on her way to room 39 to commence dispensing medication to the residents in the rooms off that corridor. About 8.22am, whilst dispensing medication in C wing, Ms Endo received a phone call from Mr McCulloch and informed him that his father had been found deceased with blood on his face. Mr McCulloch seemed quite shocked by this information and asked where the deceased had been located, and was informed that he had been found in his bed. About 8.24am, Ms Endo received a phone call from Chantelle Moore, who was working as an AIN in H wing. Ms Moore advised that Dr Cameron Lovell was in H wing to see another resident. Ms Endo informed Ms Moore of how the deceased had been located, and Ms Moore attended C wing to speak with Ms Endo because she thought Ms Endo sounded quite upset. After attending C wing, Ms Moore had a further conversation with Ms Endo, during which Ms Endo stated she believed the deceased had been bashed. As they were speaking Mr Yappa joined their conversation and it was mentioned that (VH) was possibly involved in the deceased’s death. As a result, Ms Moore and Mr Yappa went to room 43 and observed (VH) lying on his back in bed on top of the covers with his hands resting on his stomach. At this time he was wearing pyjamas and it appeared as though he had not showered that morning. Ms Moore said to (VH), “Hello, how are you going?” (VH) replied, “Good Love, how are you going?” Ms Moore then asked (VH) if she could look at his hands and held them out for her to see. Ms Moore observed something on (VH)’s left hand and therefore gently rotated his wrist so she could get a better look at it. About two centimetres below the knuckle of his little finger, she observed a triangular shaped light smear of blood, about the size of a five cent piece. Ms Moore shared her earlier observation with Mr Yappa, who stated the blood may have been from the earlier altercation between (VH) and Mr Durr. Ms Endo and Ms Moore subsequently left C wing to attend H wing to speak with Dr Webber. Ms Endo spoke*

---

<sup>7</sup> Transcript 4<sup>th</sup> May 2015 at p.32

<sup>8</sup> Transcript 4<sup>th</sup> May 2015 at p.34

*with Dr Webber in the front foyer of Jindalee, informing him that a resident had died from apparent facial injuries.” (Transcript 4<sup>th</sup> May 2015 pp.34 – 35)*

### **Involvement of Dr Webber**

16. *“Dr Webber encouraged Ms Endo to contact the Police if she thought the resident's death was suspicious. Ms Endo replied she was concerned because she had been directed by management to only contact a doctor and not the Police. Eventually Dr Webber offered to have a look at the deceased so his opinion could be passed along to. Ms Endo accepted this offer and returned to C wing with Dr Webber. Whilst walking to C wing, Ms Endo told Dr Webber she thought (VH) was responsible for the deceased's death. Ms Endo and Dr Webber immediately went to C wing. Upon entering the wing, Dr Webber observed two staff members in the vicinity of room 43, matching the description of Mr Varughese and Ms Tichivangana. He also recalled that they both smiled nervously at him as he proceeded to room 43 with Ms Endo. After entering the room through the door that was already open, Ms Endo observed the curtains around the deceased's bed was now shut. Ms Endo also observed that one of the female residents, Lydia Budiock, was lying on Mr Durr's bed and that (VH) was in the room also. Ms Endo approached the deceased's bed and pulled back the doona cover, which had been positioned so that it covered the entirety of the bed, including the pillow area near the bedhead, to show Dr Webber the deceased's injuries. After pulling back the doona, Ms Endo observed a pillow over the top of the bed, which was now covering the face of the deceased. Ms Endo was certain that this pillow was not on the deceased's face on the previous occasion she had seen him that morning. Ms Endo removed the pillow so Dr Webber could make observations of the deceased. A short time later, Dr Webber asked Ms Endo where (VH) was, due to her earlier suspicions about his involvement in Mr McCulloch's death, and Ms Endo indicated (VH) was at the rear of the room. Both Dr Webber and Ms Endo approached (VH), who was sitting in a chair in the desk area of his living room within room 43 bed C. Dr Webber said, "How are you, (V)?" (VH) said, "I'm fine, mate. I just want to see my family." At the conclusion of Dr Webber's conversation with (VH), Ms Endo recalled Dr Webber mentioned he had observed blood on the outer edge of (VH)'s hand. However, Dr Webber later stated that he did not recall seeing this blood on (VH)'s hand. Ms Endo also observed the blood on (VH)'s hand and recalled Dr Webber instructed her to ensure (VH)'s hands were not washed to preserve the blood. Dr Webber further stated that no one should be allowed to enter the room. Dr Webber insisted that Ms Endo call the Police immediately. Ms Endo and Dr Webber departed room 43 to attend H wing and contact the Police.*

*(VH) and Ms Budiock was left in room 43. The curtain surrounding the deceased's living area was shut, and the door left open so staff members could monitor (VH). However, no specific staff member was allocated to observe (VH) at this time or stay with the deceased's body to ensure it wasn't further disturbed. Ms Endo instructed the other staff members not to enter the room and not to clean (VH) or Mr Durr until further instructed. Ms Endo and Dr Webber then returned to the reception area in H wing. At about 8.39 am, Ms Endo was in the H wing reception area when she received a phone call from CALMS who instructed her to contact the Police.” (Transcript 4<sup>th</sup> May 2015 pp. 35 – 36)*

### **Mary Faulkner’s injuries**

17. Prior to the arrival of the Police, staff conducted their normal duties.

*“About 8.45 am, Ms Tichivangana went to room 48 to shower and change Mrs Faulkner. Upon entering the room, Ms Tichivangana observed Mrs Faulkner was still in bed, seated with her feet on the floor and her head on a pillow. It appeared to Ms Tichivangana that Mrs Faulkner was crying and attempting to get out of bed. Ms Tichivangana assisted Mrs Faulkner out of bed and collected the items she needed to change Mrs Faulkner. After Mrs Faulkner was mobile, she attempted to leave the room and told Ms Tichivangana, "I want to get out of this place because a man came and hit me. Call the Police." Ms Tichivangana attributed Mrs Faulkner's comments to her dementia. She assured Mrs Faulkner that she would contact the Police, but only after Mrs Faulkner allowed her to dress her as per their daily routine. Mrs Faulkner moved away from her living area and allowed Ms Tichivangana to dress her in her empty bed space in room 48. Ms Tichivangana couldn't recall if there was another resident in room 48 at the time she dressed Mrs Faulkner, but stated if so, there would have only been one of the other residents of room 48 present. Ms Tichivangana observed that Mrs Faulkner had little red spots on one of her cheeks. Originally Ms Tichivangana thought the spots were some sort of rash. Whilst changing Mrs Faulkner, Ms Tichivangana noticed she wasn't as resistive to care as she would normally be. After changing Mrs Faulkner, Ms Tichivangana escorted her to the main dining area and gave her breakfast. (Transcript 4<sup>th</sup> May 2015 pp. 36 – 37)*

### **Discovery of Maureen Magliulo’s injuries**

18. *“About 9.20 am, after observing the Police arrive at C wing, .... Mr Yappa instructed Ms Tichivangana to attend to Mrs Magliulo with Preunka Preunka, another AIN who was due to attend C wing later that day. Ms Tichivangana obtained several towels from the room opposite room 46 in preparation for attending to Mrs Magliulo and proceeded directly to her room. Upon entering her room, Ms Tichivangana initially thought there was no-one in the room. She observed the top half of Mrs Magliulo's bed was still partially upright, most likely*

*from when she had been fed breakfast some time beforehand. The doona cover was pulled all the way up to the bedhead. Ms Tichivangana pulled back the top of the doona cover located closest to the bedhead and observed a pillow which she removed. Directly underneath the pillow she observed Mrs Magliulo's head. Ms Tichivangana observed that Mrs Magliulo's nose was red, and there was blood around her nose. The pillow that had been removed from Mrs Magliulo's face was also blood-stained around the middle of the surface that had been in contact with Mrs Magliulo's face. The slippers usually worn by Mrs Magliulo were located on the bed, on the top half of the bed on the edge closest to the room entrance, and they were described by Ms Tichivangana as sprinkles of blood on the interior surface of the curtain extending across the sliding glass door of the room. These were located furthest away from the opening to the sliding glass door. Ms Tichivangana later stated to the Police that upon seeing Ms Magliulo's face, the first thing that came to her mind was what had occurred to the deceased. At this time she ran out of the room to obtain assistance from Mrs Scott. About the same time, Ms Preunka attended C wing and spoke to Mr Joseph who informed her what had happened to the deceased. Ms Preunka thought C wing staff seemed busy, and therefore went to each of the rooms in C wing to check on the residents. She first went into Mrs Magliulo's room and observed Mrs Magliulo lying in bed with dried blood on her face, nose, cheeks, and around her mouth. Ms Preunka also saw blood on the sheets and pillowcases on her bed. Ms Preunka left the room to notify Mrs Scott of Mrs Magliulo's injuries. Mrs Scott attended room 46, and after seeing Mrs Magliulo's injuries instructed Ms Tichivangana to remain in room 46 while she notified Mrs Hart. A short time later, Mrs Scott returned with Mrs Hart, Mrs Costuna, members of ACTAS, Acting Sergeant Chichi, Constable Gamara, and Constable Eliades. Mr Arneman commenced an assessment of Mrs Magliulo's condition and observed blood around her nostrils and on her right upper lip. He also noted blood spatter on her bed head and on the curtain behind Mrs Magliulo's bed. Mr Arneman found that Mrs Magliulo was breathing and that her airway was clear, also that she had a level of consciousness consistent with her normal status and was normal in his other observations. Ms Chichi then (indistinct) with Mrs Magliulo until the conclusion of her shift that day, at 3 pm that day. Ms Chichi then gave (indistinct) to the Police she hadn't seen any other residents in room 46 or 48 that morning, other than the specific residents who resided in each room. At 9.35 am, Constable Gamara cordoned room 46 as a crime scene and commenced a guard outside the room. He requested that Ms Chichi (indistinct) in the room with Mrs Magliulo to provide any care she needed. Acting Sergeant Chichi left the room and had a conversation with Mrs Costuna, during which he requested that she conduct a welfare check of all senior residents.” (Transcript 4<sup>th</sup> May 2015 pp. 45 - 46)*

### **Welfare checks on other residents**

19. No staff member was allocated to supervise VH or to monitor Mr McCulloch to ensure there were no unnecessary intrusions. No welfare check of residents was conducted following the assaults on two residents despite the directions of Acting Sergeant Chichi to Ms Costuna. *“Ms Endo and Ms Tichivangana were not aware of any welfare check conducted on the residents after the assaults had occurred on the morning of 21 January, despite the instruction by Acting Sergeant Chichi to Ms Costuna to conduct a welfare check on all residents in C wing. Between about 9.30am and 10am Ms Endo attended Ms Faulkner's room to check her blood glucose levels and administer medication. At this time she'd been informed about the injury sustained by Ms Magliulo. Upon entering Ms Faulkner's room and greeting her, Ms Endo received no response, which was unusual for Ms Faulkner who was generally either happy or angry with little variation from these moods. Ms Endo observed bruising on Ms Faulkner's face. She could see what looked like a pressure bruise, multiple small purple dots. Ms Endo notified Ms Hart about Ms Faulkner's injuries. At some point in the morning after Ms Magliulo's injuries had been detected, Ms Preunka observed Mr Durr standing in the north-south corridor near room 44. She saw that Mr Durr had bruising round his left eye. Mr Durr asked her for a cardigan, however she was unable to obtain one for him because the Police wouldn't allow her into room 43. Ms Preunka took Mr Durr outside to the courtyard of the sitting room, adjacent to the nurse's station. At the time Ms Preunka thought Mr Durr seemed quite aggressive, shouting, "Bloody bastard, hitting everyone, bang, bang, bang. He grabbed my neck, doing this to everyone." From about 10.10am onward, numerous members of criminal investigations attended Jindalee and took carriage of the incident from Acting Sergeant Chichi. About 11.03am Mr Antony McCulloch again contacted Jindalee to ascertain further information about his father's death.”* (Transcript 4<sup>th</sup> May 2015 pp. 49 - 50)

### **Investigation into Mr McCulloch's death**

20. Sergeant Casey gave evidence that the Police undertook a thorough forensic investigation into the death of Mr McCulloch and assaults of the other residents. Forensic procedures that were carried out on VH and John Durr, each of those individuals being suspects with VH suspected of causing injury to the deceased. Each individual was assessed by the forensic medical officer, who deemed that they were incapable of providing consent to take part in forensic procedures. As a result, Sergeant Casey determined it was necessary to obtain an interim forensic procedure order. As a result she contacted Coroner Dingwall who was the magistrate on call at the time and sought to make that application. She made an application to obtain photographs, swabs and fingernail scrapings from both of the men, and that was

carried out at City Police Station in the presence of their family members, and also support people as well.

21. Sergeant Casey noted that various swabs were taken from VH's left hand, palm and inner arm. All contained mixed DNA profiles. The alleles in these samples accounted (variously) for VH, Mr Durr, Mrs Magliulo and the deceased however the mixture is too complex to perform statistical calculations.
22. Sergeant Casey noted that fingernail scrapings were taken from VH's left and right hands also all contained a mixed DNA profile, the alleles in this sample could be accounted for by VH and the deceased. However the mixture was too complex to perform statistical calculations.
23. Swabs taken from VH's inner right arm contained mixed DNA profiles. VH could not be excluded as the major contributor and Mr Durr could not be excluded as the minor contributor.
24. The swab taken from VH's watch (worn on his left wrist) contained a mixed DNA profile. VH, Mr Durr and the deceased could not be excluded as contributors to this profile.
25. The swabs taken from the bloodstained pink pillowcases found covering Mrs Magliulo's face detected a male DNA profile. VH, Mr Durr and the deceased could not be excluded as the source of this profile.
26. The swabs taken from the tracksuit pants seized from VH on the morning of the deceased's death contained a mixed DNA profile. The alleles in this profile could be accounted for by VH and the deceased. However the mixture was too complex to perform statistical calculations.
27. Sergeant Casey determined that these findings are more significant because the deceased had been at JACR for less than 24 hours at the time of his death and, therefore, it is less likely to be explained by VH having incidental contact with the deceased by virtue of them residing in the same room.

28. Ultimately, the mixture of DNA profile obtained from the various forensic procedures was too complex to perform statistical calculations. Given the lack of capacity to consent, consequent upon VH suffering from dementia, no criminal charges were laid.

### **Cause of death**

29. Sergeant Casey gave evidence that *“Dr Parsons found the deceased's death to be attributable to blunt head and neck trauma. Her report details significant injuries to the deceased's face, head, and neck area. During the post-mortem several pieces of a substance which appear to be a paper napkin were observed in the deceased's mouth and airways. Dr Parsons stated the significance of these foreign items in the upper airway and multiple areas of bruising in the neck and hyoid are difficult to explain. She found that given the deceased's emphysema, a degree of neck compression and upper airway obstruction could not be excluded as contributing to his death”*.
30. Sergeant Casey noted that *“Dr David Griffiths also attended the post-mortem examination to provide an opinion on the injuries sustained in the deceased's oral cavities. Dr Griffiths found significant traumatic injuries to the dentition and associated soft tissues which appear to have occurred peri-mortem, and were consistent with a blow to the left side of the deceased's face.”*<sup>9</sup>

### **Previous incidents**

31. Sergeant Casey discussed the management of residents in Jindalee in particular the frequency of assaults occurring in Jindalee. She noted that there were a number of previous incidents and said *“During the investigation regarding this matter, the serving resident relative incident reports were reviewed. Most relate to falls and minor altercations between residents. The points of interest are summarised below. On 7 December, Mr Durr grabbed a female resident and pulled her wheelie walker away from her. Staff intervened and diverted both residents away from each other. Mr Durr the pushed out at staff and displayed verbal aggression. On 28 December 2011, staff were advised by Mrs Faulkner's roommate that she had fallen. Mrs Faulkner was subsequently found by staff on the floor of her bedroom at the foot of her bed. As a result, Mrs Faulkner sustained a laceration to her left eyebrow. On the two occasion on 13 January 2012, (VH) attempted to abscond from the facility. On the first occasion in the resident reports say (VH) pushed a flyscreen out of room 45 and then climbed out of a window. On the second occasion, staff in H wing alerted C wing staff when they observed (VH) in the courtyard outside C wing on the H wing side of the fence. (VH)*

---

<sup>9</sup> Transcript 4<sup>th</sup> May 2015 at pp.62 - 63

*had used a chair to jump the fence bordering the C wing courtyard. (VH) then returned to C wing with staff on both occasions, however during his second attempt to abscond from the facilities, he sustained a small graze to his right arm. As a result of these incidents, a surveillance chart was introduced, and a tracker belt ordered through Red Cross for (VH). (VH) wore the tracker belt for a short time, but it wasn't in use on 21 January 2012 because he always took it off. Witness statements were obtained from staff regarding this incident.”<sup>10</sup>*

32. A further incident is recorded by Sergeant Casey "About 6.45 pm on 18 January 2012 staff member, James Lukos heard a door slam in room 43. He attended the room and observed Mr Durr pacing and holding his throat. Mr Durr stated, 'He punched me and grabbed my throat.' Mr Lukos conducted a cross-examination of Mr Durr and noted no marks on his face, body or neck. (VH) was in his area of the room at the time and appeared to be laughing. It appears from the comments recorded on this form that an incident report was not filled out at the time of the incident. The form was signed off by Mrs Costuna on 24 January 2012. About 7.30 pm on 18 January 2012 Mr Durr approached staff member, Wah Sheehan, and asked for protection from (VH). As this was occurring (VH) suddenly punched Mr Durr, connecting with Mr Durr's left jaw. This occurred directly in front of Ms Sheehan. The parties were separated by staff. It was recorded in the incident that Mr Durr was distressed about the behaviour of (VH) and didn't want to return to his room. [Mr Durr had approached a member of staff and asked for protection though it appears this information was not conveyed to all members of staff]. The incident stated that (VH) denied the behaviour but demonstrated evidence of being territorial.<sup>11</sup> Information was also obtained that VH was seen on 18<sup>th</sup> January 2012 to "shape up" in a boxing stance to staff entering his room. On 19<sup>th</sup> January 2012 Mr Durr had reported to staff that he had slept in the lounge room and had been there most of the next day as he was so frightened of VH. Following the assault by VH on Mr Durr on 21<sup>st</sup> January 2012 Mr Durr had reported to family members that "VH had attempted to strangle him as he awoke and had punched him numerous times. Mr Durr had sustained bruising and a laceration on his left cheek.<sup>12</sup> Sergeant Casey noted that a number of other assaults occurred between residents after the death of Mr McCulloch. Incidents reports had been recorded on those occasions.

---

<sup>10</sup> Transcript 4<sup>th</sup> May 2015 at pp.69 - 70

<sup>11</sup> Transcript 4<sup>th</sup> May 2015 at pp.71 – 72

<sup>12</sup> Statement of Sergeant Casey dated 13<sup>th</sup> August 2013 at pp. 161 summarising statements from other staff who had witnessed VH's aggressive behaviour

33. Sergeant Casey noted that when she interviewed Ms Costuna,<sup>13</sup> she had said that JACR takes residents that other people can't manage. Most of the staff who work in C Wing have a minimum training to Certificate III Aged Care level (this was NOT the case – see below).
34. Further, Ms Costuna said that staff are regularly assaulted by the residents particularly when staff are assisting a resident with personal hygiene. However, measures are put in place to reduce assaults occurring (*there was no procedure in any policy manual for dealing with residents in this respect*). She was not aware of any incidents of the staff assaulting the residents in the facility. If this were to occur, the Police would be contacted and the matter reported to the Department of Health and Aging as it comes under mandatory reporting. Concern was raised regarding VH's "territorialness" between herself and the clinical nurse consultant. However, it was decided not to change VH's bed as there was a concern he would continually return to bed 43C, thinking it was his (*It appears that (VH) was unaware where his bed was and asked RN Endo to direct him to his room following breakfast on 21<sup>st</sup> January 2012*).

### **Record keeping**

35. Sergeant Casey noted that on 25 January 2012, a section 194 *Crimes Act* 1900 search warrant was executed at Jindalee. Most documents seized were maintained in paper files (see Exhibits 68 to 93). These included "*manila folders for client records, a document labelled 20th, 21st, and 22nd; a Jindalee floor plan document; a document titled Procedures for Raising Workplace Health and Safety Issues; a document titled Jindalee Aged Care Resident Policy and Processes Manual; the Jindalee fire evacuation procedures; the Jindalee weekly cleaning duty schedule; the June 2012 resident relative incident reports; the December 2011 resident relative incident reports; November 2011 resident relative incident reports; the Jindalee emergency procedures manual; excerpts from the Hoya wing DONs book; excerpts from the Jarrah wing DONs book; excerpts from the Grevillea wing DONs book; excerpts from the Banksia wing DONs book; excerpts from the Acacia wing DONs book; and Acacia wing duty statement.*"<sup>14</sup> A clinical data base was also in existence. There was no record keeping "system" in place at the time of Mr McCulloch's death. Jindalee's record keeping appeared to be ad hoc (both as to filing and completion of records) and uncoordinated with documents located in the back of the nurses diary, incomplete individual plans for residents

---

<sup>13</sup> Statement of Sergeant Casey dated 13<sup>th</sup> August 2013 at pp. 105

<sup>14</sup> Transcript 4<sup>th</sup> May 2015 at pp.69 - 70

contained in manila folders, incident reports not completed, a lack of co-ordination between incident reports and entries in the DON's book, and incomplete medication charts.

### **C Wing DON's book (Exhibit 91)**

36. Sergeant Casey had the opportunity of inspecting the C Wing's Don's book shortly after Mr McCulloch's death. She recorded: *"A review of the C wing DON's book was conducted with the following points of interest identified. On 1 December 2011 Mr Durr was admitted as a new resident to Jindalee. It was further noted he was on Warfarin at the time, believed to a blood thinner. On 19 December 2011 Mr Durr was taken home by his family members for two weeks social leave. On 20 December 2011 Mrs Faulkner had a fall. On 26 December 2011 Mr Durr was returned to the facility as his family were unable to manage his care. On 13 January 2012 (VH) was admitted as a new resident to Jindalee and assigned bed 43C.*
37. *There are further 5 notations about his two attempts at absconding from the facility that day. On 14 January 2012 it was reported that (VH) hadn't made any attempts to abscond from the facility and a surveillance chart would be continued. On 18 January 2012 it was noted that an incident form had been completed regarding an incident involving aggression between (VH) and Mr Durr with no injuries noted. The following day Mr Durr's son was notified, however, (VH)'s daughter could not be contacted for notification. On 19 January 2012 Mr Beleski was admitted as a new resident to Jindalee and assigned bed 40C. On 20 January 2012 the deceased was admitted as a new resident to Jindalee and assigned bed 43A. On 21 January 2012 it was noted that an incident report was completed regarding physical aggression between (VH) and Mr Durr.*
38. *There was a further notation on this day thanking staff members for their assistance regarding the deceased's death and request that staff members not speak to members of the public about what occurred as it was now a Police investigation. There is a further notation on this date from Mrs Scott stating, 'Under no circumstances can Mr John Durr or (VH) return to Jindalee Aged Care Facility without authorisation from Mr Gary Johnson'".<sup>15</sup>*

### **Jindalee Nursing Emergency Procedures Manual (Exhibit 85)**

39. Sergeant Casey gave evidence that the Police had seized the Jindalee Emergency Procedures Manual.<sup>16</sup> In her statement she noted the following:

---

<sup>15</sup> Transcript 4<sup>th</sup> May 2015 pp.72 – 73

<sup>16</sup> Statement of Sergeant Casey dated 13<sup>th</sup> August 2013 at para 234 – 237 at pp. 84 - 90

[235] the document contained no response to a deceased person located within the residence in suspicious or non - suspicious circumstances. The response to a 'medical threat' details procedures such as CPR and obtaining medical assistance;

In relation to 5.1.2. Discharge – under discharge there were no procedures in place at Jindalee that stipulate the procedure in the event of a death occurring in suspicious circumstances;

7.2.1 First Aid – there was an entry in the procedures for administering first aid but no direction with respect to severe injury to a resident. [*No first aid was administered to the deceased (or any attempt to check for vital signs) or further action undertaken by Jindalee staff upon finding the deceased as staff assumed he was dead*];

7.3 Emergencies – under emergencies there is no mention of the procedure involved in a suspicious death;

7.5 Security – under security there is no procedure for considering the involvement of persons not residing at Jindalee or employed there in the event of a death;

[237] Police attempted to obtain a log of the emergency call system within C wing for 21<sup>st</sup> January 2012. There had been a failure in the system (Acetek) and Police were unable to obtain a print out of data of all emergency activations within C wing.

40. Sergeant Casey was asked whether there was any protocol or procedure in the manual for a person to be "specialled" and she responded "*Not that I can recall, your Honour.*" Further questions were asked of Sergeant Casey:

*"Q. So no written indication as to what "specialled" meant or what requirements are supposed to be undertaken when someone is specialled?"*

*A. Not that I can recall, but it may be in there but I can't recall anything like that.*

*Q. In respect of the notation that someone was put on a surveillance chart, did you find anything in the emergency procedures manual or in the resident's protocols or procedures about what a staff member is required to do in respect of a person being placed on a surveillance chart?"*

*A. I don't recall. There may have been something under the missing persons part of one of the policies and procedures manuals but I can't recall at the moment, I'm sorry."*

*Q. You've indicated you've reviewed the Jindalee Nursing Home emergency procedures manual as it then was provided to you?*

*A. Yes.*

*Q. Was there any emergency procedure with respect to persons who had suffered a suspicious death?*

*A. No, there was not.*

*Q. Was there any emergency procedure set out for when it is suspected that a person has been killed?*

*A. No, there is not.*"<sup>17</sup>

#### **Jindalee Aged Care residents protocol (Exhibit 79)**

41. Sergeant Casey noted that Police had seized a copy of the Jindalee Aged Care residents protocol.<sup>18</sup> Sergeant Casey sought clarification whether this protocol was in place on 21<sup>st</sup> January 2012 and Ms Costuna said: *"it is noted that there are no notes in Mr Durr's JACR file which indicate his GP was informed of the assault on him that occurred on 18<sup>th</sup> January 2012. The incident forms had 'inform the GP' on them prior to the incident. It is up to the RN to inform the doctor as she sees it necessary. We did reinforce that the doctor should be notified depending on the severity circumstances of the incident after Mr McCulloch's demise..."* Sergeant Casey noted that under the protocol there was a reference to death of a resident in circumstances that warrant investigation by the Coroner for example death from a fall within specifications from the ACT Coroner, post - surgery or suspicious circumstances. In the first instance the Police are contacted if you suspect a coroner's case they will give directives. Sergeant Casey raised a concern that notwithstanding this entry in the protocol there was a delay in contacting Police to attend JACR despite the deceased's death obviously being a Coroner's case. She was asked:

*"Q. was there anything in that particular document which would indicate what staff are supposed to do in circumstances where there's a suspicious death?"*

*A. Yes. There was a notation in relation to coroner's cases. ....I have made a notation under that: This entry is considered of interest due to the delay in contacting Police to attend Jindalee despite the deceased's death obviously being a coroner's case. The deceased was originally found by Jindalee staff about 8 am and ACT policing was not contacted till 8.53*

---

<sup>17</sup> Transcript 4<sup>th</sup> May 2015 at pp. 74

<sup>18</sup> Statement of Sergeant Casey dated 13<sup>th</sup> August 2013 at para 239 at pp. 91 - 92

*am. In this time frame the deceased's body was left unattended and numerous Jindalee staff entered the deceased's room to make unnecessary observations of this body.*

*Q. Do you understand that there was a specific direction made of Nurse Endo by a director not to contact Police?*

*A. That's correct.*

*Q. Do you know when Ms Endo was required not to contact Police? Do you know about what time?*

*A. No, the original phone call that Ms Endo made to Ms Costuna was at 8.03 am and she said during her re - enactment that she wanted to contact the Police and she was told not to because no-one had seen what had occurred and therefore it couldn't be ascertained what had happened despite Ms Endo informing Ms Costuna that she thought that (VH) had killed the deceased and to contact the doctor to attend.”<sup>19</sup>*

### **Suspicious deaths**

42. Sergeant Casey stated that she had conducted a taped record of conversation with Ms Costuna and that she (Ms Costuna) had confirmed there was “*no procedure at the facility at the time for dealing with suspicious death and that that procedure came under mandatory reporting.*” She was asked:

*“Q. Do you know what that was, the mandatory reporting that they were required to undertake?*

*A. I believe that's a mandatory reporting required by the Aged Care Complaints Scheme. Q. Do you know whether that was ever done?*

*A. In relation to this death? Yes, it was, then the Aged Care Complaints Scheme came out and did an accounted site visit.”*

Sergeant Casey noted that in her statement Ms Costuna had indicated a doctor would always be involved when a death has occurred, and in the case of the deceased's death, Jindalee's response also included the Police, the deceased's family.

---

<sup>19</sup> Transcript 4<sup>th</sup> May 2015 at pp. 74 - 75

## JACR Policies and Procedures

43. Sergeant Casey conducted a record of conversation with Pam Bondfield on 23<sup>rd</sup> January 2012 in relation to the Jindalee policies and procedures (Exhibit 78 and 79). These details are set out in Sergeant Casey's statement of 13<sup>th</sup> August 2013 at [240] pp.94 – 108. Some matters of significance noted by Sergeant Casey were as follows:

- There is no procedure for locking down the facility at night, it is the responsibility of the evening nurse how this is done (*this is contrary to the procedure regarding Security as outlined in the Policy and Procedures Manual*);
- There is no record maintained of when the doors are locked or unlocked;
- C Wing is the Dementia Wing specifically designed for persons with dementia in that it is a secure enclosed unit to reduce wandering;
- Overnight the doors to resident's rooms are usually open or partially open due to the need to check on residents overnight when checks are conducted by staff (*there is no facility to lock bedroom doors within C Wing*);
- The accommodation (then) provided for 148 residents and at the time there were 146 residents;
- Jindalee seeks assistance for their dementia residents from the Dementia Behaviour Management Advisory Service (DBMAS) who specialise in behavioural management of dementia issues;
- There is no CCTV footage in A, B, C, or J Wings.;
- Residents are monitored based on individual requirements for example if a resident is a "falls risk" or if the resident is a flight risk a surveillance chart will be introduced to monitor the resident's behaviour (usually 15 to 30 minute intervals);
- Surveillance forms don't have to actually be filled out at each assigned interval. However, they must be able to show that they have observed the resident at each allocated interval;
- If a resident requires surveillance chart it is recorded in their individual care plan and there is no JACR guideline encompassing use of surveillance charts in relation to residents;
- Individual care plans were developed for each resident so that their behavioural issues were addressed. These were usually not drafted until after the first week of a resident's stay at the facility to allow a number of behavioural assessments to be carried out;
- There is a summary on the front page of each individual care plan so that carers can see at a glance what assistance is required by that person;
- The care plans are reviewed every two months'

- There are invisabeams throughout the residence but these are not used in C wing due to residents often breaking them ;
- There is an alarm in room 46 which can be switched on and off...staff have not been vigilant about using the alarm since 2011;
- Doctors visits are recorded in the residents individual file and noted in the DONS book if a doctor attends to see a practitioner;
- The admission process to JACR is the same as the 5 step plan used by other aged care residences. (*Ms Bondfield was unable to explain that process but knew that prospective residents needed to have an ACAT assessment and be deemed to require high care*);
- There is a clinical database where information is recorded about a resident by a staff member who knows them quite well;
- Ms Bondfield noted that on admission residents usually see a doctor. Mr McCulloch did not see a doctor as *“he was admitted on Friday”* and it was difficult to get a doctor to come to the facility to visit residents upon admission;
- Also during admission a resident is checked fully for bruises, cuts etc which are recorded. She was unsure whether this occurred on this occasion;
- They assisted DBMAS in managing Mr Durr’s behaviour but this had recently ceased.

### **Surveillance**

44. In relation to surveillance, Sergeant Casey said: *“What I understand that to mean is that the person filling out the surveillance chart has to witness the person under surveillance at each interval, however, they don't have to physically fill out the chart in each interval.*

She was asked:

*Q. At this next dot point you say, “If a resident requires a surveillance chart, it is recorded in their individual care plan”. Did you sight any individual care plan for Mr Charles McCulloch?*

*A. No, I did not.*

45. Evidence of some of the witnesses tasked with completing surveillance charts revealed that the charts are not completed at the time a resident is observed and some charts were falsified (i.e. completed when the resident had not been observed and completed by a staff member on behalf of another) (see below).

### **Individual care plans**

46. Sergeant Casey was asked about the individual care plan for Mr McCulloch. She was asked:

*Q. Was there one in existence?*

*A. I don't believe there was. It's my understanding*

*that - I have different information, but from the aged care department they say*

*that it takes between four and six weeks for a care plan to be come up with and*

*Jindalee say different periods of time as well but more in the matter of weeks*

*as opposed to days for the care plan to be formulated.*

*Q. Were you given a copy of any individual care plan for any resident there on or*

*before 21 January 2012?*

*A. We don't have one in relation to (VH) and Mr McCulloch. In relation to the records we have Mrs Magliulo, Mrs Faulkner and Mr Durr. I don't recall seeing them but it may be worth me going through the records to check that."*

### **Admission**

47. Sergeant Casey confirmed there were admission notes for Mr McCulloch but could not recall if it reflected any 5 step plan. Ms Bondfield was unable to state what the 5 step plan involved. In addition Ms Costuna advised that Jindalee did not accept admissions on Friday (without explaining why) though Mr McCulloch was "admitted" on the Friday. However, his bags remained unpacked at the time of his death.

### **Anthony McCulloch**

48. Mr Anthony McCulloch is the son of Mr Charles McCulloch. He participated in a record of conversation on 21<sup>st</sup> January 2012 (Exhibit 61). He gave a detailed history of his father's life and the circumstances in which he found himself in Jindalee. Anthony McCulloch noted that his father was "born on 5 February 1917 in the Riverina area of New South Wales and married Kathleen Estelle Davidson in 1938. He fathered a son, Anthony, in 1939 when he was working as a pharmacist in Sydney. In the following years he moved around New South Wales and continued working as a pharmacist in Narromine and Newcastle. In March 1972, he underwent surgery at the Royal North Shore Hospital of Sydney where he had an acoustic neuroma, a slow-growing tumour of the nerve that connects the ear and the brain, removed.

*The tumour was found to be non-malignant, but it did result in a marked droop to the right side of his face thereafter. He continued working for a short time in New South Wales as a pharmacist, but then moved to Foster where he retired. His father was very upset when his wife passed away in about 1998, but continued to live alone in his residence in Foster.*

49. *The first signs of his father's dementia occurred when his father called him to say he was very disturbed that he no longer worried about his wife's death. He was concerned about his lack of concern regarding his wife's death may be an early indication of dementia. Mr Anthony McCulloch estimated that this phone call occurred some time between 2005 and 2007. Mr McCulloch later stated that the his father managed to cope at home by himself for some time after this phone call, including walking to the local shops each day to purchase groceries.*
50. *On 9 August 2011, his father was walking back from the local shops and fell over on the footpath, resulting in abrasions to his nose and his right hand. He was assisted by someone nearby, who called an ambulance due to his facial injuries. He reportedly had little recollection of how the fall had occurred and appeared confused. He was conveyed to the Manning Base Hospital, where he was admitted for observation. Reports were obtained from the Mr McCulloch's neighbours and his son, who both indicated they believed he wasn't managing by himself at home. He was assessed by a geriatrician, who recommended a placement in an aged care facility. Mr Anthony McCulloch said that his father was extremely unhappy at being made to stay at the hospital and desperately wanted to return home. It is noted on several occasions that his father was missing from the ward. On one occasion he was located at a nearby medical centre, and on another at a community health building. There are also numerous reports of the his father refusing care and food offered by staff, and also becoming verbally and physically aggressive towards staff members.*
51. *On 1 September 2011 his father was discharged from the Manning Base Hospital to Kularoo Gardens Nursing Home in Forster. The staff at Kularoo Gardens noted numerous behavioural issues with the deceased whilst he resided at the facility, including: wandering around his room and the facility, usually during the night; emptying a water jug on the floor; moving furniture around the dining room; knocking on other residents' doors during the night; removing clothing and getting into bed with a female resident; verbally threatening staff; following other residents into their room; hitting out at staff members; entering other residents' rooms and removing their property; taking walking aids away from female residents; and leaving taps running in the bathroom, resulting in large pools of water on the floor. As a result, Kularoo Gardens requested assistance from the Transitional Behavioural*

*Assessment and Intervention Service, known as T-BASIS, at a unit in Wingham, which is part of the mental health services of the older person in New South Wales, and addresses the behavioural problems of residents in nursing homes in the area. This unit has a geriatrician, psychiatrist, a dementia behaviours management service nurse - known as a DBMS nurse - to assist with residents.*

52. *After intervention and management of the resident's behavioural issues are completed, the resident is discharged back to their original nursing home. The T-BASIS unit has a maximum of 16 residents at any one time, each housed in individual rooms. There is a registered nurse on duty at all times with an additional three staff until 9 pm, and then an additional staff member until the commencement of day shift. In addition, the nurse manager, Dawn Matters, is rostered on during the day. On 19 September the deceased was transferred from Kularoo Gardens to the T-BASIS unit known as Riverview Lodge in Wingham, in an attempt to address his problematic behaviours.*
53. *Upon arrival at Riverview Lodge, his father exhibited some of the problems noted at Kularoo Gardens, including: wandering during the night and knocking on the doors of other residents; moving furniture; stripping off his clothes in public areas; and deliberately pouring fluid on the floor. During this stint in Riverview Lodge, he seemed to be quite mobile. There are several reports of him walking around the ward without assistance, and walking in the garden. There are also numerous notations indicating that he tended to wander around the ward, kitchen area and garden until exhausted. When this occurred, he was encouraged to rest by staff. As his time at Riverview continued, there are notes recorded of him experiencing several falls, and the staff using a Pelican belt to take the deceased for a walk. A Pelican belt is a length of fairly wide material worn around the waist of a person needing assistance. The belt has canvas straps attached to it and allows carers better control of their subject.*
54. *On 31 October 2011 it was determined there was no further need for the deceased to be housed at Riverview Lodge. It was decided that due to his now-limited mobility, the problems for which he was admitted to the T-BASIS for were significantly diminished. He was discharged back to Kularoo Gardens on 3 November 2011.*
55. *Upon returning to Kularoo Gardens, a decline in his mobility was noted in his progress notes. Mr McCulloch remained at Kularoo Gardens but exhibited similar behavioural issues as experienced during his initial stay there, including: being resistant to care; grabbing out at staff inappropriately; regularly entering the rooms of female residents and frightening*

*them; and becoming verbally and physically aggressive towards staff. He was originally sent back to Riverview Lodge for assessment. However, after consultation between the two care providers, it was noted he required the permanent use of leg slider restraints, which were not used at Kularoo Gardens. It was also believed that the amount of activity at Kularoo Gardens was too stimulating for him, and a smaller and much quieter unit at Riverview Lodge was more suited to him. It was determined he would be transferred back to Riverview Lodge as at 18 November 2011, with a longer-term plan of Mr McCulloch finding his father appropriate accommodation in Canberra. Mr McCulloch was formally discharged from Kularoo Gardens by Mr McCulloch on 20 December 2011.*

56. *After returning to Riverview Lodge, Mr McCulloch again displayed problematic behaviour, such as refusing to eat and accept care from staff, and also being verbally abusive towards staff. His progress notes also detail that his mobility has declined since last being at Riverview Lodge. To reduce the risk of falls, he was regularly restrained using leg sliders to limit his mobility. His limited mobility resulted in many of the other problematic behaviours not occurring.*

57. *On 20 January 2012 Mr McCulloch was transported from Wingham, New South Wales, to Canberra by members of the New South Wales Air Ambulance Service, including Ms Jennifer Gott. Upon arrival at the Canberra Airport he was conveyed to Jindalee by ACT Ambulance members Brett Larkin and Matt Rowlinson. During the Journey he exhibited symptoms of dementia, but was able to engage in conversation. None of the persons involved in Mr McCulloch's care during the transportation noted any facial injuries on him.*"<sup>20</sup>

58. Sergeant Casey said: *"Dawn Matters at the Riverview Lodge, and others noted that the deceased enjoyed company quite a bit, and he would often call out to people to engage them in conversation when they walked past the room or were in the room with him. I point that out because it may have been something that contributed to the altercation with (VH) down the track, but they said that was his tendency to do that."*<sup>21</sup>

### **Concerns raised by the family of other residents**

59. Sergeant Casey reported: *"On 29 February 2012 Detective Senior Constable Kylie Eggins conducted a digital record of conversation with Mr Magliulo in order to obtain some background in relation to Mrs Magliulo (Exhibit 110)"*<sup>22</sup>. *He said they had been married since*

---

<sup>20</sup> Transcript 4<sup>th</sup> May 2016 pp. 63 - 67

<sup>21</sup> Transcript 4<sup>th</sup> May 2016 pp. 67

<sup>22</sup> Transcript 5<sup>th</sup> May 2016 pp. 106 - 107

1969. He observed the early signs of Mrs Magliulo's dementia in 1999. In 2008 she was diagnosed with dementia in hospital. She had been taken there after a violent episode at home and remained in care since that day. Mrs Magliulo was admitted to Jindalee on 18 May 2009. Mrs Magliulo can no longer walk by herself and needs assistance to move around. She can't hold a conversation at all and her communication is like a baby. Mrs Magliulo smiles when she sees him but he doesn't think she recognises who he is. She has bad days when she yells, telling people to, "Eff off," spits, kicks, but she hasn't had one of those days since 21 January 2012. She still has the strength to grip him with her hands sometimes but she can't feed herself at all.

60. On 21 January 2012 the alarm on Mrs Magliulo's room's door wasn't turned on. He was annoyed because Mrs Costuna had told some of the detectives that it had been turned on. He knows the alarm wasn't turned on at the time because the mechanism that controls the alarm had been taken away and therefore it wasn't functional. He felt that if the alarm had been on, it may have alerted staff to someone being in Mrs Magliulo's room and she wouldn't have sustained the injuries that she did.
61. He has walked into Mrs Magliulo's room on many occasions and the door alarm has not been turned on. However, there are now several signs advising the alarm must be turned on when Mrs Magliulo was in the room. Despite the signs now posted, he still walks into Mrs Magliulo's room and the alarm is not turned on. He has also complained in the past because the sliding glass door to Mrs Magliulo's room which opens out onto the courtyard has been left open. He feels this is a security issue because anyone could jump the fence and get into her room.
62. About 8.45 am on 21 January 2012 he phoned Jindalee and spoke with Ms Endo, at this time she told him Mrs Magliulo was fine. About 9.30 am on the same day he received a phone call from Sue Scott from Jindalee and she told him that he needed to come to Jindalee because Mrs Magliulo had a bleeding nose. About 10.10 am he attended Jindalee and saw Police everywhere. He subsequently went to C wing and saw Mrs Magliulo, whilst there were forensic procedures being carried out on her.
63. He has since been contacted by Jindalee asking for his thoughts on the installation of CCTV at Jindalee, and he told them he doesn't have an issue with it. He wishes there was a key

*code for people to enter C wing, similar to the one required to exit the wing because the current arrangements mean that anyone can enter the ward.*

64. Other family members who provided statements to Sergeant Casey and raised concerns included Margaret Anderson (Exhibit 107) Gregory Durr (Exhibit 108) Wayne and Lesley Howden (Exhibit 106) and Violetta Aslimoski (Exhibit 114).

### **Past deaths at Jindalee**

65. Sergeant Casey reported that a search of the deaths attended by Police at Jindalee since 2007 had been carried out. This identified the death of Mr Harry Castlebaum in 2009. Mr Castlebaum had been receiving palliative care at Jindalee and a medical certificate was issued regarding his death after the attendance of Police. Also identified was the death of Ms Ruth Rankin-Gibson-Musson on 1 January 2007, which was later the subject of a coronial inquest hearing held by then Coroner Grant Lalor. A review of Coroner Lalor's findings in relation to Ms Rankin-Gibson-Musson's death showed she was a resident of Jindalee as at 27 December 2006. In the early hours of that morning she was pulled out of her bed, resulting in a hospital admission due to a fractured femur. Ms Rankin-Gibson-Musson later passed away on 1 January 2007, and her death was attributed to bronchopneumonia and multi-organ failure with the antecedent cause being a morbid condition of a fractured femur giving rise to the above cause of death. It is noted in Coroner Lalor's findings that the Deputy Director of Nursing at Jindalee took part in a recorded conversation regarding the use of light beam sensors. It was stated by the Deputy director: *"As we use them for people that have frequent falls so, you know, a big risk of injury, and we also use that for someone who has a behavioural issue about being very territorial around his room site, so therefore that alerts staff if anyone is going into his room, or if he is going out of his room. But generally speaking it's about people falling regularly, which is why we use them"*. It is noted that light beam sensors were not used in (VH)'s living area, despite his noted territorialness.<sup>23</sup>
66. Sergeant Casey noted that Coroner Lalor had made recommendations including that CCTV be installed. She noted that there was a further death currently under investigation by Coroner Boss. That had occurred on 26 August 2012 and involved a gentleman, Alidar Vidak, being found with excessive amounts of alcohol in his system via a toxicology report. The outcome was not known at the time Sergeant Casey gave evidence.

---

<sup>23</sup> Transcript 5<sup>th</sup> May 2015 pp. 129

### **Evidence of Niho (Mimi) Endo**

67. Ms Endo was at the time of Mr McCulloch's death a Registered Nurse (RN) at the Jindalee Aged Care Residence. Ms Endo made a statement dated 21 January 2012 (Exhibit 5) she had participated in a re-enactment of the events of 21<sup>st</sup> January 2012 (Exhibit 6) she had made the Triple 0 call to Police (Exhibit 7) and gave oral evidence on 25 September 2015. She had also participated in a taped record of conversation with Sergeant Sarah Casey on 4 February 2012. In 2012 Ms Endo had been an RN in Australia for 3.5 years, but had been an RN in Japan for more than 11 years before that.<sup>24</sup> In Japan, Ms Endo had worked in a hospital, the first four years as a specialist in a diabetes ward, and then in surgical and ICU wards.<sup>25</sup> Jindalee was Ms Endo's first position as an RN in Australia.<sup>26</sup> Ms Endo's responsibilities at Jindalee included dispensing medication to residents, contact with doctors, giving directions to Assistants in Nursing (AINs), and contact with family members in relation to incidents or changes in medication.<sup>27</sup>
68. On the day and at the time Mr McCulloch died, Ms Endo was the most senior person on shift, as Ms Scott did not commence on weekends until 10:30am, and DONs and Deputy DONs did not then work on weekends.<sup>28</sup> Ms Endo was aware that Mr McCulloch was admitted to Jindalee on the afternoon of 20 January 2012, as she was working that day.<sup>29</sup> Ms Endo was not responsible for Mr McCulloch's admission but did not recall if she had done some of his admission.<sup>30</sup> She was unaware who had charge of VH and Mr McCulloch.<sup>31</sup> There were 4 AINs at work between 7:00am and 7:30am on 21 January 2012 for 31 residents on Casuarina Wing, which is a staff resident ratio of 1:8 rather than the ratio of 1:7 that had been suggested.<sup>32</sup>
69. Ms Endo agreed that mornings were the busiest time on the ward, as residents had to be woken, showered, dressed, medicated and fed.<sup>33</sup> Ms Endo was aware that VH was on medication.<sup>34</sup> She identified VH's personal file (Exhibit 71) as containing all relevant information with respect to VH and stated the file was kept in a

---

<sup>24</sup> Transcript 25.9.15 P3 34-44

<sup>25</sup> Transcript 25.9.15 P4 1-5

<sup>26</sup> Transcript 25.9.15 P4 L13-14

<sup>27</sup> Transcript 25.9.15 P4 L16-40

<sup>28</sup> Transcript 25.9.15 P21 L6-14

<sup>29</sup> Transcript 25.9.15 P8 L8-19

<sup>30</sup> Transcript 25.9.15 P8 L21-23

<sup>31</sup> Transcript 25.9.15 P40 L3-26

<sup>32</sup> Transcript 25.9.15 P67 L36-30, P68 L17-18

<sup>33</sup> Transcript 25.9.15 P67 L32-38, P68 L14-15

<sup>34</sup> Transcript 25.9.15 P8 L32

filing cabinet in the Casuarina Wing nursing station.<sup>35</sup> All RNs and AINS have access to residents' personal files.<sup>36</sup> Ms Endo explained that the primary medication chart in VH's file was used by RNs and ENs to administer medication prescribed by Dr Moulding for VH.<sup>37</sup> She agreed that only one medication chart was located in VH's file, and that Dr Moulding had prescribed Risperidone for VH.<sup>38</sup> She said the effect of Risperidone on VH would be to reduce his aggression behaviour.<sup>39</sup> Ms Endo said that VH used to be on Risperidone at dinner time, and while the medication chart only showed administration of Risperidone on 12 January 2012, she was sure the medication was given but the nurses forgot to sign the medication chart.<sup>40</sup> She stated that she had herself given VH Risperidone in the afternoons but could not provide an explanation why she did not sign the medication chart or why there was no signing sheet.<sup>41</sup> She stated that her practice for dispensing medication was to take the files around with the medication and complete the record then and there, and Risperidone was not a medication which required sign off from two nurses.<sup>42</sup>

70. Ms Endo was asked to comment on the clinical database form in VH's personal file, and said that it was information relating to a new admission to obtain as much relevant information on a resident that as possible.<sup>43</sup> She agreed that Jindalee knew at the time of admitting VH that he could wander, he was territorial, and he could be aggressive at times.<sup>44</sup> She agreed that she would have conveyed this information to other members of staff and AINs, and agreed that VH's Risperidone could have been prescribed to control his aggression.<sup>45</sup> Ms Endo was taken to a document detailing significant life events, where domestic violence was circled, and agreed that Jindalee staff knew VH had a history of domestic violence.<sup>46</sup> She later clarified that she did not recall that VH had a history of domestic violence when she read his notes, but that information could have been added later.<sup>47</sup> She said she had been told a few days before the incident by Rasma, the senior RN, who normally gave Ms Endo handover, that VH was territorial.<sup>48</sup>

---

<sup>35</sup> Transcript 25.9.15 P8 L34-P9 L38

<sup>36</sup> Transcript 25.9.15 P8 L40-44

<sup>37</sup> Transcript 25.9.15 P10 L1-11

<sup>38</sup> Transcript 25.9.15 P10 L13-39, P26 L12-15

<sup>39</sup> Transcript 25.9.15 P11 L36-39

<sup>40</sup> Transcript 25.9.15 P10 L20-P11-15, P26 L16-18

<sup>41</sup> Transcript 25.9.15 P11 L20-32

<sup>42</sup> Transcript 25.9.15 P12 L13-25

<sup>43</sup> Transcript 25.9.15 P31 L20-P32 L6

<sup>44</sup> Transcript 25.9.15 P32 L3-11, P57 L25-38

<sup>45</sup> Transcript 25.9.15 P32 L13-16

<sup>46</sup> Transcript 25.9.15 P32 L18-24

<sup>47</sup> Transcript 25.9.15 P56 L28-36

<sup>48</sup> Transcript 25.9.15 P57 L29-34, P58 L1-2, P60 L42-P61 L3

71. Ms Endo was also aware that VH had been placed on surveillance some time prior to 21 January 2012, because he had tried to abscond from the facility.<sup>49</sup> She located VH's surveillance charts in his personal file (Exhibit 71) and confirmed that VH was on surveillance from 13 January 2012 at 23:30 hours to 23:00 hours on 20 January 2012.<sup>50</sup> She stated that the decision to put a patient on surveillance was made by the RN in consultation with Jindalee management.<sup>51</sup> Surveillance normally required staff to observe the resident every 15 minutes.<sup>52</sup> The charts were kept in the nursing station and staff members did not have the charts with them when providing care to residents.<sup>53</sup> She stated that she considered "ditto marks" to be acceptable practice in filling out surveillance charts.<sup>54</sup> She said that surveillance charts may be filled out either at the time of the observation or sometime later, depending on how busy the staff member is.<sup>55</sup> She initially said that the chart and incident reports should not be filled out at the end of shift, but then agreed that normally this is what is done.<sup>56</sup> She did not agree with the proposition that if VH was being properly surveilled, perhaps Mr McCulloch would have been safe, saying that VH was calm all the time without signs of aggression or agitation, so she could not predict what he would do.<sup>57</sup>
72. Ms Endo was asked to locate and comment on patient progress notes (part of Exhibit 71). She said that the progress notes contained information about the resident which could be shared to other staff, such as the other RNs, AINs and ENs.<sup>58</sup> AINs and RNs would read progress notes where necessary, such as in the event of a new resident or there was an incident report in the DONs book and other changes.<sup>59</sup> She confirmed the progress notes contained details about VH attempting to abscond on two occasions and therefore being put on surveillance.<sup>60</sup> Ms Endo was taken to a note regarding a tracking belt being organised for VH but said she did not know whether VH ever received the belt. She assumed not because it might take some time to arrive.<sup>61</sup> Ms Endo was taken to a progress note dated 18 January

---

<sup>49</sup> Transcript 25.9.15 P22 L6-10, P23 L23-24

<sup>50</sup> Transcript 25.9.15 P22 L37-P23 L3

<sup>51</sup> Transcript 25.9.15 P23 L5-21

<sup>52</sup> Transcript 25.9.15 P24 L19-25

<sup>53</sup> Transcript 25.9.15 P25 L14-22

<sup>54</sup> Transcript 25.9.15 P24 L35-P25 L1

<sup>55</sup> Transcript 25.9.15 P25 L8-28

<sup>56</sup> Transcript 25.9.15 P25 L25-P26 L5, P63 L12-22

<sup>57</sup> Transcript 25.9.15 P61 L5-21

<sup>58</sup> Transcript 25.9.15 P23 L29-34

<sup>59</sup> Transcript 25.9.15 P23 L39-43

<sup>60</sup> Transcript 25.9.15 P24 L1-17

<sup>61</sup> Transcript 25.9.15 P26 L23-P27 L1

2012 in relation to VH attacking Mr Durr in the corridor.<sup>62</sup> Ms Endo agreed that there should have been an incident report in relation to this incident.<sup>63</sup>

73. Ms Endo explained that completed incident reports were kept in a folder in the back of the DONs book for a day, then the CNC considers follow up management and strategy, and then the incident report goes to the DONs tray and is filed in reception.<sup>64</sup> She said that either the staff member who finds the incident or the staff member who is allocated the resident is responsible for writing up the incident report.<sup>65</sup> She agreed that there is often a lot happening on the ward and staff members can be busy, or could be confused about which staff member is to write the report, and that it does happen that incidents occur that are not reported.<sup>66</sup> Staff are expected to attend to personal care of residents first, and write incident reports later from memory.<sup>67</sup> Ms Endo estimated that there would be 1-2 serious incident reports required each day on each wing of the dementia unit.<sup>68</sup>

74. She located two incident reports in relation to 18 January 2012, and was asked to examine the one timed at 1930 hours.<sup>69</sup> She agreed that the details recorded in the incident report appeared to be different from the incident recorded in the progress notes.<sup>70</sup> Ms Endo said that she thought that the incident report and the progress notes recorded the same incident, just expressed differently by different authors.<sup>71</sup> She explained that the abbreviation “ROT” meant Rule of Thumb.<sup>72</sup> She said the outcome of the incident was that staff needed to watch both VH and Mr Durr’s behaviour.<sup>73</sup> Ms Endo was taken to the other note of 18 January, the incident at 2230 hours, and asked to find the incident report that related to that event, but agreed that there was no incident report.<sup>74</sup> Ms Endo was taken to the third incident on 18 January, the incident report signed by Ms Costuna, and agreed that incident was not written up in the notes.<sup>75</sup> Ms Endo was taken to the entry of 18 January 2012 in the DONs book, and she said that it related to the incident report signed by Ms Costuna.<sup>76</sup> She was asked to

---

<sup>62</sup> Transcript 25.9.15 P27 L3-5

<sup>63</sup> Transcript 25.9.15 P27 L7-14

<sup>64</sup> Transcript 25.9.15 P27 L19-P28 L1

<sup>65</sup> Transcript 25.9.15 P64 L11-33

<sup>66</sup> Transcript 25.9.15 P64 L39-P65 L1

<sup>67</sup> Transcript 25.9.15 P65 L4-11

<sup>68</sup> Transcript 25.9.15 P65 L2344

<sup>69</sup> Transcript 25.9.15 P28 L3-13

<sup>70</sup> Transcript 25.9.15 P28 L15-39

<sup>71</sup> Transcript 25.9.15 P28 L41-44

<sup>72</sup> Transcript 25.9.15 P29 L1-7

<sup>73</sup> Transcript 25.9.15 P29 L17-18

<sup>74</sup> Transcript 25.9.15 P29 L27-P30 L6

<sup>75</sup> Transcript 25.9.15 P30 L6-24

<sup>76</sup> Transcript 25.9.15 P51 L15-33

confirm the number of incidents which took place on 18 January 2012 and accepted it was at least two but possibly three separate incidents.<sup>77</sup> Ms Endo was asked for an explanation as to why the surveillance chart was not completed for the period 1645 to 2035 hours on 18 January 2012, and could not go beyond saying someone forgot to do it on a hectic day.<sup>78</sup>

75. Ms Endo was also taken to the incident report for 13 January 2012 in relation to VH absconding.<sup>79</sup> Ms Endo was asked about behaviour management plans with reference to VH's personal file. She identified item 23, page 6 of 8 within Exhibit 71 as the closest thing in existence to a behaviour management plan and a document titled "*Lifestyle Plan Summary*" as the closest thing to an interim care plan.<sup>80</sup> On the latter document, Ms Endo identified the highlighting as likely having been completed by ENs or AINs, and agreed the following items had been highlighted: independent, shower, partial assistance, and diabetic (Ms Endo advised that "NIDDM" meant no insulin diabetic).<sup>81</sup> Ms Endo agreed that while there were also highlights on wandering behaviour and continence, there was no highlight on physical aggression, and she did not know why that item had not been highlighted.<sup>82</sup> She said that this form was normally developed by the CNC the next day, as was completing the resident database.<sup>83</sup> She agreed that there was no procedure, when a CNC obtains information later about a resident, for that information to be passed to staff.<sup>84</sup> She stated that staff are trained in the behaviour of residents and try to pick up signs of agitation or aggression before the behaviour gets worse and to the level of an incident.<sup>85</sup>

76. Ms Endo stated that it was management's decision about which residents are placed in what rooms.<sup>86</sup> She was unaware of any procedure or protocol about how a room was chosen.<sup>87</sup> She said she was unaware that Mr Durr had asked to be moved into another room away from VH, and this matter had never been discussed with her.<sup>88</sup> She agreed that there was a possibility, knowing that VH was territorial, that the arrival of Mr McCulloch as a new resident would possibly disturb VH.<sup>89</sup>

---

<sup>77</sup> Transcript 25.9.15 P51 L16-35

<sup>78</sup> Transcript 25.9.15 P30 L31-P31 L7

<sup>79</sup> Transcript 25.9.15 P31 L9-11

<sup>80</sup> Transcript 25.9.15 P33 L27-P34 L16

<sup>81</sup> Transcript 25.9.15 P34 L13-30

<sup>82</sup> Transcript 25.9.15 P34 L32-38

<sup>83</sup> Transcript 25.9.15 P34 L42-43, P57 L9-12

<sup>84</sup> Transcript 25.9.15 P57 L14-17

<sup>85</sup> Transcript 25.9.15 P63 L37-P64 L1

<sup>86</sup> Transcript 25.9.15 P57 L19-20

<sup>87</sup> Transcript 25.9.15 P57 L22-23

<sup>88</sup> Transcript 25.9.15 P52 L12-22

<sup>89</sup> Transcript 25.9.15 P61 L26-33

77. Ms Endo stated that she had seen residents who died at Jindalee, and the procedure to be followed in those cases was to inform the family and the doctor and to organise the funeral director, all of which was the responsibility of the RN.<sup>90</sup> She said that it was her responsibility to determine if the person had actually died, which she would do by checking pulse and listening to heart to confirm there were no signs of life.<sup>91</sup> The procedure after death was certified was that the deceased would be cleaned and presented nicely for the family, and then the curtain was shut to give the deceased resident privacy.<sup>92</sup>
78. Ms Endo explained that the purpose of the diary (Exhibit 76) is for all carers, including AINs and RNs, to read before commencing duties to ascertain what is to happen that day.<sup>93</sup> All staff are permitted to write in the diary.<sup>94</sup> References in the diary to staff names and numbers were explained as references to shift rosters and resident allocations, and Ms Endo said that the AINs understood the allocations and would check the diary upon starting their shift.<sup>95</sup> She clarified that the AIN would be responsible for their residents no matter where the resident happened to be on the wing.<sup>96</sup> Ms Endo explained that night shift staff don't get allocations, due to the smaller number of staff working as a team, but that morning and afternoon shifts have extra staff and run allocations.<sup>97</sup>
79. Ms Endo stated that the DONs book is similar to the diary, in that it contains information about changes in residents' condition, medication, incident reports, and concerns about residents who engage in physical aggression with each other.<sup>98</sup> Only RNs and ENs are allowed to write in the DONs book, AINs cannot.<sup>99</sup> She identified the entries in the DONs book for 21 January 2012 as having been written firstly by Ms Costuna (the thank you to staff) and then Ms Scott (the instructions that Mr Durr and VH were not to return to Jindalee under any circumstances).<sup>100</sup> The DONs book, together with incident reports, was how important information was passed to staff, as staff might not always look at the patient

---

<sup>90</sup> Transcript 25.9.15 P5 L32-P6 L16

<sup>91</sup> Transcript 25.9.15 P6 L36-40

<sup>92</sup> Transcript 25.9.15 P40 L25-33

<sup>93</sup> Transcript 25.9.15 P48 L30-37

<sup>94</sup> Transcript 25.9.15 P49 L3-5

<sup>95</sup> Transcript 25.9.15 P49 L7-29, P52 L28-P53 L8

<sup>96</sup> Transcript 25.9.15 P53 L10-27

<sup>97</sup> Transcript 25.9.15 P49 L44-P50 L32

<sup>98</sup> Transcript 25.9.15 P50 L44-P51 L6

<sup>99</sup> Transcript 25.9.15 P51 L34-43

<sup>100</sup> Transcript 25.9.15 P51 L40-P52 L10

database if nothing was written in the DONs book.<sup>101</sup> Staff also met at the commencement of shifts to discuss resident care and potential issues that could arise.<sup>102</sup>

## 21<sup>st</sup> January 2012

80. On the morning of 21 January 2012 Ms Endo received a handover from Ms Mathew, the night RN.<sup>103</sup> Ms Mathew had permission from management to end her shift early to go home and look after her children, while her husband Mr Varughese had permission to start his shift late.<sup>104</sup> Ms Mathew may have indicated to Ms Endo that Mr McCulloch was a new resident but Ms Endo did not recall. Ms Endo also did not recall whether Ms Mathew had advised of any administration of medications to residents in Casuarina Wing.<sup>105</sup>

81. At about 7:35 or 7:45am Ms Endo heard Mr Durr saying “*that man again, hit my face*” from room 43.<sup>106</sup> She went to room 43 but did not go in as Mr Joseph and Mr Varughese were already inside.<sup>107</sup> Ms Endo observed Mr Durr was very agitated, with blood coming from his cheek.<sup>108</sup> She agreed with the proposition that part of the problem between Mr Durr and VH was that Mr Durr wandered and VH was territorial.<sup>109</sup> The procedure she adopted then was the procedure whenever she observed a resident was injured, which is to say she asked the AINs to separate the residents and take Mr Durr to another place, and to administer first aid.<sup>110</sup> Mr Durr was heard to say “*that man hit my face again, he punched my face again*”.<sup>111</sup> Ms Endo believed Mr Durr was talking about VH given the incident between Mr Durr and VH a week or so prior.<sup>112</sup> While Ms Endo was standing in the doorway she did not hear either Mr Joseph or Mr Varughese say anything about Mr McCulloch, and she did not enter the room to see.<sup>113</sup> She had not seen Mr McCulloch that day since commencing her shift.<sup>114</sup> Ms Endo took VH to the main dining room but he kept on standing up, she thought because he did not know where he was or why he was there.<sup>115</sup> She said that VH was probably only

---

<sup>101</sup> Transcript 25.9.15 P56 L38-P57 L7

<sup>102</sup> Transcript 25.9.15 P68 L44-P69 L5

<sup>103</sup> Transcript 25.9.15 P7 L35

<sup>104</sup> Transcript 25.9.15 P7 L37-P8 L6

<sup>105</sup> Transcript 25.9.15 P24 L35-P25 L13

<sup>106</sup> Transcript 25.9.15 P15 L1-6, P62 L16-18

<sup>107</sup> Transcript 25.9.15 P20 L20-24

<sup>108</sup> Transcript 25.9.15 P6 L42-P7 L1, P15 L24-26, P16 L20-21, P62 L16-17

<sup>109</sup> Transcript 25.9.15 P57 L40-44

<sup>110</sup> Transcript 25.9.15 P7 L3-13

<sup>111</sup> Transcript 25.9.15 P15 L28-29

<sup>112</sup> Transcript 25.9.15 P15 L31-41

<sup>113</sup> Transcript 25.9.15 P16 L3-8

<sup>114</sup> Transcript 25.9.15 P16 L10-11

<sup>115</sup> Transcript 25.9.15 P16 L13-38

in the dining room eating breakfast for 5-10 minutes.<sup>116</sup> VH was not agitated nor showed any signs of aggression, but he asked to be taken back to his room.<sup>117</sup> She asked Mr Joseph and Mr Varughese to complete an incident report, notwithstanding the incident was first observed by night staff.<sup>118</sup> She agreed that the altercation was quite noisy.<sup>119</sup> She agreed she did not check on Mr McCulloch at that time, and she was not aware that Mr McCulloch was involved in the altercation.<sup>120</sup> She agreed that everyone present assumed that the incident was just between Mr Durr and VH, accepting that Mr Durr had only complained about himself, and saying that she knew Mr Noble was already in the dining room.<sup>121</sup> She accepted Counsel for the McCulloch's family's proposition that it was possible that Mr McCulloch was injured before or during the incident between Mr Durr and VH and he may have been able to receive assistance for up to half an hour.<sup>122</sup>

82. Ms Endo saw VH enter room 43 and then commenced undertaking medication activities.<sup>123</sup> She was unable to say how long she was doing medications before Mr Joseph called her to room 43, but thought it was not more than 10 minutes.<sup>124</sup> When Mr Joseph's timing were explained, Ms Endo agreed that between 7:00am and 8:00am, no one checked on Mr McCulloch, but said that she did not consider that was an unreasonable time to leave Mr McCulloch in bed.<sup>125</sup>

83. Ms Endo stated she was called by Mr Joseph back to room 43, and when she entered she immediately saw blood on the wall.<sup>126</sup> She turned back the quilt and saw Mr McCulloch's face badly injured, she could not see his nose shape, and saw blood on his face.<sup>127</sup> Ms Endo confirmed there was no pillow present over Mr McCulloch's face at that stage.<sup>128</sup> She immediately thought Mr McCulloch's face had been hit.<sup>129</sup> She moved away and screamed.<sup>130</sup> Ms Endo said she did not think about checking Mr McCulloch's vital signs or

---

<sup>116</sup> Transcript 25.9.15 P16 L17-18

<sup>117</sup> Transcript 25.9.15 P16 L20-42

<sup>118</sup> Transcript 25.9.15 P20 L25-30

<sup>119</sup> Transcript 25.9.15 P58 L36-39

<sup>120</sup> Transcript 25.9.15 P58 L41-P59 L3, P67 L18-19

<sup>121</sup> Transcript 25.9.15 P62 L20-33

<sup>122</sup> Transcript 25.9.15 P59 L28-P60 L36

<sup>123</sup> Transcript 25.9.15 P17 L38-39

<sup>124</sup> Transcript 25.9.15 P17 L39-P18 L4

<sup>125</sup> Transcript 25.9.15 P58 L10-34

<sup>126</sup> Transcript 25.9.15 P18 L14-19

<sup>127</sup> Transcript 25.9.15 P18 L14-19

<sup>128</sup> Transcript 25.9.15 P42 L19-23

<sup>129</sup> Transcript 25.9.15 P18 L21-26

<sup>130</sup> Transcript 25.9.15 P18 L28

checking for a pulse, as Mr McCulloch appeared obviously dead to her.<sup>131</sup> **She did not follow the protocol** to check the deceased or call a doctor because she was shocked and really scared, and the last thing she was thinking was to check Mr McCulloch's pulse.<sup>132</sup> She said she was scared of what she saw and Mr McCulloch's face.<sup>133</sup> This was the first time she knew Mr McCulloch was injured.<sup>134</sup>

84. She said she suspected that VH was responsible for Mr McCulloch's injuries.<sup>135</sup> She checked if VH was present and observed VH was sitting on a chair in his area of the room, but appeared unagitated.<sup>136</sup> She then left the room to get Mr Yappa, because she could not believe what she had seen and Mr Yappa was senior staff on Casuarina Wing.<sup>137</sup> Mr Yappa returned with Ms Endo to the room, and Ms Endo pulled down the doona to show Mr McCulloch to Mr Yappa.<sup>138</sup> Mr Yappa did not give any instructions, but suggested that Mr McCulloch looked like he had been dead for a while.<sup>139</sup> (Ms Endo accepted that she had not told investigating Police about Mr Yappa's statement that Mr McCulloch had been dead for a while, and could provide no reason for why this was so.<sup>140</sup>) Mr Joseph said he had taken Mr McCulloch to the toilet around 7:00am so Ms Endo determined that the death had not taken place on the night shift.<sup>141</sup> Mr Yappa and Ms Endo then left the room together and Ms Endo proceeded to reception.<sup>142</sup> Ms Endo did not give any directions about VH or about preserving Mr McCulloch's dignity.<sup>143</sup> She said it did not occur to her to ensure the safety of other residents by having someone supervise VH, but in any case there were not a lot of staff available as it was breakfast time and staff were attending to residents' care.<sup>144</sup>

85. She said that in 2012 there was no procedure for specialising a resident, but management could provide one-on-one monitoring when a resident's behaviour was getting too much for staff.<sup>145</sup> It did not occur to her at that time to tell Mr Joseph to make sure that no one touched

---

<sup>131</sup> Transcript 25.9.15 P18 L31-33, P35 L41-43

<sup>132</sup> Transcript 25.9.15 P18 L35-P19 L6

<sup>133</sup> Transcript 25.9.15 P66 L24-25

<sup>134</sup> Transcript 25.9.15 P67 L21-22

<sup>135</sup> Transcript 25.9.15 P19 L8-9

<sup>136</sup> Transcript 25.9.15 P19 L11-36, P42 L37-P43 L3

<sup>137</sup> Transcript 25.9.15 P19 L41-P20 L6

<sup>138</sup> Transcript 25.9.15 P20 L32-38

<sup>139</sup> Transcript 25.9.15 P20 L8-11, L39-42, P47 L14-15

<sup>140</sup> Transcript 25.9.15 P40 L17-30

<sup>141</sup> Transcript 25.9.15 P20 L11-18

<sup>142</sup> Transcript 25.9.15 P20 L44-P21 L1

<sup>143</sup> Transcript 25.9.15 P21 L21-27

<sup>144</sup> Transcript 25.9.15 P21 L37-P22 L1

<sup>145</sup> Transcript 25.9.15 P22 L3-4, P68 L38-42

Mr McCulloch's body until afterwards.<sup>146</sup> It did not occur to her to remove VH from the room, to shut the door and put a sign on it saying no entry.<sup>147</sup> She agreed that she could have removed VH from the room.<sup>148</sup>

86. After Mr McCulloch was found by Ms Endo and Mr Joseph, Ms Endo did not contact Mr McCulloch's relatives right away, she first contacted Ms Costuna, a Director of Nursing (DON), to inform her of the incident and ask the procedures to be followed.<sup>149</sup> Ms Endo said that ordinarily the family would be contacted for an incident and that there was no protocol requiring the DON to be contacted first, but the events were so shocking and there was no procedure to be followed for a suspicious death – "*I didn't know what to say to the family*".<sup>150</sup> Ms Endo said that Ms Costuna told her not to call Police, Ms Costuna asked her if anyone had seen the incident or what happened, and when Ms Endo said no, Ms Costuna said do not call Police, just organise a doctor to certify the death.<sup>151</sup> Ms Endo agreed that Jindalee's policies required that something as serious as what happened to Mr McCulloch be reported to Police within the hour, and she understood that requirement, but she still took advice and was told not to call Police.<sup>152</sup> Ms Endo initially said that she did not call Police then because she was busy and she was waiting for a call from CAHMS. But later in her evidence she agreed it was because her boss had told her not to call the Police and she did not want to jeopardise her job.<sup>153</sup>

87. Ms Endo arranged for Dr Webber to attend, and Dr Webber advised Ms Endo twice to call the Police.<sup>154</sup> Ms Endo took Dr Webber to Mr McCulloch at about 8:00am although she did not recall the time specifically.<sup>155</sup> She largely accepted Dr Webber's account of their conversation – that she had said "*we have just found a resident dead in bed, I think he's been punched by a member of staff or a resident*" – but thought by the time of the inquest that she was sure she did not say one of her staff.<sup>156</sup> She agreed that when Dr Webber asked who punched Mr McCulloch, she said "*I think a resident, (V), he was a boxer*".<sup>157</sup> She agreed with Dr Webber that when she and he entered room 43 a pillow was covering Mr

---

<sup>146</sup> Transcript 25.9.15 P40 L7-19

<sup>147</sup> Transcript 25.9.15 P40 L21-23

<sup>148</sup> Transcript 25.9.15 P43 L5

<sup>149</sup> Transcript 25.9.15 P21 L19

<sup>150</sup> Transcript 25.9.15 P4 L42-P5 L27

<sup>151</sup> Transcript 25.9.15 P37 L22-28

<sup>152</sup> Transcript 25.9.15 P37 L12-21

<sup>153</sup> Transcript 25.9.15 P38 L8-13

<sup>154</sup> Transcript 25.9.15 P38 L5-6

<sup>155</sup> Transcript 25.9.15 P38 L37-30

<sup>156</sup> Transcript 25.9.15 P38 L32-P39 L4

<sup>157</sup> Transcript 25.9.15 P39 L6-7

McCulloch's face, although he thought it was brown and she thought it was salmon pink.<sup>158</sup> She agreed, in hindsight, that someone in the facility had interfered with Mr McCulloch's body to put the pillow over his face while she was trying to work out what to do about Mr McCulloch's death.<sup>159</sup> Ms Endo then removed the pillow and, although she did not see Mr McCulloch's face that time, she accepted that Dr Webber saw that Mr McCulloch had large pools of blood either side of his head around his ears, and that Dr Webber formed the impression that Mr McCulloch had sustained significant assault injuries.<sup>160</sup> She agreed that Dr Webber again told her that she must notify the Police immediately, for a third time.<sup>161</sup> She disagreed with Dr Webber's evidence that VH was in his bed when she and Dr Webber entered the room – she thought VH was on his chair – and what Dr Webber said to VH.<sup>162</sup> She largely agreed with Dr Webber's account of his further conversation with her – that this was a very serious incident, that the resident had been killed, that she must ensure the other residents are safe, that the Police must be contacted, that no one must be washed and everything must be kept – but did not recall his use of the word "*killed*".<sup>163</sup> Ms Endo directed staff at some point after this time to make sure no one touched Mr McCulloch's body and no one was to enter the room, based on Dr Webber's instructions.<sup>164</sup> She recalled speaking to Mr Yappa, and probably Mr Varughese.<sup>165</sup> She agreed that she had left VH in the room after she and Dr Webber shut the curtain.<sup>166</sup>

88. Ms Endo stated that she did not immediately call the Police after Dr Webber had been.<sup>167</sup> She called Police after she had received a phone call from Ms Hart advising her that she could call the Police now.<sup>168</sup> She accepted Sergeant Casey's evidence that the call to Police took place at 8:53am.<sup>169</sup>

89. On the second occasion that Ms Endo saw VH, after Mr McCulloch had been found, she saw blood on one of VH's hands. It was on the side of one palm and down the little finger, but she could not remember on which hand.<sup>170</sup>

---

<sup>158</sup> Transcript 25.9.15 P39 L18-26

<sup>159</sup> Transcript 25.9.15 P42 L25-32

<sup>160</sup> Transcript 25.9.15 P39 L28-38

<sup>161</sup> Transcript 25.9.15 P39 L43-44

<sup>162</sup> Transcript 25.9.15 P40 L1-8

<sup>163</sup> Transcript 25.9.15 P40 L10-29

<sup>164</sup> Transcript 25.9.15 P43 L7-15, P44 L29-33, P47 L9-10

<sup>165</sup> Transcript 25.9.15 P44 L42-P45 L1

<sup>166</sup> Transcript 25.9.15 P45 L28-37

<sup>167</sup> Transcript 25.9.15 P47 L44-P48 L4

<sup>168</sup> Transcript 25.9.15 P4 L42-P5 L27

<sup>169</sup> Transcript 25.9.15 P53 L34-37

<sup>170</sup> Transcript 25.9.15 P17 L4-16

90. Ms Endo confirmed that later, while she was doing medications, she had been told by Ms Hart that Ms Magliulo was bleeding from her nose and had a pillow on her face, and that she had reacted by saying “*Oh my God, now Maureen is dead*”.<sup>171</sup> She did not go in to see Ms Magliulo but continued on her rounds and finally went to see Ms Faulkner.<sup>172</sup>
91. Although in her taped record of conversation Ms Endo said she saw Ms Faulkner at about 8:00am that morning and Ms Faulkner was fine at that time,<sup>173</sup> she clarified in court that she saw Ms Faulkner only once, at about 9:00am, and that Ms Faulkner was not fine, she would not respond to Ms Endo and Ms Endo observed bruising on her face.<sup>174</sup> The bruising was not present when Ms Endo had seen Ms Faulkner while working the day before.<sup>175</sup> The bruise appeared to be a pressure bruise and had some small purple dots.<sup>176</sup> Ms Faulkner was very quiet, which was odd for her, and would not say what happened.<sup>177</sup> Ms Endo remembered thinking that something was wrong because it was not the usual type of thing she would see at work.<sup>178</sup> She did not immediately assume someone had assaulted Ms Faulkner, because she was a high risk of fall, but someone could have injured her.<sup>179</sup> Ms Endo told Ms Hart and Ms Costuna about the bruising and they came over to examine Ms Faulkner.<sup>180</sup> At this point, Ms Endo became very paranoid because she had already found Mr McCulloch dead and she thought that someone else, other than VH, might be going around hurting people, because she believed someone was monitoring VH.<sup>181</sup>
92. Ms Endo agreed that the object of Jindalee was to ensure the safety of all residents and staff, that this object was contained in the policy and procedure manual, and that given all the information available to Jindalee, VH’s behaviour should have been monitored.<sup>182</sup> Ms Endo denied that there was insufficient staff to undertake that monitoring, saying instead that the day in question was different, and that VH was monitored.<sup>183</sup> She agreed that prior to finding Mr McCulloch, the morning had been fairly normal, even including the incident between VH

---

<sup>171</sup> Transcript 25.9.15 P48 L10-26

<sup>172</sup> Transcript 25.9.15 P48 L18-28

<sup>173</sup> Transcript 25.9.15 P12 L34-39

<sup>174</sup> Transcript 25.9.15 P13 L1-42

<sup>175</sup> Transcript 25.9.15 P14 L25-28

<sup>176</sup> Transcript 25.9.15 P13 L44-P14 L2

<sup>177</sup> Transcript 25.9.15 P14 L30-31

<sup>178</sup> Transcript 25.9.15 P14 L1-11

<sup>179</sup> Transcript 25.9.15 P14 L13-19

<sup>180</sup> Transcript 25.9.15 P14 L21-23

<sup>181</sup> Transcript 25.9.15 P14 L30-37, P66 L28-38

<sup>182</sup> Transcript 25.9.15 P32 L28-39

<sup>183</sup> Transcript 25.9.15 P32 L41-P33 L25

and Mr Durr.<sup>184</sup> She accepted that no one was assigned to monitor VH on a one-on-one basis after Mr McCulloch was discovered, but said she had given a direction to staff that he be monitored, which she later retracted in her evidence saying that she had just assumed that staff would monitor VH.<sup>185</sup> She later clarified that if it had occurred to her to direct someone to keep an eye on VH, there was sufficient staff to do so because she could have asked an AIN from another wing or she could have directed Mr Varughese to do it.<sup>186</sup> She said that, although Casuarina Wing was a special wing with lots of behaviour problems, she thought they had enough staff, but agreed that situations do happen on a daily basis where staff have to attend to a problem and leave their normal duties and allocated residents unattended.<sup>187</sup> She said that she could make decisions about calling in standby staff, and on the morning of 21 January 2012 she asked Ms Scott to come in early to support her to manage the incident.<sup>188</sup> Ms Endo said she considered a daily staff/resident ratio of 1:8 was generally comfortable, and agreed that facilities probably needed the same amount of staff for both breakfast and dinnertime.<sup>189</sup>

93. Ms Endo agreed that she had not made an incident report in relation to the matter, because she was in shock, but she had made notes in the patient progress notes, because she wanted to make a record before she went to the Police station.<sup>190</sup> She initially stated it was a truthful and accurate record of events, but when questioned about the timing of the finding of the pillow, she agreed that she and Mr Joseph did not discover Mr McCulloch covered with a pillow and a blanket, saying that she did not intend to hide the fact.<sup>191</sup> Ms Endo then agreed that details were missing from her note.<sup>192</sup> She agreed that the change to the note with the cross out of blanket and adding pillow and blanket was a deliberate change, but she could not recall why she made that change, saying she was very confused.<sup>193</sup> She denied she made the change because she was feeling guilty about having left VH on his own, but stated she regretted what she said.<sup>194</sup> She stated that she went to the Police station at the request of Police and made a statement, by which she meant she answered questions and the Police officer typed her answers up and gave her the printed statement, which she signed.<sup>195</sup> She

---

<sup>184</sup> Transcript 25.9.15 P66 L16-22

<sup>185</sup> Transcript 25.9.15 P45 L39-P47 L7

<sup>186</sup> Transcript 25.9.15 P55 L29-P56 L4

<sup>187</sup> Transcript 25.9.15 P59 L5-26

<sup>188</sup> Transcript 25.9.15 P66 L1-14

<sup>189</sup> Transcript 25.9.15 P68 L25-33

<sup>190</sup> Transcript 25.9.15 P40 L31-P41 L14

<sup>191</sup> Transcript 25.9.15 P41 L16-41

<sup>192</sup> Transcript 25.9.15 P41 L43-44

<sup>193</sup> Transcript 25.9.15 P42 L111

<sup>194</sup> Transcript 25.9.15 P42 L13-17

<sup>195</sup> Transcript 25.9.15 P53 L44-P54 L33

agreed that her Police statement correctly reflected the fact that no pillow was on Mr McCulloch's face when she and Mr Joseph first pulled back the blanket, and the pillow was there when she returned with Dr Webber.<sup>196</sup>

94. Ms Endo was asked to refer to Jindalee's policy and procedure manual (Exhibit 91) and asked about Mr Joseph's evidence that perhaps what happened to Mr McCulloch fell under Section 7.2 of the manual in relation to accidents and incidents.<sup>197</sup> She said she did not consider that this policy applied to Mr McCulloch's death.<sup>198</sup> She was asked whether the first aid and reporting policy applied to her when she first saw Mr McCulloch, and she said that she did not even consider first aid because Mr McCulloch appeared obviously dead to her, but the aspect of the policy in relation to contacting the resident's doctor would apply to her, although she did not consider that Mr McCulloch had a doctor at that time.<sup>199</sup> Ms Endo was asked about the Elder Abuse and Reportable Assaults policies. She explained that the policies required AINs to report incidents to an EN or RN straight away, the RN is then required to report it to the nurse in charge and to management, the Police must be called within 1 hour and the Department must be notified within 24 hours.<sup>200</sup> She agreed that management had a discretion not to report certain assaults by residents with cognitive and mental impairment, and explained that people with dementia have no control of what they are doing and that it would impractical to report every such assault.<sup>201</sup>
95. Ms Endo was asked by Counsel for the McCulloch family if there was anything she would do differently now that might have made a difference on the morning, and that would have been possible in the environment of the wing. She replied that she could have called Police straightaway, and the staff should have checked all residents after the incident.<sup>202</sup> Ms Endo was asked if there was any impediment to staff carrying an incident sheet, notebook or handheld recording device while on shift to record events as they happened. She replied that she did not think there was a practical reason against it.<sup>203</sup>
96. Note: after Ms Endo gave evidence, aspects of her testimony were inaccurately reported in the press. In court His Honour indicated his preliminary view that Ms Endo did nothing to try and hide things or cover up, and simply acted as one might expect a person with her

---

<sup>196</sup> Transcript 25.9.15 P54 L35-P55 L23

<sup>197</sup> Transcript 25.9.15 P35 L3-7

<sup>198</sup> Transcript 25.9.15 P35 L8-11

<sup>199</sup> Transcript 25.9.15 P35 L20-39

<sup>200</sup> Transcript 25.9.15 P36 L1-33

<sup>201</sup> Transcript 25.9.15 P36 L35-P37 L10

<sup>202</sup> Transcript 25.9.15 P62 L35-P63 L10

<sup>203</sup> Transcript 25.9.15 P63 L28-35, P69 L15-39

temperament might act upon suddenly finding such a shocking scene.<sup>204</sup> He later issued a press statement to similar effect.

### **Evidence of Bobby Joseph**

97. Bobby Joseph was at the time of Mr McCulloch's death an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence. He now works at Calvary Bruce.<sup>205</sup> Mr Joseph made a statement dated 21 January 2012 (Exhibit 11), participated in a re-enactment (Exhibit 12 and 12A) and gave oral evidence on 24 September 2015. He started work at Jindalee in August 2011.<sup>206</sup> He was trained as a Registered Nurse in India and had had six years experience in accident and emergency care in a private hospital, but was not registered as a nurse in Australia.<sup>207</sup>
98. In court, Mr Joseph clarified aspects of the statement he gave to Police on 10 February 2012. He clarified that when he went to the office to pick up the black folder, the folder contained the roster of activities such as showering and reading time, but he did not know whether or where those documents were kept by Jindalee.<sup>208</sup> Those documents were pre-made and amended by staff.<sup>209</sup> He agreed that the black folder was different to the DONs book and the diary.<sup>210</sup> He was taken to the diary (Exhibit 76) and stated that he would ordinarily check the diary when he first went to the office to get his allocation of rooms and residents.<sup>211</sup> He was shown the DONs book (Exhibit 91) and stated this was a communication book, that anything special or any special incidents to communicate to staff was written in this book, and staff were expected to check the DONs book daily and read back to the last occasion they worked.<sup>212</sup> He also said that the staff handover would also direct staff commencing their shift to the DONs book if there was anything special in the book.<sup>213</sup> Mr Joseph did not recall in 2015 whether Mr Awali had told him that anything special had happened on the night shift of 20 January 2012, and specifically, did not recall being told that Mr McCulloch had been found wandering or that VH had been up at 5:30am.<sup>214</sup> He said that that information may

---

<sup>204</sup> Transcript 29.9.15 P4 L43-P5 L2

<sup>205</sup> Transcript 24.9.15 P6 L36-37

<sup>206</sup> Transcript 24.9.15 P22 L11

<sup>207</sup> Transcript 24.9.15 P22 L15-16, P24 L38-P25 L1, P31 L21-P32 L12

<sup>208</sup> Transcript 24.9.15 P7 L38-P8 L7

<sup>209</sup> Transcript 24.9.15 P11 L11-26

<sup>210</sup> Transcript 24.9.15 P8 L14-24

<sup>211</sup> Transcript 24.9.15 P8 L28-44

<sup>212</sup> Transcript 24.9.15 P9 L13-44

<sup>213</sup> Transcript 24.9.15 P9 L40-44

<sup>214</sup> Transcript 24.9.15 P10 L1-11

have been part of Mr Awali's handover, but agreed that, if that had happened, he would have told the Police officer that information on 21 January 2012.<sup>215</sup>

## **21<sup>st</sup> January 2012**

99. On 21 January 2012 Mr Joseph was allocated rooms 39 and 40, and Mr Varughese was allocated rooms 41 and 43, but, as Mr Varughese started his shift late, Mr Joseph took handover of Mr Varughese's allocation that morning.<sup>216</sup> Mr Joseph took Mr McCulloch to the toilet at about 7:00am and ushered him back to bed.<sup>217</sup>
100. At about 7:30am Mr Joseph heard cries of "*Help me, help me*".<sup>218</sup> He did not see when Mr Varughese arrived for his shift but he saw him standing in the hallway adjacent to room 43 when Mr Joseph was taking a resident for showering.<sup>219</sup> Mr Joseph said he was instructed to separate Mr Durr and VH by Ms Endo.<sup>220</sup> He observed blood on Mr Durr's cheek.<sup>221</sup> He agreed he was required to make a note of what he had observed in the shift book, and to write an incident report at the end of his shift, which on 21 January 2012 would have been at 1:00pm.<sup>222</sup> He would be required to write a note if he was allocated to the patient or if he saw the incident, but he could not remember if he did write a note on 21 January 2012 because he was shocked.<sup>223</sup> He would write a note in a patient folder, and agreed that Exhibit 72 was the relevant document. He read onto the record the note he had made on 21 January 2012 about the incident between Mr Durr and VH.<sup>224</sup>
101. He stated that other staff members, including the RNs and the DONs, had access to the patient folder and that, during an oral handover, incoming staff would be told about an incident and told to go and check the notes.<sup>225</sup> The progress notes were kept inside a folder for each resident, which sat in a rack in a closed filing cabinet.<sup>226</sup> Mr Joseph did not recall whether he wrote the incident in the diary or DON's book but thought that he wrote an incident report. He said that AINs could not write in the DONs book because it was for the

---

<sup>215</sup> Transcript 24.9.15 P10 L9-15

<sup>216</sup> Transcript 24.9.15 P11 L35-P13 L29

<sup>217</sup> Transcript 24.9.15 P29 K31-32

<sup>218</sup> Transcript 24.9.15 P11 L37-P12 L1

<sup>219</sup> Transcript 24.9.15 P12 L3-22

<sup>220</sup> Transcript 24.9.15 P14 L34-36

<sup>221</sup> Transcript 24.9.15 P14 L38

<sup>222</sup> Transcript 24.9.15 P14 L40-P15 L15

<sup>223</sup> Transcript 24.9.15 P15 L36-P16 L1, P16 L15-16

<sup>224</sup> Transcript 24.9.15 P16 L8-24

<sup>225</sup> Transcript 24.9.15 P16 L34-44, P17 L25-28

<sup>226</sup> Transcript 24.9.15 P17 L30-37

DONs to communicate to staff and not the other way around.<sup>227</sup> He said the incident reports were kept in a folder in the nurses' station.<sup>228</sup>

102. He was taken to the folder of incident reports (Exhibit 82) and agreed there was no incident report about the scratch on Mr Durr's face, saying that he could not remember writing the report and could have been mistaken.<sup>229</sup> He thought the incident reports go to the DONs and then the DONs make further enquiries.<sup>230</sup> Mr Joseph said that after Ms Endo directed staff to separate Mr Durr and VH, he thought that another staff member was directed to watch VH, but he didn't know who that was because Mr Durr and VH were not his patients.<sup>231</sup> He did not recall seeing Mr McCulloch at the time of dealing with the incident between Mr Durr and VH.<sup>232</sup>
103. Mr Joseph did not know, prior to 21 January 2012, about VH being aggressive, or could not remember whether he knew.<sup>233</sup> He remembered being told something on handover about someone absconding but could not remember the specifics.<sup>234</sup> He did not know about VH being placed on surveillance, although he expected to have been told about this in case something happened.<sup>235</sup> He did not write any entries on the surveillance charts because VH was not his resident.<sup>236</sup>
104. Mr Joseph said that when he first saw Mr McCulloch, he put the porridge on the shelf, turned around, lifted the blanket and saw Mr McCulloch's face covered in blood.<sup>237</sup> Mr McCulloch was bleeding and was still, and Mr Joseph did not see any signs of Mr McCulloch breathing, although Mr Joseph did not know if Mr McCulloch was dead.<sup>238</sup> He said he could not remember anything covering Mr McCulloch's face, and agreed that if there had been something covering Mr McCulloch's face he would have told that to the Police when he was interviewed.<sup>239</sup> He then rushed out to tell Ms Endo, and she returned to room with him a short time later. He lifted the doona again from Mr McCulloch's face

---

<sup>227</sup> Transcript 24.9.15 P17 L1-23

<sup>228</sup> Transcript 24.9.15 P18 L9-18

<sup>229</sup> Transcript 24.9.15 P17 L44-P18 L7

<sup>230</sup> Transcript 24.9.15 P18 L20-23

<sup>231</sup> Transcript 24.9.15 P18 L25-34

<sup>232</sup> Transcript 24.9.15 P29 L23-38

<sup>233</sup> Transcript 24.9.15 P18 L40-P19 L3

<sup>234</sup> Transcript 24.9.15 P19 L5-11

<sup>235</sup> Transcript 24.9.15 P19 L13-20, P19 L43-P20 L2

<sup>236</sup> Transcript 24.9.15 P19 L32-38

<sup>237</sup> Transcript 24.9.15 P20 L14-21

<sup>238</sup> Transcript 24.9.15 P30 L9-13

<sup>239</sup> Transcript 24.9.15 P20 L20-P21 L19

to reveal Mr McCulloch's bloody face.<sup>240</sup> Ms Endo screamed and ran out of the room.<sup>241</sup> Mr Joseph said that the scene appeared similar to him and he could not remember if Mr McCulloch had moved.<sup>242</sup> He stated that he did not go back to the room after that time, other than to move the curtain.<sup>243</sup>

105. He said that he had seen deceased persons before, when he was a nurse in India, not during his time at Jindalee, but normal deaths and nothing like this.<sup>244</sup> He said that although in India he had seen people who were very severely injured, those were as a result of accidents, and he had not seen such a horrible scene.<sup>245</sup> He said it did not occur to him to check at that time whether Mr McCulloch was dead because he was shocked.<sup>246</sup> He did not see Ms Endo checking any vital signs for Mr McCulloch.<sup>247</sup>

106. At a later point, Mr Joseph went back to the room to close the curtain because, he said, he did not want anyone else to see that scene.<sup>248</sup> Mr Joseph agreed he had told Mr Varughese and Mr Yappa about Mr McCulloch, saying something like "*something terrible has happened*", and he did not recall saying "*I don't know if Charles is dead or not*" but he probably did say it.<sup>249</sup> He said that Mr McCulloch looked dead but he didn't know because he didn't check.<sup>250</sup> He also did not check if there was anyone else in the room, either when he first found Mr McCulloch or when he returned with Ms Endo, or when he returned to draw the curtain, because he was shocked.<sup>251</sup> He did not recall writing a note in the progress notes for Mr McCulloch and agreed that he did not write a note or an incident report, saying he was shocked and not up to record the incident.<sup>252</sup> He said that there were Police at Jindalee throughout his shift and the nurse had advised staff that Police would take evidence from them.<sup>253</sup>

---

<sup>240</sup> Transcript 24.9.15 P21 L21-25, P30 L15-18

<sup>241</sup> Transcript 24.9.15 P21 L27-29

<sup>242</sup> Transcript 24.9.15 P30 L20-25

<sup>243</sup> Transcript 24.9.15 P21 L31-32

<sup>244</sup> Transcript 24.9.15 P21 L38-P22 13

<sup>245</sup> Transcript 24.9.15 P25 L4-42

<sup>246</sup> Transcript 24.9.15 P22 L20-26

<sup>247</sup> Transcript 24.9.15 P24 L9-14

<sup>248</sup> Transcript 24.9.15 P25 L44-P26 L5

<sup>249</sup> Transcript 24.9.15 P22 L28-39

<sup>250</sup> Transcript 24.9.15 P22 L41-43

<sup>251</sup> Transcript 24.9.15 P23 L1-31

<sup>252</sup> Transcript 24.9.15 P23 L33-P24 L7

<sup>253</sup> Transcript 24.9.15 P30 L38-P31 L19

107. Mr Joseph stated that the training he received for dealing with deceased persons in 2012 required an AIN to ask the RN on duty to examine the resident, and the RN would ask a doctor to confirm the death.<sup>254</sup> He was unable to recall the specific protocol that applied, but, when shown the policies and procedures manual (Exhibit 79), located a protocol which stated that accidents must be reported to a RN but there was nothing provided for dealing with a suspicious death.<sup>255</sup>
108. Mr Joseph stated that every resident folder has a care plan which provided for the resident's daily routines, needs and medication.<sup>256</sup> He said that he was unaware of behaviour management plans and what they might be for, and he had no role in preparing those plans.<sup>257</sup>

### **Evidence of Mahmoud Musah Awali**

109. Mahmoud Musah Awali was at the time of Mr McCulloch's death an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence, and was still in that employment as at the date of the inquest. Mr Awali participated in a re-enactment (Exhibit 10) and gave oral evidence on 24 September 2015.
110. In January 2012, Mr Awali had been an AIN at Jindalee for about nine months, and he normally performed the night shift.<sup>258</sup> He held no qualifications at that time other than a first aid certificate, but had received on the job training as to the duties of his role.<sup>259</sup> He would ordinarily work a Friday night shift once a fortnight and would ordinarily work on A Wing, he only had one shift on C Wing.<sup>260</sup>
111. On 20 January 2012, Mr Awali commenced the night shift at about 11:15pm and concluded his shift at 7:15am on 21 January.<sup>261</sup> He was working the night shift with Mr Sharma and Mr Shahi.<sup>262</sup> Upon arrival he received a handover from outgoing staff, and his normal practice was then go from room to room to make sure all residents were in bed – sometimes in Casuarina Wing, dementia residents who were awake would need to be

---

<sup>254</sup> Transcript 24.9.15 P26 L7-30

<sup>255</sup> Transcript 24.9.15 P26 L28-P28 L35

<sup>256</sup> Transcript 24.9.15 P28 L37-42

<sup>257</sup> Transcript 24.9.15 P32 L14-34

<sup>258</sup> Transcript 24.9.15 P33 L25-29

<sup>259</sup> Transcript 24.9.15 P33 L31-P34 L11

<sup>260</sup> Transcript 24.9.15 P36 L39-P37 L11

<sup>261</sup> Transcript 24.9.15 P34 L13-17

<sup>262</sup> Transcript 24.9.15 P37 L20-29, P40 L1-3

brought to the lounge room with staff.<sup>263</sup> He said he would also read the diaries at the start of the shift,<sup>264</sup> and sign on with a timesheet or roster for attending the shift.<sup>265</sup> Mr Awali explained that staff read the diary to see if there are specific additional things staff need to know about the shift they are going to do, if there are new residents, or find out if anything happened prior to the shift.<sup>266</sup> He agreed that the diary (Exhibit 76) showed an entry for 20 January 2012 noting a new male resident in bed 43A, being Mr McCulloch.<sup>267</sup> Mr Awali stated that when he received handover on 20 January 2012, he checked on Mr McCulloch and he was in bed.<sup>268</sup> He said that upon starting his shift AINs would also read the DONs book although that is more for RNs and ENs, and only RNs and ENs are authorised to write in the DONs book.<sup>269</sup> He agreed that the DONs book also contained an entry for 20 January 2012 noting a new male resident in bed 43A, being Mr McCulloch.<sup>270</sup>

112. At about 1:15am, Mr Awali recalled a gentleman called Chris came out of room 41 or 42 to the TV room naked and agitated and speaking Russian. He and Mr Sharma first tried to return him to his room, before allowing Chris to sit with them in the TV room.<sup>271</sup> He agreed that he was required to make a note of the incident in the patient progress notes, as it was something out of the ordinary for a resident, but he was not required to complete an incident report because those are ordinarily done for things like unwitnessed falls and trespasses into another resident's room.<sup>272</sup> He did not recall having made a note of this event in the progress notes, but considered it must have been done.<sup>273</sup>

113. At around 4:20am Mr Awali recalled an agitated man in reddish pyjamas came out to Mr Shahi asking "*Why am I here, where is my wife*", and upon the man being told that his wife was coming in the morning he returned to bed.<sup>274</sup> Mr Awali did not know who the resident was but returned him to bed 43C (which meant it was VH).<sup>275</sup> He put the resident to bed and pulled the curtain.<sup>276</sup> Mr Awali agreed he should have written a note in the progress notes about that event, but did not recall having done so, and when taken to VH's notes

---

<sup>263</sup> Transcript 24.9.15 P34 L19-29

<sup>264</sup> Transcript 24.9.15 P34 L35-44

<sup>265</sup> Transcript 24.9.15 P35 L1-14

<sup>266</sup> Transcript 24.9.15 P35 L16-34

<sup>267</sup> Transcript 24.9.15 P35 L36-38

<sup>268</sup> Transcript 24.9.15 P36 L6-8

<sup>269</sup> Transcript 24.9.15 P36 L17-21, L32-37

<sup>270</sup> Transcript 24.9.15 P36 L23-30

<sup>271</sup> Transcript 24.9.15 P37 L31-44, P39 L11-13

<sup>272</sup> Transcript 24.9.15 P38 L1-P39 L9

<sup>273</sup> Transcript 24.9.15 P38 L1-5

<sup>274</sup> Transcript 24.9.15 P39 L15-29

<sup>275</sup> Transcript 24.9.15 P39 L22-29

<sup>276</sup> Transcript 24.9.15 P43 L36-37

agreed that no such note was written either by himself or Mr Shahi.<sup>277</sup> When Mr Shahi's account of this event was put to Mr Awali, and that the resident in question was VH, Mr Awali accepted Mr Shahi's account.<sup>278</sup>

114. At around 5:00am Mr Awali and Mr Shahi did a round of the wing and found Mr McCulloch awake in bed in his pyjamas.<sup>279</sup> Mr Awali and Mr Shahi washed Mr McCulloch and he was back in bed at about 5:35am.<sup>280</sup>
115. Mr Awali agreed he had done a handover to Mr Joseph on the morning of 21 January 2012, and Mr Shahi had handed over the other allocation to Mr Yappa.<sup>281</sup> Mr Awali stated that during the handover, at about 7:05am, he and Mr Joseph observed that Mr McCulloch was awake, and up and was just coming out of the bathroom when they arrived at room 43.<sup>282</sup> At that time Mr McCulloch was fine, without any injuries.<sup>283</sup> Mr Awali introduced Mr Joseph to Mr McCulloch and they put Mr McCulloch back to bed.<sup>284</sup> At that time, Mr Awali recalled another resident being present in room 43 but did not think that was VH, because Mr Awali recalled seeing VH in the lounge room during handover.<sup>285</sup>
116. Mr Awali said he was unaware of allegations of aggression between VH and Mr Durr in January 2012, given he only worked one shift a fortnight.<sup>286</sup> He was unaware of a surveillance chart for VH and he had never filled one in.<sup>287</sup> He was unaware that VH had tried to abscond, but stated that he knew VH would wander at night.<sup>288</sup>

### **Evidence of Rajesh Shahi**

117. Rajesh Shahi was, at the time of Mr McCulloch's death, an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence, and was still in that employment as at the date of the inquest. Mr Shahi made a statement dated 31 January 2012 (which was tendered as Exhibit 134) and gave oral evidence on 25 September 2015.

---

<sup>277</sup> Transcript 24.9.15 P39 L31-40, P40 L6-25

<sup>278</sup> Transcript 24.9.15 P43 L29-34

<sup>279</sup> Transcript 24.9.15 P41 L16-26

<sup>280</sup> Transcript 24.9.15 P41 L20-30

<sup>281</sup> Transcript 24.9.15 P40 L29-P41 L5

<sup>282</sup> Transcript 24.9.15 P41 L7-43

<sup>283</sup> Transcript 24.9.15 P41 L38-40, P43 L39-40

<sup>284</sup> Transcript 24.9.15 P42 L1-14

<sup>285</sup> Transcript 24.9.15 P42 L18-32

<sup>286</sup> Transcript 24.9.15 P42 L35-42

<sup>287</sup> Transcript 24.9.15 P42 L44-P43 L16

<sup>288</sup> Transcript 24.9.15 P43 L18-27

118. In January 2012 Mr Shahi had been an AIN at Jindalee for about nine months. Prior to that he had worked at the Mercy Health agency for two months.<sup>289</sup> He held a Certificate III in aged care.<sup>290</sup> He had received education from Jindalee in relation to resident aggression, and said that training involved staff reading a document about the issue and signing off.<sup>291</sup> He agreed that the policy and procedures manual (Exhibit 79) did not include anything about dealing with physically aggressive people and so that training must have been in another document.<sup>292</sup> He said staff would deal with aggression by calming the residents down, separating them, distracting them with other activities, and if necessary, notifying the RN and filling out an incident report.<sup>293</sup>
119. Mr Shahi started work on Jarrah Wing on the night shift on 20 January 2012, and performed 2 hours there from 11:15pm to 1:30am, before spending the remainder of his shift on Casuarina Wing until morning.<sup>294</sup> Mr Shahi stated that he had asked Mr Sharma to check on VH on the evening of 20 January 2012 because he was aware that VH had become very aggressive and physical towards Mr Durr.<sup>295</sup> He did not recall specifically what had happened, but had received a handover from an AIN on the previous shift with that information. He did not recall from whom.<sup>296</sup> He had not read any incident reports about altercations between VH and Mr Durr.<sup>297</sup> He knew he was required to make regular checks on VH on the night to ensure that VH and Mr Durr were not physically aggressive to each other, and because VH had tried to jump out of the window of his room.<sup>298</sup>
120. Mr Shahi stated that he would check VH every 30-45 minutes during the nightshift, except when he was on the Jarrah Wing.<sup>299</sup> He agreed that the signature “RAJ” for entries on 21 January on the surveillance chart in VH’s personal file (Exhibit 71) was his signature.<sup>300</sup> **However, he agreed that the entries he wrote for 2315 and 2345 entries were false because he was on the Jarrah Wing at that time and could not have performed those checks, and he said he completed the chart at the end of his shift some time before**

---

<sup>289</sup> Transcript 25.9.15 P71 L29-34, L38-42

<sup>290</sup> Transcript 25.9.15 P71 L36, P71 L44-P72 L12

<sup>291</sup> Transcript 25.9.15 P72 L14-27

<sup>292</sup> Transcript 25.9.15 P72 L29-40

<sup>293</sup> Transcript 25.9.15 P72 L44-P73 L8

<sup>294</sup> Transcript 25.9.15 P74 L8-17

<sup>295</sup> Transcript 25.9.15 P73 L10-20, P77 L39-40

<sup>296</sup> Transcript 25.9.15 P73 L22-29, L34-38

<sup>297</sup> Transcript 25.9.15 P73 L31-32

<sup>298</sup> Transcript 25.9.15 P73 L40-P74 L6, P74 L19-23, P77 L34-37

<sup>299</sup> Transcript 25.9.15 P74 L25-26, L42-43

<sup>300</sup> Transcript 25.9.15 P74 L30-40

7:15am.<sup>301</sup> He agreed that he made those entries because he wanted someone to believe the checks had been done. He believed Mr Sharma was conducting those checks on his behalf and he completed the form on Mr Sharma's behalf.<sup>302</sup> Mr Shahi stated that he had made the observations recorded for 7:00am and 7:15am, saying that he might have come back to the nurses' station to complete the last entry, after having completed the rest of the chart and after having done the handover to Mr Yappa.<sup>303</sup> He denied completing the form at one time, saying that he might have done it several times, but not recall how many times.<sup>304</sup>

121. Mr Shahi stated that at about 5:30am he and Mr Awali checked on every resident.<sup>305</sup> He saw Mr McCulloch standing in the middle of room 43, and Mr McCulloch appeared confused.<sup>306</sup> He agreed that he and Mr Awali thought about changing Mr McCulloch at the time but didn't do so because Mr McCulloch's clothes were not unpacked.<sup>307</sup> When he checked Ms Magliulo he noticed her alarm was not on, but she was ok, there was nothing wrong with her.<sup>308</sup> He stated that the checks were complete at about 6:45am and he made a note in Mr McCulloch's file about having seen Mr McCulloch being awake at the prompting of Ms Mathew.<sup>309</sup>

122. Mr Shahi said that, when he was doing the handover with Mr Yappa, he saw VH standing in the hallway in his nightclothes and asking where the toilet was.<sup>310</sup> He did not advise Mr Yappa about VH requiring checks because he was handing over the other side of the wing, from room 45.<sup>311</sup> Although he had been told VH was aggressive and to observe VH, Mr Shahi said he did not tell Mr Yappa or anyone on the morning shift that information, because VH had been fine that night.<sup>312</sup>

### **Evidence of Harpreet Sharma**

123. Harpreet Sharma was, at the time of Mr McCulloch's death, an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence, and was still in that employment as at the date of the inquest. Mr Sharma made a statement dated 31 January 2012 (which was tendered as

---

<sup>301</sup> Transcript 25.9.15 P75 L1-29, P76 L25-29

<sup>302</sup> Transcript 25.9.15 P75 L41-P76 L23

<sup>303</sup> Transcript 25.9.15 P76 L31-P77 L23

<sup>304</sup> Transcript 25.9.15 P77 L25-32

<sup>305</sup> Transcript 25.9.15 P78 L19

<sup>306</sup> Transcript 25.9.15 P78 L3-7, L14-16

<sup>307</sup> Transcript 25.9.15 P78 L9-12

<sup>308</sup> Transcript 25.9.15 P78 L18-25

<sup>309</sup> Transcript 25.9.15 P78 L27-33

<sup>310</sup> Transcript 25.9.15 P78 L35-44

<sup>311</sup> Transcript 25.9.15 P79 L1-6

<sup>312</sup> Transcript 25.9.15 P79 L8-19

Exhibit 17) and gave oral evidence on 25 September 2015. Mr Sharma commenced employment with Jindalee in 2011.<sup>313</sup> He held a Certificate III in aged care and a diploma in community welfare, obtained before he commenced working at Jindalee.<sup>314</sup>

124. On 20 January 2012, Mr Sharma was working the night shift which commenced at about 11:15pm and ran to 7:15am, although on the day in question he worked an extra half hour so as to satisfy immigration requirements.<sup>315</sup> He was over on the Jarrah Wing for part of his shift.<sup>316</sup> He did not specifically recall receiving information from Mr Shahi about checking on VH, but accepted the possibility it did happen, as it was a matter of practice, where a resident was aggressive or did not feel well, that staff would divide duties to conduct regular checks on the resident.<sup>317</sup>
125. Mr Sharma agreed that at some point during the shift he went into room 43 and saw Mr McCulloch in bed 43A, and Mr Durr in bed 43D, but VH was not in his own bed. He was in Mr Noble's bed, and Mr Noble was in the main TV room.<sup>318</sup>
126. Mr Sharma said he was back in the office on Casuarina Wing at about 7:30am, having just returned from the kitchen, and saw Mr Varughese arrive.<sup>319</sup> He heard Mr Durr yelling "*help me, he's hitting me again*". He then went to room 43 with Mr Joseph, Mr Varughese, Mr Yappa and Ms Endo.<sup>320</sup> He said that he went into the room with the other staff, but when he realised that there were enough staff present, he returned to the office.<sup>321</sup> He saw Mr Durr sitting on the bottom of his bed, 43D, with his hands to his face and blood on his left cheek, and VH was standing two metres away at the bottom of his bed.<sup>322</sup> Mr Sharma agreed that he was aware of an incident perhaps a week earlier between VH and Mr Durr, but he did not recall where he heard about it. He thought that it was perhaps from some of the staff.<sup>323</sup> Sometime afterwards, he saw Mr Yappa wiping VH's face.<sup>324</sup>

---

<sup>313</sup> Transcript 25.9.15 P80 L20

<sup>314</sup> Transcript 25.9.15 P80 L16-20

<sup>315</sup> Transcript 25.9.15 P80 L22-24, P81 L8-15

<sup>316</sup> Transcript 25.9.15 P81 L6

<sup>317</sup> Transcript 25.9.15 P80 L26-35

<sup>318</sup> Transcript 25.9.15 P80 L37-P81 L3

<sup>319</sup> Transcript 25.9.15 P81 L17-22

<sup>320</sup> Transcript 25.9.15 P81 L24-28

<sup>321</sup> Transcript 25.9.15 P81 L27-36, P82 L10-13

<sup>322</sup> Transcript 25.9.15 P81 L37-43

<sup>323</sup> Transcript 25.9.15 P82 L1-8

<sup>324</sup> Transcript 25.9.15 P82 L13-14

127. Mr Sharma said that he later ran into Mr Joseph in the car park, at about 1:00pm, after he dropped his wife off at Jundalee. The carpark was full of many Police.<sup>325</sup> He asked Mr Joseph what had happened and Mr Joseph told him.<sup>326</sup>

### **Evidence of Sheeba Mathew**

128. Sheeba Mathew was, at the time of Mr McCulloch's death, a Registered Nurse (RN) at the Jindalee Aged Care Residence, and was still in that employment as at the date of the inquest. Ms Mathew made a statement dated 31 January 2012 (which was tendered as Exhibit 18) and gave oral evidence on 25 September 2015.

129. In January 2012, Ms Mathew had been an RN at Jindalee for about one year and nine months. Prior to that she had worked at another aged care facility and with Southern Health in Dandenong.<sup>327</sup> She had been a registered nurse in India since 2001, but had only been registered in Australia for 12 months.<sup>328</sup>

130. Ms Mathew was on night shift from 9pm on 20 January to 7:30am on 21 January 2012.<sup>329</sup> She said that there was only one RN on night shift at Jindalee for all seven wings, and that she would need to go around and supervise all seven wings.<sup>330</sup> Her responsibilities included administering medication, checking residents after falls or incidents, assessing medical cases and deciding if admission to hospital is required, with the AINs taking primary care of residents.<sup>331</sup> She said she would receive a handover from every wing when she came onto shift and she would check the DONs book and diary.<sup>332</sup> Regular medication is administered by morning and evening rounds, she would only administer some 6:00am medications.<sup>333</sup> When administering PRN medication or an AIN would seek medication for a resident, she would first check the resident's medication chart and then administer whatever order was there.<sup>334</sup>

---

<sup>325</sup> Transcript 25.9.15 P82 L16-23

<sup>326</sup> Transcript 25.9.15 P82 L23-25

<sup>327</sup> Transcript 25.9.15 P83 L15-21

<sup>328</sup> Transcript 25.9.15 P83 L23-27

<sup>329</sup> Transcript 25.9.15 P83 L35

<sup>330</sup> Transcript 25.9.15 P83 L29-33

<sup>331</sup> Transcript 25.9.15 P83 L37-44

<sup>332</sup> Transcript 25.9.15 P86 L33-37

<sup>333</sup> Transcript 25.9.15 P86 L39-P87 L1

<sup>334</sup> Transcript 25.9.15 P87 L10-19

131. Ms Mathew stated that she was aware that VH was a resident, but she could not recall VH's medication chart, and she did not recall ever administering VH any Risperidone.<sup>335</sup> She was reminded that, in her statement, she said that she didn't administer medication to residents of Casuarina Wing.<sup>336</sup>
132. Ms Mathew was asked about the comment in her statement that she asked Mr Shahi to complete a progress note for Mr McCulloch. She said she asked Mr Shahi to do that because Mr McCulloch was a new admission and it was important to find out how he was sleeping, how he was overnight and during the day, his continence and other relevant matters to assist in preparing the care plan.<sup>337</sup>
133. Ms Mathew confirmed that she conducted a handover with Ms Endo at about 7:00am. She said that was because she had ongoing permission from Ms Costuna and Ms Hart to finish 10 minutes early, because her husband Mr Varughese worked the shift following her shift, and she has to go home to look after the children.<sup>338</sup> Ms Mathew said that she was not made aware of an incident, just prior to her departure, involving Mr Durr and VH.<sup>339</sup>
134. Ms Mathew confirmed that she received a phone call from Mr Varughese at about 8:45am, advising her that Mr McCulloch had passed away.<sup>340</sup> She said that Mr Varughese was very stressed and distressed, that this was the first such experience for him, but she did not recall whether Mr Varughese described what he had seen or how Mr McCulloch died.<sup>341</sup>

#### **Evidence of Tafadzwa Tichivangana**

135. Tafadzwa Inocentia (Fuzzy) Tichivangana was, at the time of Mr McCulloch's death, as an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence. She held no qualifications at that time.<sup>342</sup> She now works as a disability support worker with Able Australia.<sup>343</sup> Ms Tichivangana made a statement dated 21 January 2012 (Exhibit 15), participated in a re-enactment (Exhibit 16) and gave oral evidence on 29 September 2015. She was allocated to care for residents in C Wing on the morning of 21<sup>st</sup> January 2012. She

---

<sup>335</sup> Transcript 25.9.15 P84 L1-16

<sup>336</sup> Transcript 25.9.15 P84 L13-16

<sup>337</sup> Transcript 25.9.15 P84 L24-30

<sup>338</sup> Transcript 25.9.15 P84 L32-P85 L15, P86 L24-32

<sup>339</sup> Transcript 25.9.15 P85 L17-19

<sup>340</sup> Transcript 25.9.15 P85 L21-27

<sup>341</sup> Transcript 25.9.15 P85 L29-P86 L15

<sup>342</sup> Transcript 29.9.15 P6 L26-28

<sup>343</sup> Transcript 29.9.15 P5 L35-39

agreed that in the event of any inconsistency between her statements, what she told Police on the day of Mr McCulloch's death was likely to be accurate.<sup>344</sup>

136. Ms Tichivangana had worked previously at Jindalee from 2009, but left in August or September 2011 to take up another job. 20 January 2012 was her first day back at Jindalee and she had been assigned to the Jarrah Wing.<sup>345</sup> She did not know VH, but had been told by an unknown member of staff that he was aggressive although she had not personally seen that behaviour.<sup>346</sup> She agreed she would have read the diary and the DONs book and agreed that there was an incident, relating to VH and Mr Durr on 18 January 2012, recorded in it.<sup>347</sup> She agreed that she would have known from that entry that Mr Durr was also aggressive, but she also said, later in her oral evidence, that her understanding of VH being aggressive came about afterwards.<sup>348</sup> She agreed that her understanding of VH's behaviour was greatly influenced by what people had told her after Mr McCulloch's death.<sup>349</sup>

137. On the day of Mr McCulloch's death, Ms Tichivangana was working the day shift, starting at 7:00am on C Wing, and was allocated the corridor containing room 45.<sup>350</sup> This was her first day on Casuarina Wing.<sup>351</sup> She did not have any responsibility for any of the residents in room 43, which was the room in which VH, Mr Durr, Mr Noble and Mr McCulloch slept.<sup>352</sup> She arrived that day and went straight to the office for a handover from the night staff, the specifics of which she could no longer recall.<sup>353</sup> Thereafter at about 7:25am she checked on Ms Magliulo in room 46 and fed her breakfast, at which time she observed Ms Magliulo to be alright and with no injuries.<sup>354</sup> The alarm outside Ms Magliulo's room was not in use, the curtain on the sliding door was open and the door was closed, although Ms Tichivangana was not sure if the door was locked.<sup>355</sup>

---

<sup>344</sup> Transcript 29.9.15 P20 L3-23

<sup>345</sup> Transcript 29.9.15 P5 L36-P7 L3, P20 L37-40

<sup>346</sup> Transcript 29.9.15 P10 L31-44

<sup>347</sup> Transcript 29.9.15 P10 L13-P12 L22

<sup>348</sup> Transcript 29.9.15 P5 L44-P6 L12

<sup>349</sup> Transcript 29.9.15 P20 L25-35, P21 L3-10

<sup>350</sup> Transcript 29.9.15 P12 L24-27

<sup>351</sup> Transcript 29.9.15 P20 L42-P21 L1

<sup>352</sup> Transcript 29.9.15 P6 L14-19

<sup>353</sup> Transcript 29.9.15 P6 L25-P7 L2

<sup>354</sup> Transcript 29.9.15 P7 L15-P9 L2

<sup>355</sup> Transcript 29.9.15 P9 L4-16

138. Ms Tichivangana then met up with Mr Yappa, who she was to be working with that day. While Mr Yappa went to start breakfast, she checked on the rest of the residents.<sup>356</sup> She observed that Ms Faulkner was sleeping at about 7:30am and she fed her breakfast at about 7:45am, at which times Ms Faulkner was alright.<sup>357</sup> She fed Ms Magliulo breakfast at some later time. When she did, Ms Magliulo was not injured and still in her room.<sup>358</sup> Ms Tichivangana then had a conversation with Mr Yappa about a resident who had died and it was suspected another resident, “(V)”, was responsible.<sup>359</sup> Mr Yappa advised Ms Tichivangana that he did not know why the resident was suspected, that Ms Endo was trying to contact the Police or the DONs, and, when she took her break, Ms Tichivangana was to go alone and not with another person.<sup>360</sup>
139. Sometime after that, Ms Tichivangana went to find Mr Varughese to obtain more information about what happened. She found him at the doorway of room 43.<sup>361</sup> She agreed that she had asked Mr Varughese if she could go into room 43, and he said she could, but not to touch anything. She had wanted to be sure there was someone dead in the room and she was curious that a resident had been killed.<sup>362</sup> When she entered room 43 she stood by the door and observed a body on the bed with a doona fully covering the body, but she did not check if there was anyone else in the room.<sup>363</sup> She thought she may have seen a pillow on top of the doona.<sup>364</sup> Mr Varughese told her that he thought VH had “done it” because VH had been aggressive for the past few days.<sup>365</sup>
140. Ms Tichivangana stated that the protocol when a resident was found dead was to tell the staff member she was working with and then to tell the RN and seek instructions from the RN.<sup>366</sup> She said that in determining if a resident was deceased, AINs would usually seek a response from a resident and then check pulse, but call the RN for the RN to make sure.<sup>367</sup>

---

<sup>356</sup> Transcript 29.9.15 P9 L18-25

<sup>357</sup> Transcript 29.9.15 P9 L26-44, P16 L24-32, P18 L11-12

<sup>358</sup> Transcript 29.9.15 P10 L5-11

<sup>359</sup> Transcript 29.9.15 P11 L13-P12 L8

<sup>360</sup> Transcript 29.9.15 P12 L34-P13 L19

<sup>361</sup> Transcript 29.9.15 P13 L31-36

<sup>362</sup> Transcript 29.9.15 P13 L39-P14 L26

<sup>363</sup> Transcript 29.9.15 P15 L10-P16 L1

<sup>364</sup> Transcript 29.9.15 P23 L42-P24 L20

<sup>365</sup> Transcript 29.9.15 P16 L12-21

<sup>366</sup> Transcript 29.9.15 P14 L42-P15 L4

<sup>367</sup> Transcript 29.9.15 P24 L37-P25 L8

141. Ms Tichivangana went to change Ms Faulkner at about 8:45am.<sup>368</sup> When she saw Ms Faulkner, she was crying and saying “*I want to go to the Police*”, “*I want to get out of this place because a man came and hit me*”.<sup>369</sup> She observed some bruising and some red dots on Ms Faulkner.<sup>370</sup> Ms Tichivangana did not do anything about Ms Faulkner’s comments as she thought Ms Faulkner was confused due to dementia. She was going to write it up in the progress notes, and she did not tell anyone else given what was happening, but she did not get to write it up.<sup>371</sup> She later clarified that Ms Faulkner would often say that she wanted to go, and so staff did not pay much attention to what she would say because she would say a lot of things.<sup>372</sup>
142. Ms Tichivangana agreed it was possible at Jindalee that a dementia patient who was assaulted would just be ignored because of the dementia.<sup>373</sup> She said the incident would be assessed by the RN, rather than by the AINs, who could not do much.<sup>374</sup> The injuries to Ms Faulkner required Ms Tichivangana to write an incident report and report the incident to the people in charge.<sup>375</sup> If Ms Faulkner had required urgent attention, the AINs would report the incident to the RN and to other staff, but otherwise incident reports were commonly written up at the end of a shift.<sup>376</sup> Ms Tichivangana agreed that it was possible that 4-5 hours could pass after an assault without help being given to the resident, saying “*that’s what happens almost every day*”.<sup>377</sup> She clarified that this depended on the nature of the incident and the events of the day in question, but that, if a resident required first aid, that would be attended to straight away by the RN.<sup>378</sup>
143. Ms Tichivangana was told by Mr Yappa to attend to Ms Magliulo at about 9:20am to get her ready for the day.<sup>379</sup> When she entered the room, the doona was pulled up all the way to the bedhead and covering Ms Magliulo’s head. When she pulled back the doona, a pillow was covering Ms Magliulo’s face.<sup>380</sup> Ms Tichivangana removed the doona and the pillow and saw blood on the pillow and on Ms Magliulo’s nose, and she noted that Ms Magliulo’s nose was turning black. She ran to tell Ms Scott ,who was in charge of the

---

<sup>368</sup> Transcript 29.9.15 P16 L3-4, 31-22

<sup>369</sup> Transcript 29.9.15 P16 L31-42

<sup>370</sup> Transcript 29.9.15 P17 L28

<sup>371</sup> Transcript 29.9.15 P16 L44-P17 L3, P17 L30-38

<sup>372</sup> Transcript 29.9.15 P21 L39-P22 L3

<sup>373</sup> Transcript 29.9.15 P22 L5-7

<sup>374</sup> Transcript 29.9.15 P23 L14-38

<sup>375</sup> Transcript 29.9.15 P22 L9-16

<sup>376</sup> Transcript 29.9.15 P22 L18-43

<sup>377</sup> Transcript 29.9.15 P22 L41-P23 L12

<sup>378</sup> Transcript 29.9.15 P25 L26-43

<sup>379</sup> Transcript 29.9.15 P18 L1-9

<sup>380</sup> Transcript 29.9.15 P18 L14-43

facility on weekends.<sup>381</sup> She agreed that one of the things that came to her mind, after seeing Ms Magliulo, was that she was dead and the same thing had happened as had happened to Mr McCulloch.<sup>382</sup> She thought this because of the doona over Ms Magguilio's face.<sup>383</sup> Ms Scott arrived and asked Ms Tichivangana to stay with Ms Magliulo. Ms Scott located Ms Hart and Ms Costuna, who attended the room.<sup>384</sup> Ms Tichivangana saw some blood spattered on the bedhead and the curtain.<sup>385</sup> She stayed with Ms Magliulo until the end of her shift.<sup>386</sup>

### **Evidence of Sunil Varughese**

144. Sunil Varughese was, at the time of Mr McCulloch's death, as an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence, and was still in that employment as at the date of the inquest. At the time of Mr McCulloch's death, Mr Varughese held a certificate in aged care.<sup>387</sup> He made a statement dated 21 January 2012 (Exhibit 8), participated in a re-enactment with Sergeant Casey on 4<sup>th</sup> February 2012 (Exhibit 9 and 9A) and gave oral evidence on 29 September 2015. He agreed that, in the event of any inconsistency between his evidence and his statement to the Police, what he told the Police on the day of Mr McCulloch's death was likely to be accurate.<sup>388</sup>
  
145. Mr Varughese had worked at Jindalee for about two and a half years by January 2012.<sup>389</sup> He had not seen Mr McCulloch prior to 21 January 2012.<sup>390</sup> He knew VH, Mr Durr and Mr Noble from working his shifts.<sup>391</sup> On the morning of 21 January 2012, he arrived at Jindalee at about 7:30am, pursuant to an agreement with Ms Costuna and Ms Hart that he could start his shift later in the morning because his wife, Ms Mathew, would work the night shift.<sup>392</sup> Mr Varughese was allocated Mr McCulloch and Mr Noble to care for that day, as well as other residents, and Mr Yappa was allocated VH and Mr Durr as well as other residents.<sup>393</sup> Upon arriving at Jindalee Mr Varughese found Mr Joseph in room 40

---

<sup>381</sup> Transcript 29.9.15 P18 L1-7

<sup>382</sup> Transcript 29.9.15 P19 L9-15

<sup>383</sup> Transcript 29.9.15 P24 L25-35

<sup>384</sup> Transcript 29.9.15 P19 L23-29

<sup>385</sup> Transcript 29.9.15 P19 L31-32

<sup>386</sup> Transcript 29.9.15 P19 L39

<sup>387</sup> Transcript 29.9.15 P27 L19-23

<sup>388</sup> Transcript 29.9.15 P29 L41-P30 L1, P31 L31-P32 L1

<sup>389</sup> Transcript 29.9.15 P27 L25-26

<sup>390</sup> Transcript 29.9.15 P71 L27-30

<sup>391</sup> Transcript 29.9.15 P29 L13-33, P33 L15-17

<sup>392</sup> Transcript 29.9.15 P27 L28-40, P71 L32-P72 L5

<sup>393</sup> Transcript 29.9.15 P28 L4-26, P62 L8

and both he and Mr Joseph proceeded to room 39 to commence serving breakfast with Mr Yappa.<sup>394</sup> Mr Varughese did not see the handover from Mr Awali.<sup>395</sup>

146. At about 7:45am, Mr Varughese heard a man's voice saying "*Help me, help me*". He and Mr Joseph then went to room 43, from where the yelling came from.<sup>396</sup> Mr Yappa and Mr Sharma were also in the room at the time.<sup>397</sup> He saw Mr Durr sitting on his bed, crying with both hands on his face, with a lot of fresh, bright red blood running and covering his face and hands, and what appeared to be bruises under his eyes. Mr Durr said "He hit me, he hit me".<sup>398</sup> Mr Varughese believed Mr Durr's statements.<sup>399</sup> Mr Varughese did not see anyone else in the room, and specifically did not see VH, notwithstanding the evidence of other witnesses who saw VH.<sup>400</sup> Mr Joseph asked Mr Durr who hit him, and Mr Durr could not say who, but was adamant that a man had hit him.<sup>401</sup> Mr Varughese did not at that time look over to bed 43A, which was Mr McCulloch's bed.<sup>402</sup> Mr Joseph told Ms Endo what had happened, and Mr Joseph and Mr Varughese took Mr Durr to the dining room.<sup>403</sup> Mr Varughese could not recall, by the time of the inquest, whether a curtain was closed around Mr McCulloch's bed, but accepted that he had told the Police, after Mr McCulloch's death, that the curtain may have been closed.<sup>404</sup> At that time, when leaving room 43, Mr Varughese did not know where VH was.<sup>405</sup> After returning with Mr Durr to the dining room, Mr Varughese returned to breakfast duties.<sup>406</sup> Mr Varughese agreed, in hindsight, that it was possible Mr McCulloch was injured at this time but he did not know, and no one had said that to him.<sup>407</sup> It did not occur to him that Mr McCulloch might have been involved in the incident.<sup>408</sup>

147. At about 8:00 or 8:10am, Mr Varughese saw Mr Yappa and Ms Endo walk out of room 43.<sup>409</sup> Mr Joseph told Mr Varughese that Mr McCulloch had blood on his face, that someone had hit Mr McCulloch, and Mr Joseph was not sure if Mr McCulloch had passed

---

<sup>394</sup> Transcript 29.9.15 P27 L42-P28 L2

<sup>395</sup> Transcript 29.9.15 P28 L27-36

<sup>396</sup> Transcript 29.9.15 P29 L35-39, P30 L4-7, L21-28

<sup>397</sup> Transcript 29.9.15 P30 L30-32, P62 L14-20

<sup>398</sup> Transcript 29.9.15 P30 L9-15, P62 L22-27

<sup>399</sup> Transcript 29.9.15 P62 L29-37

<sup>400</sup> Transcript 29.9.15 P30 L17-19

<sup>401</sup> Transcript 29.9.15 P30 L39-44

<sup>402</sup> Transcript 29.9.15 P31 L1-14

<sup>403</sup> Transcript 29.9.15 P32 L4-5

<sup>404</sup> Transcript 29.9.15 P32 L7-P33 L10

<sup>405</sup> Transcript 29.9.15 P33 L19-20

<sup>406</sup> Transcript 29.9.15 P33 L22-23

<sup>407</sup> Transcript 29.9.15 P68 L17-35

<sup>408</sup> Transcript 29.9.15 P69 L19-P70 L4

<sup>409</sup> Transcript 29.9.15 P33 L25-26

away.<sup>410</sup> Mr Varughese walked to the entrance of room 43 and looked through the door jamb for one or two minutes. He did not go in, but he could not see much.<sup>411</sup> He did so because he was scared that something had happened.<sup>412</sup> He could not see Mr McCulloch's face, all that he could see was a person sleeping covered by a sheet or blankets or a quilt.<sup>413</sup> Mr Varughese did not talk to Ms Endo or Mr Yappa at this time, and no one had told him to go to room 43.<sup>414</sup> After seeing Mr McCulloch's body, he returned to the dining room.<sup>415</sup>

148. Mr Varughese initially could not recall whether, while he was at the door, Ms Tichivangana came and spoke to him, but then specifically denied that he had told her "(VH) had done it" or that she could enter the room, but not touch anything.<sup>416</sup> Mr Varughese's taped record of conversation<sup>417</sup> was played back and he then, eventually, accepted that the conversation had taken place, except for the statement that he told Ms Tichivangana not to touch anything, and said that he did not recall the event prior to having watched the video.<sup>418</sup>

149. When Mr Varughese took a break later in the morning, he rang his wife, Ms Mathew, to tell her about the incident.<sup>419</sup> He said he told Ms Mathew that someone had punched Mr McCulloch's face, because that was what Mr Joseph had told him. He had not seen Mr McCulloch's face and he had not told his wife who had hit Mr McCulloch.<sup>420</sup>

150. Mr Varughese initially gave conflicting evidence as to whether he recalled incidents of violence on the ward leading up to Mr McCulloch's death, and specifically the incidents between Mr Durr and VH on 18 January 2012.<sup>421</sup> He ultimately denied that anyone had told him that VH was aggressive and needed to be watched, or that VH had been placed on a surveillance chart.<sup>422</sup> He said he did not check the DONs book on 21 January 2012, nor had he seen the incident reports recording instances of aggression involving VH. He said he relied on a 5 to 10 minute handover from his colleague to know what had happened

---

<sup>410</sup> Transcript 29.9.15 P33 L28-32, P35 L30-P36 L4

<sup>411</sup> Transcript 29.9.15 P33 L34-37, P34 L14-19, P36 L6-12

<sup>412</sup> Transcript 29.9.15 P33 L37-P34 L2

<sup>413</sup> Transcript 29.9.15 P36 L14-27

<sup>414</sup> Transcript 29.9.15 P34 L5-9

<sup>415</sup> Transcript 29.9.15 P36 L29-30

<sup>416</sup> Transcript 29.9.15 P37 L1-17

<sup>417</sup> Exhibit 9A

<sup>418</sup> Transcript 29.9.15 P54 L19-P55 L42

<sup>419</sup> Transcript 29.9.15 P70 L42-P71 L3

<sup>420</sup> Transcript 29.9.15 P71 L8-17, P72 L7-13

<sup>421</sup> Transcript 29.9.15 P56 L22-P58 L16

<sup>422</sup> Transcript 29.9.15 P58 L20-24

overnight, as he would be late for his shift and miss the handover from the night staff.<sup>423</sup> On the morning of 21 January 2012, Mr Varughese asked Mr Joseph how were the residents, and Mr Joseph said they were good. He did not check Mr McCulloch after seeing the injuries to Mr Durr because Mr Joseph had earlier said the residents were good and he needed to start the breakfast and he was very busy.<sup>424</sup> He said breakfast was always a very busy time and there was no time at breakfast time to check if residents were safe.<sup>425</sup> He agreed that, if there were more AINs working, it would be easier for everybody and more frequent checks of residents could be made.<sup>426</sup> He said that residents get the help they need when staff see that help is needed.<sup>427</sup> He said that residents are violent pretty regularly, every shift, and that the first staff member to see the incident is the person required to write an incident report, but denied there was any room for confusion between staff as to who would write up the report.<sup>428</sup> He later clarified that this statement of frequency was not only physical violence but also verbal fighting.<sup>429</sup> He ultimately agreed it was possible that some incident reports didn't get written because each staff member thinks the other staff member will do it.<sup>430</sup> He said that he would report an incident, like a fall, straight away to the RN, after making the resident comfortable, and would write the incident report afterward when it was convenient and he was not busy, which would normally be 30 to 40 minutes after the incident.<sup>431</sup>

151. Mr Varughese was questioned by the Police about Ms Magliulo. He stated that he did not know whether the alarm on her room, room 45, was working in the week before her death.<sup>432</sup>

### **Evidence of Timothy August (Tim) Yappa**

152. Timothy Yappa was, at the time of Mr McCulloch's death, as an Assistant in Nursing (AIN) at the Jindalee Aged Care Residence, and was still in that employment as at the date of the inquest. At the time of Mr McCulloch's death, Mr Yappa held a Certificate III in aged care and a first aid certificate.<sup>433</sup> Mr Yappa made a statement dated 21 January 2012

---

<sup>423</sup> Transcript 29.9.15 P59 L40-P60 L34, P60 L1-P62 L6

<sup>424</sup> Transcript 29.9.15 P62 L43-P63 L24, P64 L44-P66 L10, P68 L13-15, L29-30

<sup>425</sup> Transcript 29.9.15 P63 L19-43, P64 L6-9

<sup>426</sup> Transcript 29.9.15 P64 L19-23, P68 L3-11

<sup>427</sup> Transcript 29.9.15 P64 L30-42

<sup>428</sup> Transcript 29.9.15 P65 L13-43

<sup>429</sup> Transcript 29.9.15 P70 L12-25

<sup>430</sup> Transcript 29.9.15 P66 L7-10

<sup>431</sup> Transcript 29.9.15 P66 L18-P67 L42

<sup>432</sup> Transcript 29.9.15 P36 L37-43

<sup>433</sup> Transcript 29.9.15 P39 L33-38

(Exhibit 13), participated in a re-enactment (Exhibit 14) and gave oral evidence. He agreed that in the event of any inconsistency between his evidence and his statement to the Police, what he told the Police in the aftermath of Mr McCulloch's death was likely to be accurate.<sup>434</sup>

153. As at 2012, Mr Yappa had worked continuously at Jindalee for 12 years.<sup>435</sup> He had never personally heard or witnessed physical violence between VH, Mr Durr or Mr Noble prior to 21 January 2012, although the residents had often argued amongst themselves.<sup>436</sup> He was aware that VH and Mr Durr both had a history of aggression, and he was aware of the incident reports in respect of both residents including the aggression on 18 January 2012.<sup>437</sup> He was aware of care plans for VH and Mr Durr but he was not responsible for developing those documents, as the RN was responsible for them.<sup>438</sup> He agreed he was committed, protective and loyal to Jindalee, and protective of Jindalee staff.<sup>439</sup>
154. On 21 January 2012, Mr Yappa commenced his shift at 7:00am, although he arrived at Jindalee at about 6:30am.<sup>440</sup> He was given Allocation 3 which included VH, Mr Durr, and Ms Magliulo, but not Mr McCulloch or Ms Faulkner.<sup>441</sup> He obtained his allocation from the diary and received a handover from Mr Sharma,<sup>442</sup> and read the DONs book.<sup>443</sup> The night staff did not indicate that there had been any aggression the previous night.<sup>444</sup>
155. Mr Yappa had initially told Police that on arrival he saw VH and Mr Durr asleep in their beds, but by the time of the inquest he could not recall this, and accepted that he might be mistaken.<sup>445</sup> He also told Police that he saw Mr McCulloch sleeping in his bed as the curtain was wide open. He was laying on his back, with his head up one end. Mr Yappa did not see blood on the wall at that time.<sup>446</sup> Mr Yappa did not know that Mr Shahi had seen VH at about 7:00am standing in the hallway, asking about the toilet.<sup>447</sup> As part of his early rounds, Mr Yappa also checked on Ms Magliulo and found her in bed, quite happy, with

---

<sup>434</sup> Transcript 29.9.15 P39 L40-P40 L2

<sup>435</sup> Transcript 29.9.15 P39 L28-31, P47 L40-42

<sup>436</sup> Transcript 29.9.15 P44 L10-48

<sup>437</sup> Transcript 29.9.15 P76 L26-40, P83 L7

<sup>438</sup> Transcript 29.9.15 P85 L15-22

<sup>439</sup> Transcript 29.9.15 P89 L9-15

<sup>440</sup> Transcript 29.9.15 P40 L4, P41 L18-21, L40-43

<sup>441</sup> Transcript 29.9.15 P40 L8-P41 L16

<sup>442</sup> Transcript 29.9.15 P40 L23-35

<sup>443</sup> Transcript 29.9.15 P44 L4-8

<sup>444</sup> Transcript 29.9.15 P82 L42-P83 L5

<sup>445</sup> Transcript 29.9.15 P41 L28-P42 L23

<sup>446</sup> Transcript 29.9.15 P42 L25-38, P74 L13-P75 L2

<sup>447</sup> Transcript 29.9.15 P42 L40-43

no injury.<sup>448</sup> Mr Yappa denied any knowledge of the status of the alarm on Ms Magliulo's room.<sup>449</sup> He did not observe Ms Faulkner.<sup>450</sup>

156. From about 7:05 to 7:40am Mr Yappa was getting people up and dressed, and ready for breakfast.<sup>451</sup> He said that serving breakfast involves taking food off a trolley from the kitchen and putting the food on a bench, and serving residents at tables, including sometimes feeding residents.<sup>452</sup> At about 7:40am, Mr Yappa heard two people shouting at each other. He and Mr Varughese went to room 43 where he saw Mr Durr and VH facing and throwing punches at each other.<sup>453</sup> He went into the room and separated Mr Durr and VH, and he noticed Mr Durr had what looked like scratch marks on his face, with blood on his cheeks.<sup>454</sup> Although not sure, Mr Yappa thought he took VH to the dining room but he was unable to watch him all the time, due to the other duties he was performing at the time.<sup>455</sup> Ms Endo asked Mr Yappa to remove the blood from Mr Durr's face, although Mr Yappa could not recall the sequence and whether that was before or after he took VH to the dining room.<sup>456</sup>

157. Mr Yappa recalled cleaning up Mr Durr in room 43, but did not recall if VH was present at the time.<sup>457</sup> He said that breakfast was a very busy time of day and the most busy time for staff on morning shifts, and that staff try to be in all places at the same time.<sup>458</sup> Mr Yappa did not recall whether any other staff checked any other residents in room 43 after the altercation, but agreed that would have been a prudent course of action, saying that staff were just too busy.<sup>459</sup> He agreed with a suggestion from His Honour that, in the aftermath of the altercation, no one turned their mind to whether the violence had overflowed to other patients.<sup>460</sup>

---

<sup>448</sup> Transcript 29.9.15 P43 L1-12

<sup>449</sup> Transcript 29.9.15 P43 L10-23

<sup>450</sup> Transcript 29.9.15 P43 L41-42

<sup>451</sup> Transcript 29.9.15 P43 L44-P44 L2

<sup>452</sup> Transcript 29.9.15 P48 L6-20

<sup>453</sup> Transcript 29.9.15 P45 L1-32, P73 L11-19

<sup>454</sup> Transcript 29.9.15 P45 L34-P46 L19, P73 L21-25

<sup>455</sup> Transcript 29.9.15 P46 L23-37, P87 L10-14

<sup>456</sup> Transcript 29.9.15 P46 L39-P47 L9

<sup>457</sup> Transcript 29.9.15 P47 L16-21

<sup>458</sup> Transcript 29.9.15 P47 L27-P48 L4

<sup>459</sup> Transcript 29.9.15 P76 L5-24

<sup>460</sup> Transcript 29.9.15 P92 L8-14

158. The next event of significance was that Ms Endo called Mr Yappa to come to her at about 8:15am.<sup>461</sup> He gave differing evidence as to the timing of this event: he first agreed it that could only have been 5 to 10 minutes after he separated VH and Mr Durr,<sup>462</sup> but then said that the elapsed time was 30 to 40 minutes.<sup>463</sup> At this time, Ms Endo was distributing medication, Mr Yappa was serving breakfast and Mr Joseph was serving porridge to residents in their rooms.<sup>464</sup> He thought Ms Endo was outside room 43 when she called him.<sup>465</sup> He went into the room and saw that Mr McCulloch had been bashed pretty badly, there was blood on the pillow on which Mr McCulloch's head was lying, on the wall and also possibly on the headboard.<sup>466</sup> Mr McCulloch's face was visible and there was no other item covering his face.<sup>467</sup> Mr Yappa did not recall whether there were other residents in the room at the time. He did not check for Mr McCulloch's pulse, nor did he see anyone else check.<sup>468</sup> He did not remember saying to Ms Endo "*It looks like he's been dead for a long time*" but accepted he could have said that, and agreed that was his impression.<sup>469</sup> Mr Yappa said he was satisfied Mr McCulloch was dead when he saw him, although he did not check if Mr McCulloch was breathing, because of the appearance of Mr McCulloch's face.<sup>470</sup> He accepted, at the hearing, that it was possible Mr McCulloch was lying in bed injured at the time he entered room 43 to separate Mr Durr and VH, although he did not observe that.<sup>471</sup> Ms Endo was very distressed by the incident and relied on Mr Yappa to assist in resolving the incident.<sup>472</sup> Mr Yappa was unaware of who Ms Endo contacted about the incident.<sup>473</sup> He did not recall seeing VH in room 43 after Mr McCulloch was discovered and did not know where VH was, thinking that VH was perhaps in the dining room.<sup>474</sup> He also did not know where Mr Durr was.<sup>475</sup> He did not initially suspect VH was the assailant, but began to consider it as a possibility when Police arrived, as he had to return to his duties to other residents and support the other staff.<sup>476</sup> He told one of the other staff members that he thought VH was responsible.<sup>477</sup>

---

<sup>461</sup> Transcript 29.9.15 P48 L22-26, P49 L7-9, P50 L4-7, P73 L25-26

<sup>462</sup> Transcript 29.9.15 P75 L8-18

<sup>463</sup> Transcript 29.9.15 P87 L39-P88L1

<sup>464</sup> Transcript 29.9.15 P48 L28-P49 L3

<sup>465</sup> Transcript 29.9.15 P49 L11-12

<sup>466</sup> Transcript 29.9.15 P49 L14-39, P73 L28-37

<sup>467</sup> Transcript 29.9.15 P77 L4-6, P87 L16-17

<sup>468</sup> Transcript 29.9.15 P49 L44-P50 L7, P77 K8-9

<sup>469</sup> Transcript 29.9.15 P39 L28-31, P73 L41-P74 L11, P27-31

<sup>470</sup> Transcript 29.9.15 P87 L23-33

<sup>471</sup> Transcript 29.9.15 P75 L33-P76 L2, P88 L3-13

<sup>472</sup> Transcript 29.9.15 P78 L2-17, P88 L15-20

<sup>473</sup> Transcript 29.9.15 P78 L19-27

<sup>474</sup> Transcript 29.9.15 P78 L29-34, P79 L13-20

<sup>475</sup> Transcript 29.9.15 P79 L22

<sup>476</sup> Transcript 29.9.15 P78 L36-P79 L11, P88 L28-37

<sup>477</sup> Transcript 29.9.15 P82 L28-40

159. Mr Yappa said that the protocol for dealing with a deceased resident was to notify the RN and wait with the body for the RN to attend, that he would not himself check vital signs as the RN would do that, the RN would then try to locate the doctor and eventually the undertakers would collect the body.<sup>478</sup> He would not ordinarily provide first aid to a resident before the RN had checked the resident.<sup>479</sup> The process is prescribed by Jindalee's policy and procedures manual (Exhibit 79). It appears to apply to RNs and AINs, but the obligation on AINs is only to notify the RN.<sup>480</sup> He agreed that contrary to practice, no one stayed with Mr McCulloch, as all staff left the room together.<sup>481</sup> He could not recall whether the curtain was pulled to give Mr McCulloch some privacy.<sup>482</sup> Mr Yappa agreed that there should be a proper protocol and training for staff to deal with events like Mr McCulloch's death, that someone should remain with the deceased at all times, that no one to touch anything, and Police be immediately notified by an AIN, not just an RN or waiting for the instructions of an RN.<sup>483</sup>

160. It was put to Mr Yappa that he had gone back to room 43 with Chantelle Moore so that Ms Moore could have a look at Mr McCulloch. He could not recall that, but said it might have happened and, as Ms Moore said it had happened, he believed her.<sup>484</sup> He agreed it would have been absolutely inappropriate for he and Ms Moore to go back and "*sticky beak*", and that it would be very disturbing to Mr McCulloch's relatives.<sup>485</sup> He said "*It was none of anybody's business*" what happened to Mr McCulloch, but Mr Yappa did not mean to refer to the Coroner, Police or Mr McCulloch's relatives in that statement.<sup>486</sup> Mr Yappa agreed that he did not enable rumours.<sup>487</sup> He did not recall, as Ms Moore stated, that VH was in room 43 when she and Mr Yappa returned to the room, and that a smear of dried blood was visible on VH's hands.<sup>488</sup> He said he was not present with Ms Moore when Dr Webber returned to room 43.<sup>489</sup>

---

<sup>478</sup> Transcript 29.9.15 P50 L9-22, P50 L44-P51 L11, P77 L11-13

<sup>479</sup> Transcript 29.9.15 P50 L24-34, P51 L13-14

<sup>480</sup> Transcript 29.9.15 P51 L40-P52 L25

<sup>481</sup> Transcript 29.9.15 P77 L15-20, P79 L24

<sup>482</sup> Transcript 29.9.15 P77 L22-29

<sup>483</sup> Transcript 29.9.15 P82 L8-26

<sup>484</sup> Transcript 29.9.15 P79 L35-P80 L35

<sup>485</sup> Transcript 29.9.15 P80 L20-29

<sup>486</sup> Transcript 29.9.15 P81 L6-P82 L6

<sup>487</sup> Transcript 29.9.15 P88 L39-P89 L12

<sup>488</sup> Transcript 29.9.15 P80 L37-P81 L4

<sup>489</sup> Transcript 29.9.15 P85 L8-10

161. Mr Yappa stated he had given a direction to Ms Tichivangana to attend to Ms Magliulo, and that he subsequently learned that Ms Magliulo had been assaulted.<sup>490</sup> He said that he had visited Ms Magliulo himself after the assault to see what happened.<sup>491</sup> Mr Yappa said that staff should have positive proof something has happened before they start to talk about it.<sup>492</sup> He rejected an assertion that Jindalee had insufficient staff to properly monitor residents and prevent assaults, and another assertion that assaults happen all the time in Jindalee without staff observing.<sup>493</sup>
162. Mr Yappa was aware of the Jindalee policy on the reporting requirements for elder abuse and the requirement for staff to report assaults on and by residents.<sup>494</sup> He was aware of the requirement for the RN to investigate immediately and prepare an incident report, to report the matter to the DON and that the DON is to inform Police within 1 hour.<sup>495</sup> He agreed this was particularly important in a dementia unit because the residents are sometimes frail and confused and may not recall what happened to them.<sup>496</sup>
163. Mr Yappa agreed that all staff, both AINs and RNs, failed to properly manage the incident.<sup>497</sup> He said he had never experienced anything like the day's events in his 12 years of experience.<sup>498</sup> He agreed what happened to Mr McCulloch was horrific.<sup>499</sup>
164. Mr Yappa was aware of surveillance charts, and agreed if his name was on a chart for VH he would have completed it.<sup>500</sup> He agreed that the practice was to fill those charts in at the end of a shift,<sup>501</sup> but that staff would still have made the required observations, and if the chart indicated the person had been in a different locality that would have been filled in at the time of the observation.<sup>502</sup>
165. Mr Yappa's honesty was challenged by Counsel for the McCulloch family on the basis of changes in his evidence in the aftermath of Mr McCulloch's death compared to his

---

<sup>490</sup> Transcript 29.9.15 P85 L24-29

<sup>491</sup> Transcript 29.9.15 P85 L31-39

<sup>492</sup> Transcript 29.9.15 P84 L9-13

<sup>493</sup> Transcript 29.9.15 P84 L15-21

<sup>494</sup> Transcript 29.9.15 P84 L23-37

<sup>495</sup> Transcript 29.9.15 P84 L39-42

<sup>496</sup> Transcript 29.9.15 P84 L44-P85 L3

<sup>497</sup> Transcript 29.9.15 P77 L31-38

<sup>498</sup> Transcript 29.9.15 P77 L4-9

<sup>499</sup> Transcript 29.9.15 P82 L11-12

<sup>500</sup> Transcript 29.9.15 P85 L41-P86 L6

<sup>501</sup> Transcript 29.9.15 P86 L7-19

<sup>502</sup> Transcript 29.9.15 P86 L26-38

testimony in court.<sup>503</sup> He agreed that he was cautious in his dealings with Police in January and February 2012 but was trying to do his best and get the facts of the matter straight.<sup>504</sup> He agreed that there was nothing that he had not already told the Police or the court which was of significance that happened that morning which would assist further.<sup>505</sup>

**Evidence of Joanne Frances (Jo) Costuna (now Temple)<sup>506</sup>**

166. **Joanne Costuna** was, at the time of Mr McCulloch's death, one of two Directors of Nursing at Jindalee Aged Care (the other being Cheryl Hart). Ms Costuna made a statement dated 21 September 2015 (which was tendered as Exhibit 149) and gave oral evidence on 20 April 2016. She had also participated in a taped record of conversation with Constable Rick Gill on 25 January 2012, which was tendered as Exhibit 97.
167. Ms Costuna commenced work as a RN at Jindalee in 1996, and worked in Casuarina Wing (the dementia unit), becoming the Nurse Unit Manager in 1997, before, in 2006, becoming a Deputy Director of Nursing, and in 2011 a Director of Nursing (DON).<sup>507</sup> In the latter role, she was responsible for Casuarina, Diosma, Hoya and Jarrah Wings, and Ms Hart was responsible for the rest of the nursing home.<sup>508</sup> Ms Costuna has 31 years of experience as a registered nurse and three years of experience prior to that as an assistant in nursing.<sup>509</sup> She had received two awards for nursing and aged care.<sup>510</sup>
168. Specific details as to staffing levels and shifts both in 2012 and 2015, and how staff numbers were determined, were included in Ms Costuna's statement.<sup>511</sup> When Mr McCulloch arrived there was one RN responsible for Ms Costuna's half of the nursing home, and one in-charge RN in the afternoon.<sup>512</sup> The dementia wing was staffed with a majority of "*core staff*" who have been there a long time and have a lot of training.<sup>513</sup> Staff were rostered to work by the roster clerk working with the DONs and Deputy DONs, and the senior nurse on the unit allocates residents to staff members on day and afternoon shifts

---

<sup>503</sup> Transcript 29.9.15 P89 L17-P91 L2

<sup>504</sup> Transcript 29.9.15 P91 L6-31

<sup>505</sup> Transcript 29.9.15 P91 L33-P92 L4

<sup>506</sup> Transcript 20.4.16 P7 L8-9

<sup>507</sup> Exhibit 149, [1.3]; Transcript 20.4.16 P7 L44-P8 L6

<sup>508</sup> Transcript 20.4.16 P7 L26-37

<sup>509</sup> Exhibit 149, [1.2]

<sup>510</sup> Exhibit 149, Section 3

<sup>511</sup> Exhibit 149, Section 3

<sup>512</sup> Transcript 20.4.16 P9 L32-43

<sup>513</sup> Transcript 20.4.16 P32 L4-6

by recording allocations in the diary on the wing.<sup>514</sup> There is no allocation system on night shift, as there was no need to allocate staff to particular residents.<sup>515</sup> Ms Costuna's statement contained details of Jindalee's training of staff in relation to physical aggression and behaviour management.<sup>516</sup>

169. Ms Costuna confirmed that she had never met Mr McCulloch, but knew him to be a resident arriving from interstate with dementia, who had previously been in hospital and previously had falls.<sup>517</sup> She had had a telephone conversation with Mr McCulloch's son prior to Mr McCulloch's arrival in which she had been given background as to Mr McCulloch's needs and condition.<sup>518</sup>
170. Section 4 of Ms Costuna's statement<sup>519</sup> detailed the admission process for residents entering Jindalee, and specifically being admitted to Casuarina Wing. The RN for Casuarina Wing on the Friday night would have started the admission process for Mr McCulloch, but Ms Costuna did not recall who that was,<sup>520</sup> and she did not herself complete the admission form.<sup>521</sup> She thought she would have seen Mr McCulloch's ACAT form prior to his admission but was not sure,<sup>522</sup> and would have read it sometime within the previous couple of weeks before his arrival but would not have retained a clear recollection of the contents.<sup>523</sup>
171. Ms Costuna said normally Jindalee do not take admissions on a Friday afternoon but did so for Mr McCulloch because he was transferred from interstate.<sup>524</sup> She was unaware that Mr McCulloch's bag had not been unpacked on arrival, saying that the person allocated the resident on the unit would unpack bags and belongings.<sup>525</sup> She said that when a resident arrives at Jindalee, a nurse will meet the resident and welcome the resident to the wing. The resident will be offered something to eat and drink and introduced to the nurse looking after the resident on that allocation. The RN will then commence the paperwork.<sup>526</sup>

---

<sup>514</sup> Transcript 20.4.16 P31 L41-P32 L24

<sup>515</sup> Transcript 20.4.16 P33 L4-15

<sup>516</sup> Exhibit 149, Sections 5 and 6

<sup>517</sup> Transcript 20.4.16 P9 L5-17

<sup>518</sup> Transcript 20.4.16 P41 L45-P42 L10

<sup>519</sup> Exhibit 149

<sup>520</sup> Transcript 20.4.16 P9 L25-30, L44-45

<sup>521</sup> Transcript 20.4.16 P41 L40-43

<sup>522</sup> Transcript 20.4.16 P42 L24-32

<sup>523</sup> Transcript 20.4.16 P43 L6-13

<sup>524</sup> Transcript 20.4.16 P43 L32-37

<sup>525</sup> Transcript 20.4.16 P43 L29-30, L35-37

<sup>526</sup> Transcript 20.4.16 P61 L15-23

172. Although the suitability of an allocation is considered, rooms are generally allocated on the basis of availability.<sup>527</sup> It was known that VH had issues with aggression and had had two previous altercations, but Ms Costuna considered that VH was easily diverted so that was not a reason not to accept Mr McCulloch's allocation to that room.<sup>528</sup> Also, even if VH were moved into another room, he would still return to his original room.<sup>529</sup> She accepted that it was known to Jindalee, prior to Mr McCulloch's arrival, that the altercations between VH and Mr Durr were due to Mr Durr wandering into VH's space, and that Jindalee knew Mr McCulloch was a wanderer.<sup>530</sup> She agreed that there was little that could be done in a dementia ward about violent incidents that happen suddenly.<sup>531</sup> Ms Costuna agreed that the only alternative would be to not admit a resident like VH, and certainly from now Jindalee's policy is that they will no longer admit a resident with a significant physical aggression background, but that, on what was known about VH at the point of his admission, he would probably still be admitted today.<sup>532</sup> The information in VH's record would probably today lead to additional enquiries being made.<sup>533</sup>

173. Ms Costuna was specifically asked about VH's admission form, and stated that in 2012 it was completed by the senior nurse on the floor, the clinical nurse consultant (although in 2015 Jindalee now has an admissions clerk).<sup>534</sup> She stated that if a resident is transferred from a hospital, as VH was, the file will contain a transfer sheet, information about nursing management, diagnosis, discharge plan, food and drink preferences, and ACAT form.<sup>535</sup> On VH's ACAT form he had been permanently placed at Jindalee for high level residential care, which at that time reflected factors relating to activities of daily living, medications, and skin integrity.<sup>536</sup> She agreed that the action plan for assessments and details for admitting were not completed for VH.<sup>537</sup>

174. Ms Costuna detailed her involvement in the events of 21 January 2012 at Section 2 of her statement.<sup>538</sup> In court, Ms Costuna was advised of Ms Endo's evidence as to a telephone conversation between the two of them at about 8:00am on 21 January 2012 in which Ms

---

<sup>527</sup> Transcript 20.4.16 P61 L25-34, P66 L32-33, P66 L42-P68 L1

<sup>528</sup> Transcript 20.4.16 P61 L28-36, P66 L5-33

<sup>529</sup> Transcript 20.4.16 P67 L22-27

<sup>530</sup> Transcript 20.4.16 P61 L38-P62 L4

<sup>531</sup> Transcript 20.4.16 P62 L18-20

<sup>532</sup> Transcript 20.4.16 P68 L5-33, P72 L4-7

<sup>533</sup> Transcript 20.4.16 P69 L1-14

<sup>534</sup> Transcript 20.4.16 P31 L15-27, P66 L35-40

<sup>535</sup> Transcript 20.4.16 P33 L40-P34 L17

<sup>536</sup> Transcript 20.4.16 P34 L16-33

<sup>537</sup> Transcript 20.4.16 P50 L31-38

<sup>538</sup> Exhibit 149

Endo suggested calling the Police, but was told by Ms Costuna not to panic or call the Police but to call a doctor. She agreed this conversation had taken place but clarified that her instruction to Ms Endo to contact the doctor was because no one had seen or heard anything.<sup>539</sup> She agreed she directed Ms Endo not to call Police,<sup>540</sup> but said that if someone had seen something happen she would have instructed Ms Endo to call the Police,<sup>541</sup> and said that she would not and did not instruct Ms Endo to override a directive from the doctor to call the Police.<sup>542</sup> The intention in seeking the doctor's advice was to follow the doctor's direction,<sup>543</sup> Ms Costuna did not think it would take as long to do that as it did.<sup>544</sup> She said that she thought Mr McCulloch might have fallen.<sup>545</sup> When His Honour suggested that she had been told by Ms Endo that Mr McCulloch was found in bed and that would tend against a fall, Ms Costuna said that she had seen often people fall but get themselves back into bed.<sup>546</sup> Ms Costuna agreed that Ms Endo advised her of Ms Endo's belief that Mr McCulloch had been punched by VH because there was blood on Mr McCulloch's face.<sup>547</sup>

175. Although Ms Costuna told Police on 25 January 2012 that Ms Endo advised her in the 8:00am phone call that Dr Webber had seen Mr McCulloch, she accepted now (in 2015) that this was not correct.<sup>548</sup> Ms Costuna strongly denied that she intended to cover up what had happened to Mr McCulloch because no one had seen what had happened.<sup>549</sup> She said that she considered she had a duty to call the Police in the event of a suspicious death only if the doctor thought the death was suspicious.<sup>550</sup>
176. She accepted that Mr McCulloch could have been only injured at the time of the incident between VH and Mr Durr and had been laying in bed dying from then until he was eventually found.<sup>551</sup> She accepted that in the period after his discovery, Mr McCulloch was afforded no dignity and his body was interfered with in an undignified manner.<sup>552</sup> She agreed that it was possibly open to staff to have put VH in another room, where staff could

---

<sup>539</sup> Transcript 20.4.16 P10 L1-42, P18 L11-31

<sup>540</sup> Transcript 20.4.16 P10 L44-45

<sup>541</sup> Transcript 20.4.16 P18 L30-31

<sup>542</sup> Transcript 20.4.16 P26 L34-39

<sup>543</sup> Transcript 20.4.16 P27 L1-6; Exhibit 149, [2.6]

<sup>544</sup> Transcript 20.4.16 P61 L25-34, P63 L7-34

<sup>545</sup> Transcript 20.4.16 P11 L1-15, P65 L34-38

<sup>546</sup> Transcript 20.4.16 P15 L40-P16 L2

<sup>547</sup> Transcript 20.4.16 P11 L30-36, P52 L22-28

<sup>548</sup> Transcript 20.4.16 P11 L17-23

<sup>549</sup> Transcript 20.4.16 P11 L41-43, P23 L25-26, P64 L39-P65 L18

<sup>550</sup> Transcript 20.4.16 P11 L45-P12 L2

<sup>551</sup> Transcript 20.4.16 P65 L3-11

<sup>552</sup> Transcript 20.4.16 P65 L20-25

have observed him after the altercation with Mr Durr, instead of allowing him to return to his room, but said she thought VH had requested to return to his room after breakfast.<sup>553</sup>

177. Ms Costuna agreed that she was the author of a four page document provided to the Department of Health and Ageing in her name dated 26 June 2013,<sup>554</sup> as part of a meeting between Jindalee staff and the Department.<sup>555</sup> She spoke of meetings that took place between the Department on 23 and 30 January 2012 and a number of Jindalee staff, but was unable to say why Ms Endo did not meet with the Department, given Ms Endo's knowledge of matters, suggesting she may not have been at work due to stress.<sup>556</sup> She was taken to the Department's detailed resolution report (Exhibit 138) and asked where she obtained the information that Mr McCulloch was discovered with a blanket and pillow over his face. She replied that she did not know because she was told that Mr McCulloch was found deceased with an injury to his face.<sup>557</sup> Ms Costuna confirmed that she was told by Ms Endo on the morning of the death that Mr McCulloch had been seen with blood on his face and Ms Endo had mentioned neither a pillow nor a blanket.<sup>558</sup> She said she was told over the next couple of days about the involvement of a pillow and blanket when Dr Webber went to see Mr McCulloch.<sup>559</sup> She agreed that the second discovery of the blanket and pillow indicated that Mr McCulloch's body had been tampered with.<sup>560</sup>

178. Ms Costuna said that this was the first time it had been pointed out to her that the Departmental report contained an error in relation to the circumstances of Mr McCulloch's discovery, that she now accepted that information was incorrect. She had considered the information was correct, but believed that she had had discussions with the Department as to the correct facts as to how Mr McCulloch was found.<sup>561</sup> She agreed that nothing was done with the Department to correct what was said to be a fundamental mistake of fact.<sup>562</sup>

179. Ms Costuna said she had a good recollection of the Department visiting Jindalee in the aftermath of Mr McCulloch's death, but she did not recall the specifics of the meetings.<sup>563</sup>

---

<sup>553</sup> Transcript 20.4.16 P72 L10-36

<sup>554</sup> Exhibit 139

<sup>555</sup> Transcript 20.4.16 P44 L7-23

<sup>556</sup> Transcript 20.4.16 P44 L32-P45 L14, P46 L8-P47 L27

<sup>557</sup> Transcript 20.4.16 P47 L 29-P48 L2, P48 L35-39

<sup>558</sup> Transcript 20.4.16 P48 L4-9

<sup>559</sup> Transcript 20.4.16 P48 L17-23, P48 L41-P49 L5

<sup>560</sup> Transcript 20.4.16 P49 L7-10

<sup>561</sup> Transcript 20.4.16 P49 L25-P50 L29, P52 L10-17

<sup>562</sup> Transcript 20.4.16 P52 L19-20

<sup>563</sup> Transcript 20.4.16 P74 L28-44

She said she could not recall if the Department ever gave her a copy of its report in draft to check for accuracy.<sup>564</sup>

180. Ms Costuna claimed she was unaware that Sergeant Casey had formed the view, on the evidence, that both Ms Magliulo and Ms Faulkner had been assaulted on the morning of 21 January 2012, with Ms Magliulo having been found with a pillow and blanket over her face and was thought by Ms Tichivangana to be deceased.<sup>565</sup> She did not know who told the Department that the likely explanation for Ms Faulkner's injuries was a fall, but it could have been her.<sup>566</sup> She said that by 30 January she would have reviewed incident reports to check what had happened, but did not recall seeing an incident report in relation to Ms Faulkner's injuries and Ms Faulkner had not told Ms Costuna that she had been hit by a man.<sup>567</sup>

181. She did not agree the Department was not supplied with accurate information, saying that she answered all questions and provided all information sought, but agreed she gave the Department information which tended to the view that falls were the explanation for Mr McCulloch's and Ms Faulkner's injuries.<sup>568</sup> She agreed that no incident report was completed in regards to Mr McCulloch by staff, saying that "*it was absolutely chaos*" and suggesting that completing an incident report that morning was not high on her priority list,<sup>569</sup> that everyone who needed to know afterwards what happened did know.<sup>570</sup> She said that staff are required to write an incident report for every aggressive incident, including for verbal aggression, either at the time or later if duties require, and to report the incident to the RN, but accepted that while staff are trained to record all matters it is possible matters could be forgotten.<sup>571</sup>

182. Ms Costuna stated that, together with Ms Hart, she was the author and developer of Jindalee's policy and procedures manual (Exhibit 79), in collaboration with senior management, Deputy DONs and clinical nurse consultants.<sup>572</sup> Section 8 of her statement<sup>573</sup> detailed Jindalee's relevant policies and procedures. She said that most of the policies were already in place before she became a DON, but the policies were certainly checked

---

<sup>564</sup> Transcript 20.4.16 PP75 L1-2

<sup>565</sup> Transcript 20.4.16 P55 L19-P56 L41

<sup>566</sup> Transcript 20.4.16 P54 L20-36

<sup>567</sup> Transcript 20.4.16 P54 L38-P56 L15

<sup>568</sup> Transcript 20.4.16 P57 L1-33

<sup>569</sup> Transcript 20.4.16 P58 L27-P60 L15

<sup>570</sup> Transcript 20.4.16 P75 L34-35

<sup>571</sup> Transcript 20.4.16 P69 L16-41, P75 L39-P76 L2

<sup>572</sup> Transcript 20.4.16 P14 L36-P15 L9

<sup>573</sup> Exhibit 149

by herself and Ms Hart.<sup>574</sup> When asked to comment on the section in relation to death (p31), Ms Costuna agreed the process detailed there would not have applied to Mr McCulloch.<sup>575</sup> She agreed that, under the section on elder abuse (p39), assaults on residents are reportable to the DON,<sup>576</sup> but said that she did not consider the incident in relation to Mr McCulloch reportable as she thought he had probably fallen.<sup>577</sup> She did not accept Ms Endo's judgement about Mr McCulloch having been punched by VH, as no one had seen anything, so she asked Ms Endo to get the doctor to examine Mr McCulloch to give direction as to next steps.<sup>578</sup>

183. Ms Costuna accepted if Mr McCulloch had fallen and injured himself that would not need to be reported as abuse.<sup>579</sup> She said that if the doctor had said that the injuries were the result of an assault, then that would have been reported to the Police and the Department.<sup>580</sup> Ms Costuna said that she did not consider that Ms Endo had made a report of elder abuse to her in accordance with the policy, because Ms Endo did not know that the injuries resulted from an incident of abuse, because no one witnessed the injury and it could have been a fall.<sup>581</sup> She said she understood references in the policy to an incident of abuse were to something that was witnessed or seen or heard.<sup>582</sup> She accepted that the policy required staff to document and report incidents of abuse to the DON who would decide what action to take with the Department, and that was what Ms Endo had done, but she considered that "*documenting the incident*" required a report of what was seen and heard.<sup>583</sup> When taken back to the policy, and it was pointed out that the document required reporting of suspected assaults, Ms Costuna agreed that Ms Endo had complied with the policy and reported a suspected assault. Ms Costuna clarified that Ms Endo would have been in breach of the new suspicious deaths protocol by following the instructions Ms Costuna gave her in respect of Mr McCulloch.<sup>584</sup>

184. Ms Costuna strongly rejected a suggestion that she did not accept Ms Endo's account and had decided to treat the matter as a fall and that was the story that everyone was to be told, saying that her instruction was to get the doctor and if the doctor had suggested something

---

<sup>574</sup> Transcript 20.4.16 P11 L1-15, P20 L14-20

<sup>575</sup> Transcript 20.4.16 P13 L21-39

<sup>576</sup> Transcript 20.4.16 P13 L43-P14 L1

<sup>577</sup> Transcript 20.4.16 P14 L4-7

<sup>578</sup> Transcript 20.4.16 P14 L9-21, P23 L28-41

<sup>579</sup> Transcript 20.4.16 P14 L23-26

<sup>580</sup> Transcript 20.4.16 P14 L28-34

<sup>581</sup> Transcript 20.4.16 P16 L29-P17 L16

<sup>582</sup> Transcript 20.4.16 P17 L22-29; Exhibit 149, [2.5]

<sup>583</sup> Transcript 20.4.16 P17 L31-44

<sup>584</sup> Transcript 20.4.16 P18 L33-P19 L17, P65 L40-P66 L2, P73 L6-P74 L4

had happened, or Mr McCulloch had been assaulted, then the Police would have been called.<sup>585</sup> Ms Costuna said that Ms Endo was directed to call Police by Ms Hart, when Ms Costuna and Ms Hart were driving to Jindalee, and after they had been told that Dr Webber had seen Mr McCulloch, but that she did not hear the conversation as she was driving.<sup>586</sup> When advised that Ms Endo's evidence was that there were two calls made from the car, and not until the second call at about 8:30am was the direction to call the Police given, Ms Costuna said she did not recall the events and did not recall any conversation between herself and Ms Hart in the car prompting the second call.<sup>587</sup> A Departmental file note,<sup>588</sup> which erroneously stated that Police were called at 8:10am, was put to Ms Costuna. She said that she understood the call to have been before 8:30am but that she did not know what time the call was, and she did not remember if she was the person who provided this information to the Department.<sup>589</sup>

185. Ms Costuna said that in 2012 there was no protocol at Jindalee for suspicious deaths, but there was a coroners' policy at the back of the policy and procedure manual.<sup>590</sup> That document had been created due to a previous situation where the treating doctor could not be contacted.<sup>591</sup> She accepted the document detailed that the coroner was to be involved in respect of deaths in suspicious circumstances, and accepted that the information provided to her by Ms Endo was sufficient to infer suspicious circumstances, but said that she did not consider the circumstances to be suspicious because no one saw or heard anything and a fall could not be excluded.<sup>592</sup> She was taken back to her record of conversation with Police in 2012 where she had stated that she accepted Mr McCulloch's death was suspicious and said that was because the doctor had already been involved in the matter.<sup>593</sup>
186. Section 7 of Ms Costuna's statement<sup>594</sup> detailed Jindalee's reporting obligations. She was taken to the policies in relation to compulsory reporting and reportable assaults and confirmed that sometimes management deemed it not appropriate to report an assault in circumstances where the individuals involved suffer from a cognitive or mental impairment.<sup>595</sup> She stated the process required staff to complete an incident form, and the

---

<sup>585</sup> Transcript 20.4.16 P17 L45-P18 L9, P62 L27-37, P63 L4-5

<sup>586</sup> Transcript 20.4.16 P25 L1-31

<sup>587</sup> Transcript 20.4.16 P25 L35-P26 L21

<sup>588</sup> Part of Exhibit 120

<sup>589</sup> Transcript 20.4.16 P53 L39-P54 L18

<sup>590</sup> Transcript 20.4.16 P12 L4-17, P20 L3-6

<sup>591</sup> Transcript 20.4.16 P12 L17-20, P15 L12-14, P22 L20-23

<sup>592</sup> Transcript 20.4.16 P22 L39-P23 L11

<sup>593</sup> Transcript 20.4.16 P24 L19-40

<sup>594</sup> Exhibit 149

<sup>595</sup> Transcript 20.4.16 P20 L22-P21 L1

discretion whether to report was to be exercised by DONs or Deputy DONs.<sup>596</sup> She agreed that she would use her management and skill in the case of a person with dementia to determine whether it was appropriate to report the assault to Police.<sup>597</sup> She said she understood Jindalee complied with the policy requirement to report the assault resulting in Mr McCulloch's death to Police within the hour after Dr Webber had seen Mr McCulloch, and Jindalee had complied with its obligation to report the matter to the Department within 24 hours.<sup>598</sup>

187. Ms Costuna was asked to comment on VH's surveillance charts contained within his personal file.<sup>599</sup> She explained the purpose of the surveillance chart is so staff "eyeball" a resident during waking hours, and was used for VH because he had previously absconded from the facility and had voiced a desire to leave,<sup>600</sup> and because he had exhibited aggression on two prior instances.<sup>601</sup> Ms Costuna was told of the evidence of other witnesses to the effect that the surveillance charts had been falsified and did not reflect that checks were actually conducted, to which she stated that she was unaware of this fact, the conduct was unsatisfactory and should not happen.<sup>602</sup> She could not explain why surveillance of VH ceased at 7:15am but suggested that the discovery of Mr McCulloch was very stressful and a lot was happening and the unit was in confusion.<sup>603</sup> Given Mr McCulloch was found at about 7:40am, there should have been a sighting of VH at 7:30am.<sup>604</sup> She said that the job of monitoring that surveillance is conducted belongs to the RN in charge, who must check her assessments at the end of her shift, but spot checks are sometimes also done.<sup>605</sup> However, she accepted that ultimately it was her responsibility.<sup>606</sup>

188. Contrary to the evidence of her staff at the hearing that a tracking belt had been ordered for VH but not arrived, Ms Costuna stated that she was told by the clinical nurse consultant on the floor that the belt had arrived but VH used to take it off, but said, in any case, the belt was only for locating a person once they had left the facility and could not at that time pinpoint a location within the facility.<sup>607</sup> New belts can be monitored using a watch and

---

<sup>596</sup> Transcript 20.4.16 P21 L3-11

<sup>597</sup> Transcript 20.4.16 P21 L44-45

<sup>598</sup> Transcript 20.4.16 P22 L10-16

<sup>599</sup> Exhibit 71

<sup>600</sup> Transcript 20.4.16 P28 L10-21

<sup>601</sup> Transcript 20.4.16 P30 L8-16

<sup>602</sup> Transcript 20.4.16 P28 L41-P29 L24, P30 L11-16

<sup>603</sup> Transcript 20.4.16 P58 L1-25

<sup>604</sup> Transcript 20.4.16 P60 L17-21

<sup>605</sup> Transcript 20.4.16 P29 L26-41, P30 L18-41

<sup>606</sup> Transcript 20.4.16 P31 L10-13

<sup>607</sup> Transcript 20.4.16 P51 L5-18

can be programmed to give an alert to a telephone line when the person is outside the set range, and will pinpoint a resident within the facility, but Ms Costuna said she was not sure if it could be programmed to alert if a resident was in a room in the facility that they should not be.<sup>608</sup> Section 10 of Ms Costuna's statement<sup>609</sup> also addressed the issue of a magnetic alarm that had been installed in Ms Magliulo's room, but was not operative at the time of the assault on Ms Magliulo, as the alarm had been installed to prevent incursion by another patient who had subsequently died.

189. The evidence that had emerged in the inquest that VH had not been provided with his prescribed Risperidol was not known by Ms Costuna.<sup>610</sup> She agreed that Risperidol can be used to reduce aggression, but said it was prescribed to VH because he suffered from hallucinations.<sup>611</sup> She stated that it was the RN's responsibility to dispense medications, saying that while she conducts intermittent audits it was not possible for her to look at 169 medication charts every day.<sup>612</sup>

190. Ms Costuna agreed that she had told the Department that the DONs believed CCTV would not have any positive impact on the incident involving Mr McCulloch if it was a roommate who attacked him, but may have noted who went into Ms Magliulo's room.<sup>613</sup> She went into further detail as to her belief about the ineffectiveness of CCTV at Section 9 of her statement.<sup>614</sup> She denied that the reason why staff did not check on Mr McCulloch after the incident between Mr Durr and VH was insufficient staff, but said that staff should have checked everyone in the room was safe and she supposed that the focus of staff was the residents having the altercation.<sup>615</sup> Jindalee's new suspicious deaths policy<sup>616</sup> now expressly requires a check to be carried out on all other residents on the wing.<sup>617</sup>

191. She said that the incident took place at breakfast time, when full staffing was in place, also that the possibility existed to seek staff from other wings, but agreed that, given what happened that day, either there was insufficient staff or nobody sought support from staff on other wings.<sup>618</sup> She said that, subsequent to this incident, staff have been trained to

---

<sup>608</sup> Transcript 20.4.16 P51 L17-P52 L8

<sup>609</sup> Exhibit 149

<sup>610</sup> Transcript 20.4.16 P34 L41-44

<sup>611</sup> Transcript 20.4.16 P35 L21-26

<sup>612</sup> Transcript 20.4.16 P35 L1-8, L31-42, P62 L39-P63 L1

<sup>613</sup> Transcript 20.4.16 P53 L2-6

<sup>614</sup> Exhibit 149

<sup>615</sup> Transcript 20.4.16 P53 L8-L23, P69 L43-P70 L12

<sup>616</sup> Exhibit 146

<sup>617</sup> Exhibit 149, [11.1]

<sup>618</sup> Transcript 20.4.16 P69 L43-P70 L30

check after an altercation whether anybody else is injured, after diverting and separating the assailants.<sup>619</sup>

192. Ms Costuna recalled the inquest into the death of Ruth Mussen (another Jindalee resident) but did not immediately recall if that inquest resulted in Jindalee reviewing its procedures.<sup>620</sup> She later agreed that the Mussen inquest resulted in a review of procedures, based on the date of the findings<sup>621</sup> She recalled that Police were not called immediately in that matter because the resident did not pass away in the nursing home.<sup>622</sup>
193. Ms Costuna said that in 35 years of nursing she had never encountered a situation like what happened to Mr McCulloch.<sup>623</sup> She said that now she would certainly do some things differently,<sup>624</sup> and, absolutely, if another resident died in Jindalee now in suspicious circumstances, the Police would be called, even if no one saw or heard anything.<sup>625</sup> She could provide no explanation to Mr McCulloch's family for why he died the way he did, saying that it was an absolute tragedy and she hoped the family and the staff never had to experience that again.<sup>626</sup> Ms Costuna said that the changes at Jindalee since Mr McCulloch's death included CCTV in the corridors (although the feed was not actively monitored), an extra staff member on night shift in the dementia unit, DONs or Deputy DONs now being rostered on weekends during the day, and an extra RN in charge who floats on the afternoon shift, but agreed that other than the CCTV nothing had changed at breakfast time.<sup>627</sup>
194. Ms Costuna confirmed that Jindalee's new suspicious deaths policy (Exhibit 146) had been implemented.<sup>628</sup> When it was put to her that the new policy still delegated the decision to call Police to a doctor or DON, Ms Costuna accepted that, in the event of suspicious death, the Police should be called immediately and undertook to change the policy.<sup>629</sup> The new policy allowed for an RN to call the Police but still maintained the requirement that the situation be witnessed. Ms Costuna agreed that would also be addressed.<sup>630</sup> While the

---

<sup>619</sup> Transcript 20.4.16 P53 L25-37

<sup>620</sup> Transcript 20.4.16 P12 L24-34

<sup>621</sup> Transcript 20.4.16 P15 L20-25

<sup>622</sup> Transcript 20.4.16 P12 L36-P13 L3

<sup>623</sup> Transcript 20.4.16 P15 L11-12, P23 L41-42, P24 L6-7, P70 L32-36

<sup>624</sup> Transcript 20.4.16 P23 L42-43

<sup>625</sup> Transcript 20.4.16 P24 L1-8, P64 L3-9

<sup>626</sup> Transcript 20.4.16 P61 L7-13

<sup>627</sup> Transcript 20.4.16 P70 L35-P72 L2; Exhibit 149, Section 12

<sup>628</sup> Transcript 20.4.16 P37 L26-27

<sup>629</sup> Transcript 20.4.16 P38 L15-P39 L12, P40 L10-13, P64 L9-37, P74 L14-17

<sup>630</sup> Transcript 20.4.16 P39 L14-26

policy now stated that someone should stay with the resident until the Police arrived, Ms Costuna agreed that a hostel services or maintenance worker should not be the guard and that the policy would be revised to refer to a nursing staff member.<sup>631</sup> (Subsequently, a revised version of Exhibit 146 –the suspicious deaths policy – was drafted by Ms Costuna based on matters that came out during the course of the inquest and was tendered as Exhibit 152. Senior Constable Thexton gave additional evidence commenting on the new policy which was largely in favour but suggested some minor changes.

### **Evidence of Cheryl Joy Hart**

195. Cheryl Hart, now retired, was, at the time of Mr McCulloch’s death, one of two Directors of Nursing at Jindalee Aged Care (the other being Jo Costuna). Ms Hart made a statement dated 2 February 2012 (which was tendered as Exhibit 26) and gave oral evidence on 21 April 2016. She had also participated in a taped record of conversation (together with Pam Bondfield) with Detective Sergeant Casey on 21 April 2015 (Exhibit 142A).
196. At the time of Mr McCulloch’s death in January 2012, Ms Hart had worked at Jindalee for 25 years, the last four and half years as a Director of Nursing (DON)<sup>632</sup> and immediately prior to that she had been a Deputy Director of Nursing.<sup>633</sup> In the latter two roles, she had been responsible for Acacia, Banksia and Grevillea Wings – approximately 70 residents in 2012 – and Ms Costuna was responsible for Casuarina (the dementia unit), Hoya and Jarrah Wings – approximately 90 residents.<sup>634</sup> She had 42 years experience in aged care.<sup>635</sup>
197. Ms Hart confirmed that in January 2012, Jindalee was staffed by a Level 3 registered nurse (RN) in charge of the facility, a RN who went across all wards and administered medication, assistants in nursing (AINs), and activities staff, who also had personal care workloads.<sup>636</sup> The duties of an AIN included toileting, showering, personal care, feeding, and assistance with mobility.<sup>637</sup> Although some AINs had the annual medication management competency and could administer prepacked (Webster Pack) medication to residents, it remained the responsibility of the RN to administer Schedule 4 and Schedule 8 drugs.<sup>638</sup> She noted that current practice has put a second RN on at night for the facility.<sup>639</sup>

---

<sup>631</sup> Transcript 20.4.16 P39 L37-43, P40 L5-9

<sup>632</sup> Transcript 21.4.16 P2 L34-43

<sup>633</sup> Transcript 21.4.16 P3 L1-3

<sup>634</sup> Transcript 21.4.16 P3 L5-21. P12 L26-P13 L6

<sup>635</sup> Transcript 21.4.16 P27 L42

<sup>636</sup> Transcript 21.4.16 P13 L12-17, P14 L11-17, P14 L37-P15 L14

<sup>637</sup> Transcript 21.4.16 P15 L16-21

<sup>638</sup> Transcript 21.4.16 P12 L37-41, P13 L12-P14 L7

Ms Hart was unable to comment in detail on the staffing arrangements for Casuarina Wing in January 2012.<sup>640</sup>

198. Ms Hart said she was not responsible for Mr McCulloch's admission, and did not know who he was.<sup>641</sup> She did not accept a proposition that the admission form was brief or skeletal, saying it contained the required information.<sup>642</sup> She agreed with Ms Costuna's evidence that it was unusual to admit residents at 3pm on a Friday night,<sup>643</sup> as there were less administrative staff working on the weekend, but refuted that staff would be in a hurry to go home at 4pm for the weekend.<sup>644</sup> She said that the information Jindalee would receive about a patient before admission was a transfer sheet from the previous facility and an ACAT assessment.<sup>645</sup> Ms Hart said that Ms Costuna was responsible for deciding Mr McCulloch's placement, as Ms Costuna was responsible for that wing, and Ms Hart was responsible for allocating beds for residents for her wings.<sup>646</sup> She said the resident's placement depends on where vacancies exist, saying that it is difficult to place people until they have been at the facility for a little while and have been assessed.<sup>647</sup>
199. Ms Hart stated that an interim care plan should be completed for each resident on the first day of their admission, and that over the next four weeks a comprehensive plan was developed.<sup>648</sup> She stated that the interim care plan was the lifestyle plan front sheet, and that contained relevant information.<sup>649</sup> She accepted that there was no interim care plan for Mr McCulloch prepared by Jindalee staff at the time of his admission to Jindalee, although there was a lifestyle plan on his file from his previous facility,<sup>650</sup> and the comprehensive lifestyle plan for VH was not complete.<sup>651</sup>
200. Ms Hart was reminded of the allegation that VH had choked Mr Durr around the throat. She said she was unaware of the incident, but agreed that the incident was not reported to the Department,<sup>652</sup> and said that she would not have reported it to the Department had she

---

<sup>639</sup> Transcript 21.4.16 P14 L11-13

<sup>640</sup> Transcript 21.4.16 P14 L19-35

<sup>641</sup> Transcript 21.4.16 P15 L26-29

<sup>642</sup> Transcript 21.4.16 P15 L37-39

<sup>643</sup> Transcript 21.4.16 P15 L41-44

<sup>644</sup> Transcript 21.4.16 P16 L1-5

<sup>645</sup> Transcript 21.4.16 P16 L7-10

<sup>646</sup> Transcript 21.4.16 P16 L12-18

<sup>647</sup> Transcript 21.4.16 P16 L20-27

<sup>648</sup> Transcript 21.4.16 P16 L 32-33, P17 L13-37

<sup>649</sup> Transcript 21.4.16 P16 L 32-41, P17 L8-122

<sup>650</sup> Transcript 21.4.16 P16 L29-30, P16 L43-P17 L11, P18 L11-12

<sup>651</sup> Transcript 21.4.16 P17 L41-P18 L9

<sup>652</sup> Transcript 21.4.16 P10 L5-13

been aware of it.<sup>653</sup> Ms Hart was reminded that Ms Magliulo was found with a pillow and a doona covering her and, on removal of the pillow, Ms Magliulo was found to have blood on her face and it appeared she had been assaulted. Ms Hart agreed that this incident also would not have been reported to the Department, nor would Police have been called, but that the relatives would have been informed.<sup>654</sup>

201. Ms Hart confirmed that she was aware that Mr McCulloch was first discovered by Mr Joseph and Ms Endo as having blood on his face and appearing to be deceased, but said that she was unaware that blood was observed on the wall.<sup>655</sup> In response to a question as to whether she recalled that, when Ms Endo returned with Dr Webber, Mr McCulloch was observed with a doona cover and pillow over his face, Ms Hart said that she recalled someone mentioning a pillow.<sup>656</sup> She said she was not aware that Ms Endo was initially told not to contact the Police after an inquiry was made of her as to whether anyone saw anything.<sup>657</sup> However, Ms Hart agreed that the instruction to Ms Endo, to call a doctor and have the doctor make a decision to call Police, was appropriate.<sup>658</sup>

202. Ms Hart said that Mr McCulloch was deceased when he was found the first time,<sup>659</sup> but said that was because it was normally obvious to a RN if someone is deceased, and said it was not normal to check by taking a pulse, that she would not take a pulse.<sup>660</sup> She was unaware that Ms Endo did not know if Mr McCulloch was deceased when Ms Endo discovered him.<sup>661</sup> Ms Hart said she could not comment on Ms Endo's practice in relation to checking vital signs.<sup>662</sup> When asked to assume that Mr McCulloch was not dead upon first observation, Ms Hart said "*Someone would have stayed with him and they would have got a doctor*", but agreed there was no policy in relation to a staff member staying with an assault victim, either in 2012 or now, saying that this is what she would expect to happen and it is impossible to have a policy for every scenario.<sup>663</sup> The appropriate response would depend on the circumstances of the injury and the degree of what was needed, and would be assessed at the time.<sup>664</sup>

---

<sup>653</sup> Transcript 21.4.16 P10 L15-16

<sup>654</sup> Transcript 21.4.16 P10 L24-36

<sup>655</sup> Transcript 21.4.16 P10 L38-43

<sup>656</sup> Transcript 21.4.16 P11 L8-14

<sup>657</sup> Transcript 21.4.16 P23 L12-15

<sup>658</sup> Transcript 21.4.16 P30 L8-17

<sup>659</sup> Transcript 21.4.16 P27 L32-33

<sup>660</sup> Transcript 21.4.16 P28 L8-13, P29 L18-19

<sup>661</sup> Transcript 21.4.16 P28 L28-38

<sup>662</sup> Transcript 21.4.16 P28 L15-19

<sup>663</sup> Transcript 21.4.16 P29 L20-44

<sup>664</sup> Transcript 21.4.16 P30 L1-6

203. Ms Hart was challenged about the assertion in her statement that she was called at about 8am by Ms Costuna, to advise of a call from Ms Endo informing that Mr McCulloch had been found deceased in bed with a pillow on his face.<sup>665</sup> Ms Endo's evidence (that she observed Mr McCulloch apparently dead with blood on his face, and then called Ms Costuna) was put to Ms Hart and Ms Hart suggested that perhaps she had the timing wrong, as perhaps this was what she thought she was told at the time.<sup>666</sup> She said that she was unaware Mr McCulloch did not have the pillow on his face when first discovered by Ms Endo, only after Ms Endo returned with Dr Webber, and she had assumed that the pillow was removed by staff to check Mr McCulloch's face.<sup>667</sup> She was unaware that the allegations of interference with Mr McCulloch also related to the pillow and was not just the napkins.<sup>668</sup>
204. Ms Hart strongly denied that she had contrived this part of her statement, that she had known that upon first discovery there was no pillow or doona covering Mr McCulloch, and that she had deliberately failed to tell this to the Department of Health and Ageing.<sup>669</sup> She maintained this position even when questioned in regards to the Departmental file note<sup>670</sup> made of her initial contact of the day of the death,<sup>671</sup> although she said she did not recall having seen the Departmental report<sup>672</sup> into the incident.<sup>673</sup> She was unable to say whether the error was due to her inquiry or because she received incorrect information, and she did not recall who advised her of the pillow and blanket.<sup>674</sup>
205. Ms Hart was unable to comment upon the details of the 000 call made by Ms Endo which omitted any reference to a pillow and blanket on Mr McCulloch's face.<sup>675</sup> She accepted that the error in the Departmental paperwork about the initial discovery with a pillow and a blanket over Mr McCulloch's face may have arisen from the information she had supplied, but said that was what she thought had happened.<sup>676</sup> Ms Hart said that as it was Ms Costuna's "*end of the building*", Ms Costuna investigated the matter, and she (Ms Hart)

---

<sup>665</sup> Transcript 21.4.16 P26 L3-7

<sup>666</sup> Transcript 21.4.16 P26 L9-33

<sup>667</sup> Transcript 21.4.16 P26 L9-P27 L5, P31 L34-37

<sup>668</sup> Transcript 21.4.16 P26 L7-L16

<sup>669</sup> Transcript 21.4.16 P26 L18-28

<sup>670</sup> Part of Exhibit 150

<sup>671</sup> Transcript 21.4.16 P35 L17-31

<sup>672</sup> Exhibit 138

<sup>673</sup> Transcript 21.4.16 P35 L33-35

<sup>674</sup> Transcript 21.4.16 P61 L12-19

<sup>675</sup> Transcript 21.4.16 P31 L38-P62 L11

<sup>676</sup> Transcript 21.4.16 P35 L37-40, P36 L24-26

merely went along to support staff, relatives and residents and provide general assistance.<sup>677</sup> She said it was the RN's responsibility to deal with the situation at the time.<sup>678</sup>

206. Ms Hart refuted Ms Endo's account of a telephone conversation between the two of them, sometime after 8:30am, in which Ms Endo said Ms Hart told her to get a doctor, saying that she had asked Ms Endo if she had rung CALMS after hours medical service and, upon being told that CALMS recommended contacting the Police, agreeing that Ms Endo should contact Police.<sup>679</sup> Ms Hart said that Ms Endo's account of a first telephone call in which Ms Endo was told to await the arrival of the DONs and a second telephone call five minutes later in which the instruction to call Police was delivered **was not true**.<sup>680</sup> Upon being advised that Police investigation confirmed two calls were made from her phone to Ms Endo five minutes apart, Ms Hart said she did not recall two calls and the calls might have been about something else, but two phone calls were possible.<sup>681</sup>
207. Ms Hart did not recall being part of the Departmental investigation which took place on 30 January 2012 but, when shown relevant documents,<sup>682</sup> accepted she was interviewed by Departmental staff.<sup>683</sup> Ms Hart said she had no input into the document drafted by Ms Costuna describing the events which was provided to the Department,<sup>684</sup> but agreed that she was the person who notified the Department on the day about Mr McCulloch's suspicious death.<sup>685</sup> Ms Hart called the Department because Ms Costuna was doing something else, perhaps dealing with Police, but probably because Ms Costuna had asked her to assume that role.<sup>686</sup>
208. The Departmental file note suggested that Ms Hart advised that Mr McCulloch's family was contacted immediately, but when it was put to Ms Hart that was not the case, she said she did not know about that and did not recall why she would have said it.<sup>687</sup> When asked to comment on details (incorrectly) recorded in Departmental file notes in relation to the pillow, that VH had no history of aggression, that his aggression was first noticed on 18

---

<sup>677</sup> Transcript 21.4.16 P28 L40-P29 L4

<sup>678</sup> Transcript 21.4.16 P29 L6-11

<sup>679</sup> Transcript 21.4.16 P31 L39-44

<sup>680</sup> Transcript 21.4.16 P32 L9-39, P33 L4-7

<sup>681</sup> Transcript 21.4.16 P32 L41-P33 L2, P61 L21-33

<sup>682</sup> Exhibit 150

<sup>683</sup> Transcript 21.4.16 P33 L9-30

<sup>684</sup> Transcript 21.4.16 P33 L36-39

<sup>685</sup> Transcript 21.4.16 P34 L5-16

<sup>686</sup> Transcript 21.4.16 P36 L6-16, P62 L13-18

<sup>687</sup> Transcript 21.4.16 P35 L42-P36 L4

January, Ms Hart did not recall from where she had received that information.<sup>688</sup> She did not recall which staff she had spoken to in relation to the information she provided the Department that it appeared Mr McCulloch had been punched.<sup>689</sup> When asked to explain a Departmental file note which said that she became tearful and asked for assistance from the Department in relation to handling the media, Ms Hart could not provide an explanation, but said she was concerned about the media because of the impact on other residents and relatives.<sup>690</sup> When asked about a reference in a Department file note to VH and Mr Durr being “specialled”, Ms Hart explained that meant one-on-one nursing, and, because that involved extra staffing, at Jindalee, that could be done only with the approval of the proprietor (Mr Johnson) – but surveillance did not require this level of approval.<sup>691</sup>

209. Ms Hart gave evidence that both she and Ms Costuna were responsible for the procedure manual in force at the time of Mr McCulloch’s death (Exhibit 79), which was based on a previous version that she and Ms Costuna had reviewed and updated.<sup>692</sup> This was an internal document only. It was not approved by the Department of Health and Ageing.<sup>693</sup> Ms Hart said that development of policies and procedures would include consultation with relevant staff, with final review by senior management.<sup>694</sup> Ms Hart agreed that there was nothing in the procedure manual that focuses special treatment on dementia patients, but said there was a protocol that applied.<sup>695</sup> She said that protocols were in a manual labelled “*protocol manual*” separate to the procedures manual, and copies of each manual were kept on each wing.<sup>696</sup> However, when shown the protocol manual (Exhibit 78) Ms Hart could not locate a dementia specific protocol.<sup>697</sup> She said that residents with dementia were housed in a dementia specific unit, for which there was specific education and training and resources.<sup>698</sup> Ms Hart understood that there was an education program and manual for staff, but was unable to provide specifics.<sup>699</sup> She said that she was unaware of a specific training program for staff who worked on Casuarina (the dementia) Wing but that

---

<sup>688</sup> Transcript 21.4.16 P37 L4-35

<sup>689</sup> Transcript 21.4.16 P37 L13-15

<sup>690</sup> Transcript 21.4.16 P36 L34-P37 L2

<sup>691</sup> Transcript 21.4.16 P37 L37-P38 L30

<sup>692</sup> Transcript 21.4.16 P3 L23-37

<sup>693</sup> Transcript 21.4.16 P4 L4-9

<sup>694</sup> Transcript 21.4.16 P3 L39-P4 L2

<sup>695</sup> Transcript 21.4.16 P4 L11-14

<sup>696</sup> Transcript 21.4.16 P4 L25-39

<sup>697</sup> Transcript 21.4.16 P4 L41-44

<sup>698</sup> Transcript 21.4.16 P5 L1-9

<sup>699</sup> Transcript 21.4.16 P5 L11-15

many of the staff on that wing were “*core staff*”,<sup>700</sup> and that most of the Wings have regular staff that don’t rotate through specific wings.<sup>701</sup>

210. Ms Hart was questioned specifically on the protocol relating to coronial cases within Exhibit 78. She agreed that the relevant document was the protocol that existed as at January 2012.<sup>702</sup> She gave evidence that that the Coroner was only ever called to investigate a matter if the resident’s doctor was unable to furnish a death certificate.<sup>703</sup> She indicated she was aware of another coronial matter still pending for a resident in 2012 with a raised alcohol level, but that she had instructed staff to call Police in that matter because the doctor in question refused to sign a death certificate.<sup>704</sup> She said that there was nothing suspicious about the way the person had died, and it was only after the autopsy, that questions were asked about the alcohol, but she accepted that the matter was a coronial case from the beginning because the GP would not sign a death certificate.<sup>705</sup>
211. Ms Hart was also asked about the coronial case of Ruth Mussen but said that she was not involved in that case, and that she had no knowledge of anybody notifying the coroner, because Ms Mussen died in hospital three days after leaving Jindalee.<sup>706</sup> In response to a question from His Honour about the circumstances of Ms Mussen’s death being after an assault by another patient, Ms Hart suggested that the theory was the other patient may have been trying to assist Ms Mussen, but said that she did not know what happened and agreed that it could be classed as assault.<sup>707</sup>
212. In relation to questions as to the process to be followed in the event of a suspicious death, Ms Hart said that protocol required the RN to contact a doctor first and then inform a DON, but she did not believe this was a written protocol in 2012, more of a normal practice.<sup>708</sup> When taken to the coronial cases protocol (part of Exhibit 78), Ms Hart agreed the document read as though, if a suspicious death warranted further investigation, it was a matter for the coroner, but said that the doctor had to make the call as to whether it was a

---

<sup>700</sup> Transcript 21.4.16 P5 L17-20

<sup>701</sup> Transcript 21.4.16 P5 L26-27

<sup>702</sup> Transcript 21.4.16 P5 L33

<sup>703</sup> Transcript 21.4.16 P5 L36-38

<sup>704</sup> Transcript 21.4.16 P5 L43-P6 L35

<sup>705</sup> Transcript 21.4.16 P62 L39-P63 L9

<sup>706</sup> Transcript 21.4.16 P6 L8, L40-P7

<sup>707</sup> Transcript 21.4.16 P6 L12-44

<sup>708</sup> Transcript 21.4.16 P11 L16-44

coroner's matter, even though the document does not say that.<sup>709</sup> She agreed that in this case, the coronial protocol was not followed as no one contacted the coroner.<sup>710</sup>

213. Ms Hart stated that it was never the practice at Jindalee in the event of a death that a staff member was to stay with the deceased, but that there is now under the new, current protocol (Exhibit 146) a practice to stay with the deceased and preserve the potential crime scene if death is suspicious.<sup>711</sup> However, Ms Hart said that it is not presently normal practice for a staff member to stay with a deceased person until the doctor arrives, saying that it will depend on the circumstances, mostly the person's relatives are with the resident and will stay, and it can take up to six hours for the funeral directors to arrive, in the meantime other residents will need care.<sup>712</sup>
214. Ms Hart agreed that it would have been a good idea for someone to have stayed with Mr McCulloch, given all the surrounding circumstances, and that would happen now.<sup>713</sup> She accepted now that Mr McCulloch had been interfered with after his death (a pillow placed over his face, doona cover covering his body, and napkins placed in his throat) and gave a qualified agreement that the possibility of interference with a body and protecting the integrity of the deceased was a sound reason for having a staff member monitor the deceased, saying it depended on the circumstances.<sup>714</sup> She agreed that it would not have been appropriate to allow any person in Jindalee to interfere with the body of a deceased person.<sup>715</sup>
215. Ms Hart said that she had observed cases of a person with dementia assaulting another resident, and at no time had she had reported those assaults to Police or to the Department of Health and Ageing.<sup>716</sup> She said that the mandatory reporting guidelines and legislation permitted facilities to use discretionary powers to not report the assault, where both parties suffered from dementia.<sup>717</sup> She said that whether an assault by a dementia patient on a visitor would be reported would depend on the circumstances,<sup>718</sup> but that there had never been any need as there had never been an assault where only one of the parties had

---

<sup>709</sup> Transcript 21.4.16 P12 L1-13

<sup>710</sup> Transcript 21.4.16 P12 L15-19

<sup>711</sup> Transcript 21.4.16 P24 L6-30

<sup>712</sup> Transcript 21.4.16 P24 L32-P25 L10

<sup>713</sup> Transcript 21.4.16 P25 L14-20

<sup>714</sup> Transcript 21.4.16 P25 L22-39

<sup>715</sup> Transcript 21.4.16 P27 L35-P28 L2

<sup>716</sup> Transcript 21.4.16 P8 L1-25, P9 L23

<sup>717</sup> Transcript 21.4.16 P8 L27-43, P9 L7-16

<sup>718</sup> Transcript 21.4.16 P9 L3-5

dementia.<sup>719</sup> Ms Hart agreed with His Honour that, in making decisions about whether to report, staff make a judgment as to the person's degree of cognitive impairment, but also that residents with dementia are taken to be so cognitively impaired that it would not be practical to report.<sup>720</sup> She said that the number of incidents were not high.<sup>721</sup>

216. Ms Hart was questioned in relation to aspects of her record of conversation with Detective Sergeant Casey on 21 April 2015.<sup>722</sup> She agreed again that VH's medication sheet was not filled in, and that she did not have an explanation for that.<sup>723</sup> She also agreed that no incident report had been completed in relation to Mr McCulloch's assault because the Police were involved.<sup>724</sup> She agreed that references in the conversation to the "*updated protocol*" were to the document now tendered as Exhibit 146.<sup>725</sup> Ms Hart said that the updated suspicious deaths protocol was signed off by herself and Ms Costuna.<sup>726</sup> When asked about who determines whether a death is suspicious, Ms Hart originally said that the DON determines that, but then said that the RN, and then finally said the doctor decides, because a doctor will always be called in the event of a death.<sup>727</sup>

### **Evidence of Gary Johnson**

217. Gary Johnson was called as a witness. Mr Johnson provided a statement dated 31 August 2015 (which was tendered as Exhibit 153) and gave evidence on 21 April 2016 by telephone from interstate. Mr Johnson is the managing director and sole owner of Johnson Villages Services P/L (JVS), a company established in 1985 to operate residential aged care facilities.<sup>728</sup> JVS owns and operates the Jindalee Aged Care Residence, which it acquired in 1996 from the ACT Government.<sup>729</sup> He personally has 38 years of experience in the residential aged care industry, which he detailed in his oral evidence.<sup>730</sup> Mr Johnson was responsible for rehiring staff originally employed by the ACT Government – including Ms Costuna and Ms Hart, and possibly others – and hiring additional employees once JVS

---

<sup>719</sup> Transcript 21.4.16 P8 L29-30, P9 L25-27

<sup>720</sup> Transcript 21.4.16 P9 L29-32

<sup>721</sup> Transcript 21.4.16 P9 L34-36

<sup>722</sup> Exhibit 142A – there was some initial confusion about the date and Ms Hart suggested that it was not last year but 2015 is correct

<sup>723</sup> Exhibit 142A, Q45-78, Q148-149

<sup>724</sup> Exhibit 142A, Q150-166

<sup>725</sup> Transcript 21.4.16 P22 L30-40

<sup>726</sup> Transcript 21.4.16 P22 L3

<sup>727</sup> Transcript 21.4.16 P30 L23-39, P31 L17-23

<sup>728</sup> Transcript 21.4.16 P65 L27, P73 L37-43, Exhibit 153, [1.1]

<sup>729</sup> Transcript 21.4.16 P65 L29-30, Exhibit 153, [1.1]

<sup>730</sup> Transcript 21.4.16 P65 L11-P67 L13, Exhibit 153, [1.1]

took over the running of Jindalee.<sup>731</sup> He personally approves the staff roster and rostered hours and times, and every item of training undertaken by Jindalee staff, but the individual records of training are maintained at head office in Queensland.<sup>732</sup>

218. Mr Johnson's statement included background information as to the involvement by JVS in the residential aged care industry, and its involvement in Jindalee specifically.<sup>733</sup> Mr Johnson attached to his statement reports in respect of Jindalee's reaccreditation, one from the Australian Aged Care Quality Agency dated 2-4 June 2015,<sup>734</sup> and another from the Department of Health and Ageing dated May 2012.<sup>735</sup> He stated that "*Jindalee is always rated highly by the [relevant] Department ... and complies with its obligations under the Aged Care Act 1997 and related legislation*".<sup>736</sup>
219. Following Mr McCulloch's death, the Department of Health and Ageing visited Jindalee. Mr Johnson attached to his statement an "*Aged Care Complaints Scheme Detailed Resolution Report*", dated 14 February 2012, identifying three issues for resolution and associated discussion,<sup>737</sup> and a letter to Jindalee from the Department dated 17 February 2012 setting out the outcomes from the process.<sup>738</sup> The Department determined not to proceed with two of the issues (in relation to the behaviour management of the specific residents involved, and Jindalee's plan for care management and safety of residents) to full resolution because Mr McCulloch's death was to be the subject of an inquest, because the Department could not determine the circumstances giving rise to the issues, and there was no evidence that Jindalee was not meeting its responsibilities under the Act.<sup>739</sup> The other issue identified – that Jindalee was not correctly maintaining its database of reportable assaults – was resolved during the course of the Department's visit to Jindalee.<sup>740</sup>
220. Under cross-examination, Mr Johnson agreed he was not present in Canberra after Mr McCulloch's death, nor for the visits to Jindalee by the Department and so the information he was provided with came from his staff, although he did not specifically recall talking to

---

<sup>731</sup> Transcript 21.4.16 P67 L15-39

<sup>732</sup> Transcript 21.4.16 P69 L41-P70 L22

<sup>733</sup> Exhibit 153, [1.1]-[1.4] and Attachment GJ1

<sup>734</sup> Exhibit 153, Attachment GJ2

<sup>735</sup> Exhibit 153, Attachment GJ3

<sup>736</sup> Exhibit 153, [1.5]

<sup>737</sup> Exhibit 153, Attachment GJ4

<sup>738</sup> Exhibit 153, Attachment GJ5

<sup>739</sup> Exhibit 153, Attachment GJ5, p77

<sup>740</sup> Exhibit 153, Attachment GJ5, p81

the relevant RN, Ms Endo, about the events surrounding Mr McCulloch's death.<sup>741</sup> Mr Johnson was questioned on records subpoenaed from the Department of Health and Ageing. He stated that he did not specifically recall the events recorded in a file note dated 21 January 2012, said to have been a conversation between a Departmental officer and himself.<sup>742</sup> He denied suggesting to anyone that Jindalee was willing or able to take back Mr Durr or VH, noting that he had a responsibility to provide safety and security for Jindalee's other residents, and that obligation conflicted with the obligations he had in respect of security of tenure for Mr Durr and VH, but agreed that it was highly likely he had had that conversation.<sup>743</sup> The next part of the file note (which suggested that Mr Johnson had discussed with the Department a previous incident where Jindalee was forced to take back a resident and that course of action resulted in further injuries to residents and staff and the death of a resident) was not accepted by Mr Johnson. He said that the incident he recalled did result in injuries but not the death of a resident, and that such an event resulting in a death had never happened.<sup>744</sup> Mr Johnson stated that his being "*forced ... to take the resident back*" was an abbreviated way of referring to the facts, that his recollection was that the Department reminded him of his obligations under the Act in relation to security of tenure and the penalties in the event of breach and left the decision up to him as to what to do.<sup>745</sup> He recalled that in that case, he had sought advice and decided to trial the return of the resident, on the basis that the resident was believed to have been manageable, but that the resident attacked a member of staff and had to be removed by Police from the facility.<sup>746</sup> He said that Government and Aged Care Assessment Team experts often look optimistically on facilities' abilities to care for people with severe aggression and sometimes that optimism was not warranted. Mr Johnson stated that the reference in the file note to CCTV and a previous coronial recommendation related to the Mussen case, and he recalled the facts of that case.<sup>747</sup>

221. Mr Johnson was also questioned about conversations with the investigating officer, Sergeant Casey, in the aftermath of Mr McCulloch's death. He denied that he had told Sergeant Casey that this matter was in the hands of the Federal Minister for Health and Ageing, the Honourable Mark Butler MP, saying instead that he had told the Sergeant that the matter was at a very high level within the Minister's Department and the Minister's

---

<sup>741</sup> Transcript 21.4.16 P68 L30-P69 L3

<sup>742</sup> Transcript 21.4.16 P71 L1-20

<sup>743</sup> Transcript 21.4.16 P71 L13-P71 L21

<sup>744</sup> Transcript 21.4.16 P71 L23-48

<sup>745</sup> Transcript 21.4.16 P73 L10-29

<sup>746</sup> Transcript 21.4.16 P73 L29-35

<sup>747</sup> Transcript 21.4.16 P72 L40-P73 L9

delegates were looking into the matter.<sup>748</sup> Mr Johnson said that he had not gone to the Federal Minister over this incident.<sup>749</sup> He said he could not recall having told Sergeant Casey that the matter was with the State Minister and, for him to have said so, would have been unusual because the State Government does not have involvement with aged care facilities.<sup>750</sup> Mr Johnson denied wanting to leave Sergeant Casey with the impression that the matter had been raised with the Federal Minister, saying that he had wanted the Sergeant to have the impression that the matter was in the hands of the Minister's Department, because he was trying to solicit information as to whether VH or Mr Durr were suspects in the matter, so he could consider his obligations to the residents' families and to the residents in respect of security of tenure.<sup>751</sup> [Later in his evidence, in response to a question from His Honour in relation to discussions with government about funding reductions for Jindalee, Mr Johnson recounted having personally made representations to the Federal and State Ministers about funding reductions.<sup>752</sup>]

222. Mr Johnson agreed with other aspects of the conversation, as recounted by Sergeant Casey, including that he had asked for information off the record, that Sergeant Casey had declined to provide information without the authority of the coroner, that he had told the Sergeant that there was no way Mr McCulloch's death was caused by an outside person or member of staff, but did not recall saying to Sergeant Casey "*in summary you are saying to me that the men are released from custody and you have no further interest in them*".<sup>753</sup> Mr Johnson agreed that he had given the direction, recorded in the DONs diary<sup>754</sup> by Sue Scott, that "*under no circumstances can Mr John Durr and (VH) return to Jindalee ... without the authorisation from Mr Gary Johnson*".<sup>755</sup>

223. Mr Johnson's statement included a section discussing Jindalee's supervision and care arrangements for residents. He attached a document to his statement which reported on staffing ratios across the residential aged care industry,<sup>756</sup> and suggested that the services Jindalee provided were in excess of the industry median, both at the time of the hearing and at the time of Mr McCulloch's death.<sup>757</sup> However, under cross examination, Mr

---

<sup>748</sup> Transcript 21.4.16 P74 L7-18, L27-39, P75 L13-26

<sup>749</sup> Transcript 21.4.16 P74 L25, L37-38

<sup>750</sup> Transcript 21.4.16 P74 L20-23

<sup>751</sup> Transcript 21.4.16 P74 L41-P75 L7

<sup>752</sup> Transcript 21.4.16 P81 L23-26

<sup>753</sup> Transcript 21.4.16 P75 L31-P77 L16

<sup>754</sup> Exhibit 91

<sup>755</sup> Transcript 21.4.16 P77 L27-33

<sup>756</sup> Exhibit 153, Attachment GJ6

<sup>757</sup> Exhibit 153, [2.2]-[2.3]

Johnson conceded his calculations were on the basis of Casuarina Wing having 30 residents when the inquest had before it evidence that Casuarina Wing had 31 residents at the time of Mr McCulloch's death.<sup>758</sup> He explained the changes in Jindalee's protocols, put in place after Mr McCulloch's death, the key one being that a Director or Deputy Director of Nursing will now be rostered on duty each Saturday and Sunday.<sup>759</sup> Mr Johnson stated that Jindalee's staff training was well in excess of government requirements.<sup>760</sup> He stated that the reason behind Casuarina Wing being a secure wing is because that unit cares for dementia residents with a propensity to wander, so locking the doors is to maintain residents within that environment for their own safety.<sup>761</sup> Mr Johnson clarified, in response to a question from His Honour, that he believed Jindalee had the highest average of staff to residents as compared to all similar facilities throughout Australia, and that, while Government funding to Jindalee had decreased in 2015, Jindalee had not changed the staffing ratios in any wing of the facility.<sup>762</sup> He noted that C wing costs more to run than the funding and income it receives in respect of its residents.<sup>763</sup>

224. Mr Johnson also commented in his statement on Coroner Lalor's recommendation in the 2007 Mussen inquest concerning the introduction of CCTV camera in residential aged care facilities. He said that at the time of the recommendation JVS made enquiries as to the use of CCTV in these facilities, and found that CCTV was only used in common areas and not in personal living areas, like bedrooms, for privacy and confidentiality reasons.<sup>764</sup> Mr Johnson said that he sought advice after the Mussen recommendation from DBMAS, and that advice did not support the use of CCTV in non-common areas.<sup>765</sup> He commented that, under the legislation, care providers have an obligation to protect privacy and dignity and to provide a facility which makes people feel they are living in their home.<sup>766</sup> He also noted that the psychogeriatric ward at Calvary Hospital only has CCTV in two corridors, and that the feed is not monitored.<sup>767</sup> Mr Johnson stated JVS has installed CCTV in common areas, but resourcing constraints preclude 24/7 monitoring of the feed, saying that "CCTV is unlikely to prevent a serious incident between residents from occurring".<sup>768</sup> He attached an opinion from Dr Jones at DBMAS, obtained in 2012, which was not supportive

---

<sup>758</sup> Transcript 21.4.16 P67 L41-P68 L20

<sup>759</sup> Exhibit 153, [2.4]

<sup>760</sup> Exhibit 153, [2.5]

<sup>761</sup> Transcript 21.4.16 P69 L33-39

<sup>762</sup> Transcript 21.4.16 P81 L1-35

<sup>763</sup> Transcript 21.4.16 P81 L15-21

<sup>764</sup> Exhibit 153, [3.1]

<sup>765</sup> Exhibit 153, [3.4]

<sup>766</sup> Exhibit 153, [3.1], Transcript 21.4.16 P69 L29-33

<sup>767</sup> Exhibit 153, [3.1]

<sup>768</sup> Exhibit 153, [3.3]

of CCTV, calling it “a rather crude and clumsy approach to a complex and difficult situation and, unfairly, places yet another resource burden on the individual aged care facility”.<sup>769</sup> Mr Johnson deferred to the expertise of Jindalee staff in respect of arrangements for admission and implementation of care plans, saying that he had no specific knowledge about care plans.<sup>770</sup>

225. In response to questions from Counsel representing the McCulloch family, Mr Johnson agreed that he had failed in his obligations to secure the safety of residents on site on the morning that Mr McCulloch died.<sup>771</sup> The explanation he provided in court was that these sort of occurrences are extremely rare.<sup>772</sup> Mr Johnson stated that Jindalee has a near perfect compliance record during the 20 years of his ownership and put forward a belief that Jindalee was one of a small number of facilities with that kind of record.<sup>773</sup> He stated that he had never experienced a situation like the death of Mr McCulloch and admitted that Jindalee staff were not fully trained for that kind of event.<sup>774</sup> He noted that at present one-third of his staff’s time was taken up by filling out paperwork and, while it is important that incident reports are kept and kept accurately, and that Jindalee could have done better in this respect, the deficiency was explicable due to funding cuts and staff not having time to do everything.<sup>775</sup>

226. Mr Johnson offered his condolences to Mr McCulloch’s family and stated that he was sorry that Mr McCulloch died in the way he did at Jindalee.<sup>776</sup> He gave an assurance that Jindalee will do everything it can so that similar occurrences don’t happen in future.<sup>777</sup> He said that Jindalee had already instigated an number of initiatives to ensure that patients with a history of severe aggressive behaviour in the dementia state would not be admitted in future, including not accepting at face value the Government assessment team’s recommendation for care, and conducting its own inquiries into the history of a resident (such as asking the hospital or previous aged care facility who last looked after the resident).<sup>778</sup> He also noted a recent initiative by the Federal Government to establish, within the last 12 months, a mobile severe aggressive dementia response unit that will

---

<sup>769</sup> Exhibit 153, Attachment GJ7, specifically p85

<sup>770</sup> Exhibit 153, [4.1], Transcript 21.4.16 P70 L26-31

<sup>771</sup> Transcript 21.4.16 P77 L44-P78 L6

<sup>772</sup> Transcript 21.4.16 P78 L35-38

<sup>773</sup> Transcript 21.4.16 P78 L16-19

<sup>774</sup> Transcript 21.4.16 P78 L30-44

<sup>775</sup> Transcript 21.4.16 P80 L25-38

<sup>776</sup> Transcript 21.4.16 P78 L9-12

<sup>777</sup> Transcript 21.4.16 P78 L12-13

<sup>778</sup> Transcript 21.4.16 P78 L44-P79 L27

assess a resident and provide additional funding to give special one-on-one nursing to the patient while a care plan is being developed.<sup>779</sup> Jindalee's Director of Nursing, or person in charge of the facility, would make the decision to call in the expert unit, based on factors including incident reports identifying the increasing aggression of the resident and reports from the nurses in charge of the unit.<sup>780</sup> Mr Johnson indicated that an emergency response team is located in Canberra and Jindalee had cause to use it recently.<sup>781</sup>

### **Evidence of Tony Schumacher Jones**

227. Tony Schumacher Jones was called as an expert witness on behalf of Jindalee Aged Care. Dr Jones provided a statement dated 17 September 2015 (which was tendered as Exhibit 151) and gave oral evidence on 21 April 2016. Dr Jones has a PhD in political philosophy, a Masters degree in political science, and is qualified as a registered psychiatric nurse, with a speciality in aged care nursing.<sup>782</sup> He was a visiting fellow at the ANU Medical School between 2004 and 2006, where he undertook research into aged care, and was awarded a Churchill Fellowship in 2013 to study best practice care for people with dementia in residential care facilities in Holland and Scotland.<sup>783</sup> Dr Jones was the manager of the ACT Dementia Behaviour Management Advisory Service (DBMAS) between 2008 and 2013, and from that date to the present was the Senior Behaviour Consultant with the Service.<sup>784</sup>
228. Dr Jones said he had had considerable involvement with Jindalee,<sup>785</sup> and advised that his relationship with Jindalee commenced out of work he had previously undertaken with the Older Persons Mental Health Service before DBMAS commenced in the ACT in October 2007.<sup>786</sup> He said that DBMAS would conduct education and training for Jindalee, and the two bodies would make referrals of patients to each other.<sup>787</sup> He personally has been providing occasional training to Jindalee staff since 2008 on an ongoing basis, up to five times a year for an hour or so.<sup>788</sup> Additionally, he is involved through DBMAS in

---

<sup>779</sup> Transcript 21.4.16 P79 L34-P80 L9

<sup>780</sup> Transcript 21.4.16 P80 L11-23

<sup>781</sup> Transcript 21.4.16 P81 L37-40

<sup>782</sup> Exhibit 151, [1.1]; Transcript 21.4.16 P41 L12-14, P50 L5-21

<sup>783</sup> Exhibit 151, [1.1]; Transcript 21.4.16 P41 L16-24

<sup>784</sup> Exhibit 151, [1.1]-[1.2]; Transcript 21.4.16 P41 L31-36

<sup>785</sup> Transcript 21.4.16 P41 L37-38

<sup>786</sup> Transcript 21.4.16 P43 L41-P44 L1

<sup>787</sup> Transcript 21.4.16 P44 L8-14

<sup>788</sup> Exhibit 151, [1.2]; Transcript 21.4.16 P50 L25-P51

providing four to six weekly capacity building workshops to Jindalee up to twelve times a year.<sup>789</sup>

229. Dr Jones' statement commenced with background information relating to the Australian residential aged care system, the presence of dementia in aged care residents, the nature of the dementia system, forms of challenging behaviours and managing those behaviours.<sup>790</sup> He explained further, in his oral evidence, that behaviours of people with dementia change over time, saying that behavioural issues tend to decrease as the person becomes more frail and less mobile.<sup>791</sup> He said that physical aggression is probably the most common form of challenging behaviours found in residential aged care facilities, and is likely to be more common in dementia specific units.<sup>792</sup> His evidence was that aged care, and dementia-specific facilities particularly, have to balance difficult issues of patient safety and health with patient autonomy, which often necessitates facilities being locked, but that curtails one of the key factors of being human - being able to do as we wish.<sup>793</sup>
230. His statement went on to discuss managing aggressive behaviour, stating in this regard that *"[a]s a general proposition the supervision arrangements at aged care facilities across the industry require improvement and I understand this to be a nationwide problem"*.<sup>794</sup> Dr Jones described a process for dealing with an aggressive incident, generally and in the specific context of dementia residents.<sup>795</sup> He advised that there is no mandated staffing level for aged care facilities, but commented that, on the advice he had received as to Jindalee's staffing ratios, those ratios were very good for the industry, and in accordance with guidance from the Australian Nursing Federation.<sup>796</sup> However, when questioned further in relation to staffing ratios for high needs patients, as compared to low needs patients, Dr Jones was unable to comment in detail, noting only that the needs of people change and the staffing resourcing was the call of the managers of the facility.<sup>797</sup> Dr Jones also agreed that those ratios from the ANF related to nurses, but that there were a number of staff in aged care facilities who are referred to as nurses but are not actually nurses at all.<sup>798</sup> He agreed with His Honour that there ought to be mandated staffing ratios in

---

<sup>789</sup> Transcript 21.4.16 P51 L17-18, P51 L31-3

<sup>790</sup> Exhibit 151, Section 2

<sup>791</sup> Transcript 21.4.16 P42 L37-P43 L4

<sup>792</sup> Transcript 21.4.16 P43 L31-35

<sup>793</sup> Transcript 21.4.16 P43 L15-29

<sup>794</sup> Exhibit 151, [3.1]

<sup>795</sup> Exhibit 151, [3.2]-[3.4]

<sup>796</sup> Exhibit 151, [3.5]

<sup>797</sup> Transcript 21.4.16 P52 L39-P53 L19

<sup>798</sup> Transcript 21.4.16 P54 L29-42

residential aged care notwithstanding the advice from the Federal Minister that this was a matter best left to individual facilities.<sup>799</sup> Dr Jones agreed he was not an expert on appropriate staffing ratios. He is an expert on behaviour interventions and supporting persons with dementia and their carers.<sup>800</sup>

231. In his statement at [3.7], Dr Jones listed a number of matters purporting to describe the events of 21 January 2012, and went on to say that, on the basis of the matters listed, he considered that the management of VH was consistent with proper practice.<sup>801</sup> He reiterated this position in his testimony and expanded by saying that physical aggression happens “*very, very frequently*” in dementia specific units, but that the death of a person as a response to physical aggression happens extremely rarely, so, if staff were to regard every possible physically aggressive incident as a potential for the death of an individual, they could not possibly do their jobs.<sup>802</sup> Dr Jones said that by virtue of the illness, predicting behaviours and triggers in people with dementia, particularly if and when events are going to occur, is exceedingly difficult.<sup>803</sup> However, when questioned further, Dr Jones agreed that the information at [3.7] of his statement was given to him by lawyers and that he was not made aware of matters that had come out in the inquest hearing, such as a failure to give VH medication, the falsification by staff of surveillance records, the failure of the RN to take the vital signs of Mr McCulloch when he was discovered and the chaotic nature of events at Jindalee upon the discovery of Mr McCulloch.<sup>804</sup> Dr Jones did not concede, in the light of those matters, that the actions taken would not represent proper practice, but indicated that he needed to know all the facts of the case before he could comment.<sup>805</sup> He conceded, after some discussion with His Honour, that after the altercation between VH and Mr Durr it would have been reasonable and appropriate for staff to check the welfare of anyone else in the room to see if they were alright.<sup>806</sup>

232. Dr Jones’ evidence was that Jindalee had a reputation for excellent care and that Jindalee was considered as a facility that could manage challenging behaviours and difficult clients, including clients “where no other facility in the ACT would take them”.<sup>807</sup> He said Jindalee staff have a very good understanding of how to care for and manage people with

---

<sup>799</sup> Transcript 21.4.16 P53 L23-36

<sup>800</sup> Transcript 21.4.16 P53 L43-P54 L4, P57 L5-22

<sup>801</sup> Exhibit 151, [3.8]

<sup>802</sup> Transcript 21.4.16 P45 L1-12

<sup>803</sup> Transcript 21.4.16 P47 L19-43

<sup>804</sup> Transcript 21.4.16 P56 L1-26

<sup>805</sup> Transcript 21.4.16 P56 L28-34

<sup>806</sup> Transcript 21.4.16 P58 L3-43

<sup>807</sup> Transcript 21.4.16 P44 L1-22

dementia, as compared to the broader industry, and described Jindalee as “one of the best in the ACT”.<sup>808</sup> Dr Jones noted that his praise was directed more at management of Jindalee, given the high staff turnover typical in aged care, but said that Jindalee’s management were “the most informed and sensitive and professional management of any [ACT] facility” and “impressive”.<sup>809</sup> He singled out Ms Costuna for specific praise, saying “she is probably one of the most professional and knowledgeable directors of nursing that [he had] ever met”, but said he had little to do with Ms Hart or Mr Johnson.<sup>810</sup>

233. Dr Jones’s statement contained a short discussion on the use of CCTV in residential aged care facilities and attached an excerpt from a paper on the subject that he was to present at a forthcoming conference.<sup>811</sup> He also gave oral evidence that while CCTV might monitor staff to staff aggression or resident to staff aggression (which he said was quite high in aged care facilities), it would not have any effect on physical assaults by a person with dementia to another person with dementia.<sup>812</sup> This could be due to the nature of the disease itself, but also possibly because there is reluctance, particularly in the UK, to put CCTV into intimate areas due to privacy concerns, and evidence suggests that most assaults occurred with engagement with intimate activities of daily living.<sup>813</sup> He also questioned why CCTV should be placed in nursing homes and not in other areas where equally vulnerable cohorts of people live or are treated.<sup>814</sup> Dr Jones also raised issues to do with cost, use of footage, retention of footage, whether agreeing to CCTV is a precondition of admission and other ethical challenges, including whether residents want CCTV – he said that a survey of staff, residents and family members in a large group of aged care facilities found that while relatives were supportive of CCTV, 53% of residents did not want CCTV in their facilities.<sup>815</sup> He said “I don’t see it as a panacea for solving problems like this.”<sup>816</sup>
234. Dr Jones also commented very briefly in his statement about care plans, concluding that nine days (the time VH was at Jindalee before the incident) was an insufficient time to determine the full needs and behavioural aspects to complete a care plan.<sup>817</sup> He expanded on this statement in his testimony by saying that time is required to know the person before

---

<sup>808</sup> Exhibit 151, [3.6]; Transcript 21.4.16 P45 L19

<sup>809</sup> Transcript 21.4.16 P45 L21-33

<sup>810</sup> Transcript 21.4.16 P45 L35-P46 L1

<sup>811</sup> Exhibit 151, Section 4 & Attachment TSJ2

<sup>812</sup> Transcript 21.4.16 P46 L12-20

<sup>813</sup> Transcript 21.4.16 P46 L20-27

<sup>814</sup> Transcript 21.4.16 P46 L29-34

<sup>815</sup> Transcript 21.4.16 P46 L35-42, P47 L3-11

<sup>816</sup> Transcript 21.4.16 P46 L42-43

<sup>817</sup> Exhibit 151, Section 5

establishing behaviour patterns, and this is also complicated, in the case of a person with dementia, because the person and their behaviours change as their brain decays.<sup>818</sup>

### **Evidence of Rosemary Robyn Neale**

235. Rosemary Neale was called as an expert witness on behalf of Jindalee Aged Care. Ms Neale provided a statement dated 8 April 2015 (which was tendered as Exhibit 155) but did not give oral evidence in the proceedings. Ms Neale is a registered nurse and completed her nursing training in 1964. She also holds a Bachelor of Administration (Nursing) achieved in 1996.<sup>819</sup> She worked exclusively in the aged care industry as a private nursing consultant from 1995 until retirement in 2013, with experience in high and low care residential facilities and dementia units similar to Jindalee's dementia unit.<sup>820</sup>
236. Ms Neale was asked to assume a listed set of facts and express an opinion on a number of issues relating to the operation of Jindalee, and specifically the dementia wing, following the incident on 21 January 2012 which resulted in Mr McCulloch's death. The facts Ms Neale was asked to assume were set out in her statement at [7] to [60]. Ms Neale was also provided with a number of documents listed at [61] of her statement, all of were ultimately tendered at the inquest hearing. However, Ms Neale's statement predated much of the evidence given at the inquest hearing, so some of the matters she was asked to assume differed from the evidence given in court, and additional contextual evidence about certain facts that came out in the hearing was not put to Ms Neale (such as the instruction to Ms Endo not to call Police).
237. Ms Neale stated that she believed the supervision arrangements for residents in the dementia wing of Jindalee were adequate and appropriate in the areas of staffing and staff education, although she considered that there were issues relating to the ward environment and the individual management of VH that were not entirely appropriate or adequate.<sup>821</sup> She considered that ideally a best practice design for a dementia unit was a secure unit of ideally around 16 residents in single rooms,<sup>822</sup> that the surveillance charts for VH were not appropriately filled out and should have required the recording of activity or behaviour at the time of sighting,<sup>823</sup> and that VH may have been more suitably housed in a single room

---

<sup>818</sup> Transcript 21.4.16 P49 L3-16

<sup>819</sup> Exhibit 155, [2], Annexure A

<sup>820</sup> Exhibit 155, [3]-[4]

<sup>821</sup> Exhibit 155, [64]

<sup>822</sup> Exhibit 155, [69]

<sup>823</sup> Exhibit 155, [70]-[73]

following his first attacks on Mr Durr on 18 January 2012.<sup>824</sup> She stated that supervision arrangements at Jindalee in 2012 were of a similar standard to those that would have been found in similar facilities throughout Australia, and were above the 2015 national benchmarks.<sup>825</sup> Ms Neale considered that the installation of CCTV in the corridors at Jindalee was a positive improvement, but she could not comment on the effectiveness given no information about the position of the monitors or frequency of monitoring.<sup>826</sup>

238. In terms of whether arrangements at Jindalee are sufficient to prevent the physical injury and/or death of any resident in the future, Ms Neale stated that “[i]t is virtually impossible for any aged care facility or dementia unit to absolutely prevent unpredictable behaviours in residents with unrecognised triggers, particularly in the early days following a resident’s admission ... [t]he most important strategies to assist with the safety of vulnerable and frail aged persons is to recognise the signs of dangerous or escalating physical aggression by implementing appropriate and timely behaviour management monitoring, and a behaviour management plan that will alert staff to aggression triggers and situations.”<sup>827</sup> She stated that, notwithstanding VH’s repeated attacks on Mr Durr on 18 January and other aggressive incidents, she considered that the fatal assault on Mr McCulloch and the assault on Ms Magliulo and Ms Faulkner were not foreseeable, as VH had not given any sign of attacking other residents who had apparently not provoked him.<sup>828</sup>

239. Ms Neale considered there were no tangible benefits to be gained by installing CCTV in residents’ rooms, because she believes that CCTVs in bedrooms are inappropriate for privacy reasons and they are unlikely to prevent incidents of physical aggression.<sup>829</sup> A better way of handling physically aggressive residents is to provide one-on-one staff monitoring of the instigator until the resident is transferred to an acute psychogeriatric unit for assessment and management.<sup>830</sup> She noted the financial costs of installing and monitoring CCTV in residential aged care facilities would be prohibitive.<sup>831</sup>

---

<sup>824</sup> Exhibit 155, [74]-[78]

<sup>825</sup> Exhibit 155, [79]-[83]

<sup>826</sup> Exhibit 155, [84]

<sup>827</sup> Exhibit 155, [87]

<sup>828</sup> Exhibit 155, [89]

<sup>829</sup> Exhibit 155, [91]-[93], [96]

<sup>830</sup> Exhibit 155, [94]

<sup>831</sup> Exhibit 155, [96]

240. Ms Neale stated that interim care plans are a very important part of the admission documentation, and required by staff to enable them to begin caring for the resident appropriately and safely.<sup>832</sup> Interim care plans should be completed within 24 to 36 hours following admission, pending more detailed assessments to be completed over the next four to six weeks, as part of the comprehensive care plan, and should be updated or changed as new information becomes known.<sup>833</sup> She listed a number of categories of information that she considered an interim care plan should contain, specifically noting the need for information about challenging behaviours and the likelihood of displays of physical aggression.<sup>834</sup> She noted that she was not provided with any documentation of behaviour assessment or monitoring of VH, notwithstanding he presented with a history of domestic violence and challenging behaviour which escalated following admission.<sup>835</sup> Ms Neale also noted that Jindalee's policies scheduled behaviour assessments in week two following admission, stating that such scheduling is normal practice under the requirements of the Aged Care Funding Instrument, which does not allow for services to claim for challenging behaviours exhibited within the first seven days after admission.<sup>836</sup>

#### **Evidence of Tristan Eric Thexton**

241. Tristan Thexton was recalled to give evidence on 21 April 2016. He was shown the draft replacement Jindalee proposal in respect of suspicious deaths<sup>837</sup> and asked to comment, particularly on a question raised by His Honour in relation to whether a direct contact with the AFP Coroner's officers would be appropriate. Senior Constable Thexton gave evidence of four concerns he held in relation to direct contact with the AFP Coroner's officers, as follows:

- while the Coroner's Office is always on call there is a possibility that calls to the work mobile phone might not be immediately answered (if for example the officer was attending a post mortem procedure), whereas calls direct to Police via 131 444 or 000 will be answered 24/7;
- if the Coroners officer made a determination that a Police response was required (for example a patrol to secure the scene followed by crime investigators), that response would be directed from the Police operations centre and the Coroner's

---

<sup>832</sup> Exhibit 155, [99]

<sup>833</sup> Exhibit 155, [103]-[104]

<sup>834</sup> Exhibit 155, [100]-[101]

<sup>835</sup> Exhibit 155, [102]

<sup>836</sup> Exhibit 155, [105]-[106]

<sup>837</sup> Exhibit 152

officer would need to make an additional communication for that purpose, adding a level of delay;

- it is easier to wind back an investigational response than to try to ramp up an initial inadequate response by which point evidence may already have been compromised; and
- all calls made to 131 444 and 000 are recorded and may be used in a subsequent investigation, whereas calls to the Coroner's office mobile are not routinely recorded.<sup>838</sup>

242. Senior Constable Thexton also raised two further concerns in relation to the draft protocol. These are that the requirement to contact Police should not be constrained or restricted to witnessing an event, for example where a suspicion is held appropriately on the totality of the circumstances, and, while visitors and staff should be asked to remain in the facility, Jindalee have no power to ensure attendance and the protocol, as drafted, could incline staff to take actions that might constitute a wrongful arrest.<sup>839</sup>

#### **Evidence of Plaxy St Clair McCulloch**

243. Plaxy McCulloch read an unsworn statement<sup>840</sup> onto the record on behalf of the McCulloch family during the hearing on 21 April 2016. She recounted details of Mr McCulloch's life and engagement with family, and his decline, dating from August 2011, when he fell and injured himself and was taken to hospital, where he was diagnosed with a rapidly progressing dementia.<sup>841</sup> Ms McCulloch recounted the family's anguish to find a nursing home for Mr McCulloch, first in his home town of Foster in NSW, and then in Canberra to be closer to family, to be finally told that a place was available at Jindalee.<sup>842</sup> She said that, although Mr McCulloch's family were unable to visit on the night he arrived and was admitted at Jindalee, the family were intending to visit him the next day, which was also Ms McCulloch's birthday.<sup>843</sup> Instead, the family found themselves dealing with his death.<sup>844</sup> Ms McCulloch recounted the significant effects of Mr McCulloch's death, and the events leading up to his death, had in relation to herself and each member of her family, saying that the lasting impact is likely to be a fear of nursing *home environments which*

---

<sup>838</sup> Transcript 21.4.16 P83 L19-P84 L25

<sup>839</sup> Transcript 21.4.16 P84 L27-P82 L5

<sup>840</sup> later tendered as Exhibit 154 note non-publication order prohibiting the identification of any persons named in the statement (see Transcript 21.4.16 P89 L14-16)

<sup>841</sup> Transcript 21.4.16 P87 L8-27

<sup>842</sup> Transcript 21.4.16 P87 L28-39

<sup>843</sup> Transcript 21.4.16 P88 L7-10

<sup>844</sup> Transcript 21.4.16 P88 L10-15

will only grow as family members age.<sup>845</sup> She said the family accepted it was likely to be inappropriate to lay blame at the feet of any individual staff member for the conditions that enabled Mr McCulloch's death, but that there are likely to be systemic and ongoing factors that contributed to his death relating to staffing, training, regulations, funding arrangements and ageism, for which there are no quick cures.<sup>846</sup>

### **Report by aged care complaints**

244. Sergeant Casey noted, in her evidence, that *“On 23 June 2013 a report compiled by the Aged Care Complaints Scheme, part of the Department of Health and Aging, in relation to Jindalee's compliance with the issues relevant to the deceased's death was received. The report identified three issues to be considered by their investigators including the behaviour management of those residents identified as involved in the incidents which occurred on 21 January 2012 proximate to the death of Mr McCulloch, including a previous incident between two of those care recipients on 18 January 2012. The approved provider's - which is Jindalee's - plan for the management of care recipient's needs, with particular reference to resident safety, and the approved provider was not maintaining a consolidated register of reportable assaults in accordance with the requirements of the act. The report finds that further investigation relating to the first two issues should not be concluded, because the matter is subject to a coronial inquiry, and despite reasonable attempts the circumstances giving rise to the issues could not be determined.”*<sup>847</sup> Sergeant Casey also noted that a Ms Costuna advised her in June 2013 that a number of changes had been made following Mr McCulloch's death which included the following: *“An additional staff member is rostered on for each shift on C wing including night shift. Six CCTV cameras have been installed in C wing and monitor the main traffic and communal areas. The surveillance monitor ...and a GP is to be informed every time there is a physical altercation between residents, either witnessed by staff or an allegation of the same is made by a resident.”*
245. The Coroner asked Sergeant Casey whether she had had seen the CCTV cameras, whether they monitored the nurses station and whether they were being actually monitored by anyone on a constant basis or even an intermittent basis. Sergeant Casey said: *“It's my understanding that it's a hub, it's where people go in and check their duty details and that sort of thing. So there's often people around. But I don't understand there to be one person standing in that room the whole time. So from the point of view of the utility of CCTV*

---

<sup>845</sup> Transcript 21.4.16 P88 L17-38

<sup>846</sup> Transcript 21.4.16 P88 L38-P89 L2

<sup>847</sup> Transcript 5<sup>th</sup> May 2015 p131

*cameras, even if they were in the main thoroughfares and even in rooms, they'd only get much value if they were being constantly monitored or monitored on a very regular basis."*

246. Sergeant Casey was asked questions about the requirement under the *Aged Care Act* in relation to Elder Abuse for the recording of reportable assaults. She noted that the JACR policy provided as follows:

*"Compulsory reporting of reportable assaults.*

*Staff must immediately report if they see or suspect an assault on a resident. Staff must report the incident to the RN in charge. The RN in charge must immediately contact the DONs. The DONs must report to both the Police and the Office of Aged Care Quality and Compliance within 24 hours of the altercation or the allegation being made."*

Sergeant Casey said there was no report of an assault on Mr McCulloch.



11<sup>th</sup> July 2016

Office of the Coroner  
Magistrates Court Building  
Knowles Place, ACT 2601  
Attention: Coroner Dingwall

**Re: Improvements at Jindalee Aged Care Residence- C Wing (Jindalee)**

This letter briefly sets out additional improvements that have been/will be made at Jindalee Aged Care, C wing in particular, to ensure that the circumstances surrounding the death of Mr. Charles McCulloch on the 21<sup>st</sup> January 2012, do not happen again.

- Jindalee has taken comprehensive steps to ensure that residents with any history of serious aggression are not admitted to the facility. We no longer accept the government's assessment of dementia residents, but rather, carry out our own exhaustive examination of each potential resident's history and documentation to determine suitability for admission. We can report that there are currently no residents accommodated in C wing displaying aggressive behaviours.
- Construction works have commenced in C wing to reduce the size of the secure dementia area from 32 residents to 20 residents, with a new secure door added to separate these residents at risk of wandering. Completion of this project is scheduled for September 2016 and includes new interior design, furniture, artwork, décor, floor coverings and curtains. These improvements will provide a more home like and soothing environment for residents with dementia, and those that experience disorientation and mild behavioural issues. Initially, there will be 15 female and 5 male residents. However, it is our intention that this will eventually be a female only wing. I have attached two images to demonstrate the new design concept for the C wing renovations. The remaining 12 beds in C wing will be converted to general nursing home places.
- Based on the draft recommendations, from Counsel assisting the Coroner, we believe that Jindalee will be able to adopt all recommendations to the satisfaction of the Coroner. This should ensure that our management and staff are better equipped to deal with unprecedented events such as those that occurred on the 21<sup>st</sup> January 2012.
- The above changes to C wing have been made much more difficult by the reduction in funding by the Federal Government during the past two years. This includes Jindalee's subsidy reductions of:
  - i. The payroll tax supplement removal- 1<sup>st</sup> January 2015 (\$624,000 per annum).
  - ii. Dementia supplement (initially introduced to fund aged care operators for residents with severe dementia and behaviours) - 1<sup>st</sup> August 2014 (\$180,000 per annum).
  - iii. Subsidy reductions to the aged care funding instrument (ACFI) in July 2016, with further cuts coming in January 2017, mainly in the Complex Health Domain (CHC) (Approximately \$800,000 over 4 years and thereafter, \$300,000 per annum).

Operational expenses in C Wing are already greater than total income for that wing. This loss of funding continues to place significant strain on aged care operators Australia wide.

Yours Sincerely,

GARY JOHNSON  
MANAGING DIRECTOR  
JOHNSON VILLAGE SERVICES PTY LTD  
P: 07 5646 3900  
E: jvs1@jindalee.net.au

**Proposed Protocol for Australian Capital Territory (ACT) Aged Care Providers regarding Suspicious Deaths**

Pursuant to section 13 of the Coroner's Act 1997, the ACT Coroner has jurisdiction to investigate the manner and cause of death of a person who-

- (a) dies violently, or unnaturally, in unknown circumstances; or
- (b) dies under suspicious circumstances; or
- (c) dies during or within 24 hours after, or as a result of—
  - (i) an operation of a medical, surgical, dental or like nature; or
  - (ii) an invasive medical or diagnostic procedure;  
  
other than an operation or procedure prescribed by regulation to be an operation or procedure to which this paragraph does not apply; or
- (d) dies and a doctor has not given a certificate about the cause of death; or
- (e) dies not having been attended by a doctor at any time within the period commencing 6 months before the death; or
- (f) dies after an accident where the cause of death appears to be directly attributable to the accident; or
- (g) dies, or is suspected to have died, in circumstances that, in the opinion of the Attorney-General, should be better ascertained; or
- (h) dies in custody.

This protocol applies to deaths subject to the jurisdiction of the ACT Coroner, where they occur in Aged Care facilities in the ACT.

Nothing in this protocol prevents staff members in Aged Care facilities checking for signs of life and administering first aid to residents.

**In the event that staff locate a resident who is deceased in circumstances that appear suspicious it is vital the deceased and their surrounding area not be disturbed in any way, and that measures are taken to preserve any evidence.**

**Additionally, the following must be carried out:**

- the resident must be checked for signs of life, and first aid administered by staff as deemed appropriate;
- in circumstances where deemed necessary by staff, ACT Ambulance Service should be called to attend; and
- ACT Policing must be contacted immediately on '000' in an emergency and 131444 at any other time.

**ACT Policing must be informed:**

- that a resident has been located deceased in suspicious circumstances;
- of any suspected cause of death (including injuries to the deceased);
- of the details and last known location of any suspected offender; and
- any other relevant details, including the name and address of the aged care facility.
- staff at the aged care facility's reception area are to be notified of impending Police attendance and be in a position to escort Police to the deceased's location; and
- staff are to carry out any directions provided by ACT Policing.

**The following must be carried out:**

- a staff member must remain with the deceased until otherwise directed by a member of ACT Policing. That person should record notes of their involvement, including the time they were allocated to remain with the deceased and any other relevant events;
- if the deceased is located in a common area, ensure other residents are moved away from the area;
- in the event staff have any suspicion that the deceased's death was caused by another person, where safe a staff member must be assigned to remain with the suspect until otherwise directed by a member of ACT Policing. That staff member will ensure the suspect remains in the same clothing and is not washed (including their hands);
- staff should conduct a welfare check of all other residents in the area. A record should be made of which staff member/s conducted the welfare check and the residents checked by them;
- staff should immediately advise a member of ACT Policing of other residents with recent injuries as identified during the welfare check;
- any visitors to the facility should remain there until otherwise directed by a member of ACT Policing. If visitors insist on leaving a record should be made of their details, a description of their appearance, details of any vehicle they depart in and the time they left the facility. If the visitor is not known to staff photographic identification should be requested and details recorded; and

- any cleaners and laundry workers operating at the residence should be stopped until otherwise directed by Police, including the emptying of bins, collection and washing of laundry throughout the residence.

The following conduct **should not** be carried out until otherwise directed by Police:

- the deceased should not be disturbed in any way (this includes placing a sheet over them);
- the deceased should not be moved;
- the deceased should not be washed;
- the deceased should not be touched, other than to check for signs of life and potentially administer medical assistance;
- when the deceased dies after medical assistance, no apparatus should be removed from the deceased's body;
- the deceased's family members should not be contacted; and
- the deceased's belongings should not be touched.

It should be noted that it is a criminal offence not to report a suspicious death to Police or the ACT Coroner.

## **Section 77 of the Coroner's Act 1997**

### **Obligation to report death**

- (1) A person commits an offence if the person—
- (a) knows that a death has happened; and
  - (b) has reasonable grounds to believe that—
    - (i) a coroner would have jurisdiction to hold an inquest in relation to the death; and
    - (ii) the death has not been reported to a coroner or a police officer; and
  - (c) does not report the death to a coroner or a police officer as soon as practicable after becoming aware of it and having the reasonable grounds mentioned in paragraph (b).

Maximum penalty: 50 penalty units, imprisonment for 6 months or both.