



## **FINDING OF INQUEST**

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 7<sup>th</sup> and 8<sup>th</sup> days of April 2008, the 8<sup>th</sup> and 16<sup>th</sup> days of May 2008 and the 6<sup>th</sup> day of November 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Rolando Cecere.*

*The said Court finds that Rolando Cecere aged 71 years, late of Saint Hilarion Aged Care, 410 Henley Beach Road, Lockleys, South Australia died at Lockleys, South Australia on the 22<sup>nd</sup> day of January 2006 as a result of positional asphyxia. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction**

- 1.1. Mr Rolando Cecere was a 71 year old Italian born man who suffered from severe dementia, non-insulin dependent diabetes, depression and schizophrenia. He was a resident of the Saint Hilarion Aged Care in the suburb of Lockleys in South Australia for two weeks before his death which occurred sometime between 2225 hours on 22 January 2006 and 0055 hours on 23 January 2006.
- 1.2. Mr Cecere was found in horrific circumstances. His neck was wedged into the wooden slats of a picket gate adjacent to an external wall of the nursing home. He was wearing tracksuit pants and the knee of the left leg of the pants was caught on one of the slats of the gate. The result was that Mr Cecere's entire weight was hanging from the gate itself, divided between his neck and his lower body which was supported by the tracksuit pants hanging from the gate.
- 1.3. This Inquest was largely devoted to finding out how Mr Cecere came to be in that situation.

## **2. Mr Cecere is assessed by the Aged Care Assessment Team**

- 2.1. Susan Mellors is a social worker employed by the Department for Families and Communities as an Assessment Officer in the Aged Care Assessment Team (ACAT). She deals with referrals concerning elderly people who are facing difficulties with accommodation. She made two assessments relating to Mr Cecere. She explained that copies of her assessments would be sent to the relevant Commonwealth funding agency and to Mr Cecere's family.
- 2.2. Mr Cecere had been receiving domiciliary care services and his Domiciliary Care Case Manager, Julie Thomas, had referred his case to ACAT. Ms Mellors met with Mr Cecere and his wife for the first time on 9 February 2005. On that occasion Mr Cecere was assessed as requiring 'low care'.
- 2.3. Mr Cecere's medical notes from the Queen Elizabeth Hospital were admitted as Exhibit C8. They contain a letter from Dr Short of the Neurology Department to Mr Cecere's General Practitioner, Dr Chitti. The letter is dated 4 April 2005. Mr Cecere was referred to the Memory Unit of the Neurology Department for further assessment of his Alzheimer's dementia. The letter notes that Mr Cecere had a past medical history of non-insulin dependent diabetes melitis, an anxiety depressive disorder, schizophrenia and gastro oesophageal reflux disease. The letter noted a significant family history of Alzheimer's disease in Mr Cecere's father, paternal grandmother and his father's brother, all of whom suffered from late onset dementia in their 70s and 80s. Mr Cecere was initially diagnosed with Alzheimer's disease in 2000 and the letter records a steady progressive decline in Mr Cecere's memory since that time. Dr Short concluded that Mr Cecere had severe dementia which was being appropriately medicated but that there was little more that could be done for him. It was Dr Short's view that ultimately Mr Cecere would need permanent residential care.
- 2.4. On 10 May 2005 Mr Cecere was again assessed by Ms Mellors. On that occasion she assessed him as requiring high care. She noted that he had the potential to wander and regarded a nursing home environment to be appropriate for him because of the availability of 24 hour care and secure accommodation.

### **3. Admission to Queen Elizabeth Hospital Emergency Department – January 2006**

- 3.1. Between May 2005 and January 2006 Mr Cecere continued to live at home with Mrs Cecere. On 6 January 2006 she felt unable to cope with him at home because of his escalating aggression and agitation. As a result, he was admitted to the Queen Elizabeth Hospital on 7 January 2006. The nursing discharge summary, which appears in Exhibit C8, records that Mr Cecere had been ‘specialled’ by a carer. This means that he was under constant observation while in the Queen Elizabeth Hospital. Mr Cecere was discharged on 9 January 2006 to Saint Hilarion Aged Care.

### **4. Admission to Saint Hilarion Aged Care**

- 4.1. Mr Cecere was admitted to the Saint Hilarion Aged Care by Ms Cuming who at that time was the Site Director. She was a registered nurse who had previously been the Clinical Nurse Consultant at Saint Hilarion. At the time of giving evidence she had returned to the position of Clinical Nurse Consultant. A number of assessments were conducted upon Mr Cecere on 9 January 2006. His casenotes were admitted as Exhibit C9. They contain these assessments. A physiotherapy assessment contains the following notes:

'... tends to wander - supervision @ all times

SUMMARY OF FINDINGS - Tends to wander + try to leave facility - needs supervisions + direction.'

A respite care plan filled out by Ms Cuming records under the heading of ‘Safety’ that Mr Cecere ‘tries to escape’. Ms Cuming was provided with a copy of the ACAT assessment of 10 May 2005. That assessment includes a statement as follows:

'At risk of wandering but wife keeps doors secure.'

There is also an entry in the notes by Dr Chitti on 9 January 2006 which refers to Mr Cecere’s having absconded.

- 4.2. I find that there was ample evidence in the hands of Saint Hilarion Aged Care to the effect that Mr Cecere was likely to abscond or attempt to escape and that he required a secure environment. Indeed, Ms Cuming said that she saw this as a risk but that she did not think any harm would come to Mr Cecere within what she described as ‘a

secure environment<sup>1</sup>. She elaborated that she believed that St Hilarion was secure and that Mr Cecere would not be able to escape.

## **5. Mr Cecere's attempts to abscond**

- 5.1. Christine Smith gave evidence at the Inquest. She was working as a registered nurse at Saint Hilarion in January 2006. She recalled Mr Cecere and by reference to his casenotes<sup>2</sup> she identified an entry she had made on 10 January 2006 that Mr Cecere had, on that day, wandered around the facility trying all of the doors to get outside. At one stage he did manage to get outside to the maintenance shed during tea time. Nurse Smith recalled that she had realised that Mr Cecere was missing and started to look for him straight away. She had looked through the interior of the facility and then decided to look in the laundry because she was aware that the door into the laundry could not be locked at that time. She did not find Mr Cecere in the laundry but went outside via the external laundry door. That door was able to be opened from the inside of the building. It had a lock but the lock could be undone from inside without the need for a key.
- 5.2. She found Mr Cecere near the maintenance shed a short distance away from the external laundry door. Mr Cecere was standing near the gate between the maintenance shed and the main building. It was this gate on which Mr Cecere was found in the early hours of the morning of 23 January 2006 in the circumstances described above.
- 5.3. Nurse Smith wrote an incident report about this event. She also wrote about it in the casenotes. She placed the incident report under the Site Director's (Ms Cuming's) office door so that she would find it first thing the following morning. There was no copy of this incident report in Exhibit C9. It appears that it has been lost by Saint Hilarion Aged Care, because Nurse Smith was quite clear that she completed it<sup>3</sup>. Although Ms Cuming's recall was rather vague, she confirmed that she did recall receiving at least one incident report involving Mr Cecere<sup>4</sup>.

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<sup>1</sup> Transcript, page 299

<sup>2</sup> Exhibit C9

<sup>3</sup> Transcript, page 43

<sup>4</sup> Transcript, page 234

- 5.4. Nurse Smith said there was a second instance where Mr Cecere was found outside. She had made a second note in his casenotes:

'Very restless. Has climbed up the fence at 1830 hrs and had to be coaxed down by staff member.'

This was the second time he had left the premises. He was clearly trying to escape from the facility. Nurse Smith said that she completed an incident report in relation to this event as well as making an entry in the casenotes. She said that she placed that incident report under the Site Director's door just as she had with the first.

- 5.5. I find that by 12 January 2006, Saint Hilarion Aged Care was in possession of a considerable amount of information establishing that Mr Cecere was prone to wander and was making active attempts by trying doors, climbing fences and other actions, to abscond from the premises.

## **6. The night of 22 January 2006 and early morning of 23 January 2006**

- 6.1. The last person to see Mr Cecere before he was found deceased was one of the carers in the home, Mr Adnan Khan. He gave evidence that he recalled seeing Mr Cecere outside his room at approximately 10:25pm<sup>5</sup>.
- 6.2. Mr Khan gave evidence that the staff, including himself, had been asked to check on Mr Cecere at 15 minute intervals. There was evidence at the Inquest to suggest that this was a response to the propensity shown by Mr Cecere to wander.
- 6.3. It was clear from the evidence that there were two possible means by which Mr Cecere could have left the facility that night. One was by means of the laundry door. As I have said, it was at that time possible to unlatch that laundry door from the interior of the building. The other possibility was a door on the eastern side of the building that was referred to in evidence as the 'garden' door. It is situated immediately adjacent to Mr Cecere's room. There was nothing in the evidence that suggested that it was more likely that he would have exited by means of that door because of its proximity to his room. It seems equally possible that he exited the building by way of the laundry door. In any event, the garden door was also capable of being opened from inside the facility by means of an internal latch.

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<sup>5</sup> Transcript, page 88

- 6.4. Saint Hilarion had a security system which would activate if the external doors were opened after the security system was armed. Nurse Smith understood that the system would operate if any of the external doors was opened<sup>6</sup>. Nurse Smith was of the understanding that a signal would be sent to a security company which would then contact Saint Hilarion to inform them that there had been a breach and which of the doors had been opened. There was some confusion as to the time at which the alarm was supposed to be activated at night. In any event, the evidence was clear that it would be activated at the latest at the time when the afternoon shift registered nurse handed over to the night duty registered nurse and the former had left the premises. This could occur any time between 11pm and midnight.
- 6.5. It transpired that Nurse Smith was wrong in her understanding that all of the external doors were alarmed. Mr Peter Hill, the Chief Executive Officer of the Society of Saint Hilarion Incorporated, gave evidence at the Inquest. He said that he found out after Mr Cecere's death that the laundry door had been part of the security system but that the wiring for that particular door had been disconnected at some point<sup>7</sup>. He said that after he became aware of that he arranged for the laundry door to be reconnected to the security system<sup>8</sup>.
- 6.6. I find that Mr Cecere could have left the premises by means of the garden door at some time prior to the activation of the alarm system, or the laundry door at any time regardless of when the alarm was activated.
- 6.7. I have been unable to come to a conclusion about which of these two doors was used by Mr Cecere to exit the building. Furthermore, I have been unable to gain any assistance from the position in which Mr Cecere was subsequently found on the gate. The evidence showed that the gate can be approached on one side from the laundry door, and approached on the other side from the garden door. Theoretically, if one could establish that Mr Cecere had become stuck on the gate when climbing it from one side or the other, it would be possible to infer from which of the two doors he had exited the building. However, I cannot rule out the possibility that Mr Cecere may have successfully climbed over the gate from one side before attempting to climb back over it again. All I can conclude is that, whether he had previously climbed over the gate that night or not, at some point he attempted to climb over the gate and his

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<sup>6</sup> Transcript, page 36

<sup>7</sup> Transcript, page 274

<sup>8</sup> Transcript, page 275

clothing became stuck on the gate. Mr Cecere's neck then came into a resting position between two of the pickets of the gate, with the result that he was asphyxiated.

- 6.8. The South Australian Ambulance Service Patient Report Form recording the attendance of paramedics at Saint Hilarion that morning was admitted as Exhibit C3a. It records that the ambulance was summoned at or about 1:02am and that it arrived on the scene at 1:09am. I infer that Mr Cecere was discovered some time shortly before 1:02am, although the recollections of the various witnesses about timing was somewhat inconsistent. By the time Mr Cecere was discovered, he was cold to the touch and so it appeared likely that he had been on the gate for some time before the discovery was made. In the result, I find that Mr Cecere died some time between 10:25pm on 22 January 2006 and 12:55am on 23 January 2006.

## 7. **Conclusion**

- 7.1. I find that there was abundant evidence in the hands of Saint Hilarion Aged Care prior to 23 January 2006 that Mr Cecere was at risk of wandering and, if possible, absconding from the facility.
- 7.2. The securing of the premises of Saint Hilarion Aged Care was inadequate. In fact, the premises could not be described as secure. The fact that the laundry door was not alarmed, and the fact that both the laundry door and the 'garden' door were able to be opened from the inside in much the same way as any door in a normal house can be, meant that the premises were not capable of safely containing a person such as Mr Cecere who actively tested the boundaries of his environment in order to find a means of escape. It was only a matter of time before he succeeded.
- 7.3. There was evidence that Ms Cuming initiated a request to staff that Mr Cecere be observed every 15 minutes. The evidence showed that this was not practical<sup>9</sup>.
- 7.4. The incident reports prepared by Nurse Smith and referred to in her evidence were never provided to the Court despite the issuing of two Directions for documentation relating to Mr Cecere. I am not suggesting that Saint Hilarion has deliberately withheld those documents. It is clear that those documents have been misplaced or lost.

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<sup>9</sup> For example see Transcript, page 46 and Transcript, page 91

- 7.5. During the course of the Inquest it became clear that certain documents relating to Mr Cecere that should have been provided pursuant to the first Direction for documents relating to him had not been provided. A second Direction had to be issued. I am critical of Saint Hilarion for having failed to manage documentation in relation to Mr Cecere in a manner that would have enabled the Court to be provided with all documentation when it made the first request.
- 7.6. It need hardly be stated that it is reprehensible that Mr Cecere met his death in the manner he did. Had Saint Hilarion been properly secured, this would not have happened. Mr Cecere's death in such distressing circumstances was entirely avoidable.
- 7.7. Saint Hilarion Aged Care had no clear policies in relation to the checking of residents. It appeared that there was an assumption that the premises were secure, and therefore checking was not crucial. Clearly the premises were not secure. Even if they had been secure, in my view it is inappropriate for an aged care facility to rely on the security of the premises alone in this respect. There should be a regular check made of the residents to ensure their wellbeing and safety.
- 7.8. Saint Hilarion identified a number of changes made within their facility since Mr Cecere's tragic death. They are as follows:
- 1) A coded keypad was installed on the garden door;
  - 2) A coded keypad and a slide lock were installed on the sluice room door;
  - 3) A coded keypad was installed on the internal laundry door;
  - 4) An extra sliding lock was installed on the internal laundry door;
  - 5) The external laundry door was reconnected to the alarm;
  - 6) Official forms for recording the sighting of residents at 30 or 60 minute intervals were instigated;
  - 7) There was an increase in staff including a Safety Assurance Officer<sup>10</sup>;
  - 8) The gate on which Mr Cecere died has been removed and replaced with a swimming pool type gate with rounded surfaces;

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<sup>10</sup> Transcript, page 33

- 9) The alarm is now activated at 9pm instead of approximately 11pm;
- 10) There is a clearer delineation of roles regarding security<sup>11</sup>;
- 11) The Society of Saint Hilarion has recognised that the Lockleys premises are outdated and is actively endeavouring to replace the facility as quickly as possible.

7.9. These matters are commended. Some of them, such as the reconnection of the laundry to the alarm system and the proper securing of the sluice door, the laundry door and the garden door, were basic essentials to render the premises fit for their purpose and were, for that reason, the least one would expect.

## **8. Recommendations**

8.1. Having regard to the horrendous circumstances in which Mr Cecere died, I recommend that the Commonwealth Department of Health and Ageing and the Aged Care Standards and Accreditation Agency conduct a thorough review of the facilities, practices and policies of the Saint Hilarion Aged Care facility at Lockleys and that, in particular, an assessment is made of the following:

- 1) Whether the facility is properly equipped to care for patients with dementia;
- 2) Whether the facility's practices in relation to the admission of patients, are sufficient to ensure that inappropriate admissions are not made;
- 3) Whether the facility has sufficient nursing and caring staff to provide an appropriate standard of care;
- 4) Whether the record keeping practices are adequate, particularly in relation to incident reports;

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<sup>11</sup> Transcript, pages 291-292

- 5) Whether the facility provides a safe environment to residents;
- 6) Whether the facility's policies, practices and procedures are appropriate to deal with residents who wander.

*Key Words: Asphyxia; Dementia; Psychiatric/Mental Illness; Nursing Home*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 6<sup>th</sup> day of November, 2008.*

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*State Coroner*