CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 29th and 30th days of May 2017, the 2nd and 6th days of June 2017, the 1st, 27th and 28th days of February 2018, the 1st day of March 2018, the 5th, 19th and 27th days of April 2018, the 10th day of May 2018, the 15th day of June 2018, the 2nd, 3rd and 6th days of August 2018 and the 28th day of September 2018, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Graham Rollbusch.

The said Court finds that Graham Rollbusch aged 70 years, late of Makk House, 200 Fosters Road, Oakden, South Australia died at Oakden, South Australia on the 28th day of February 2008 as a result of combined effects of severe pulmonary emphysema, ischaemic heart disease and recent trauma to the head and neck. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Graham Rollbusch was 70 years of age as at the date of his death on 28 February 2008. At the time of his death he was a resident of the Oakden Older Persons Mental Health Service ('Oakden'). At that service he was housed within that part of the facility known as Makk Ward or Makk House.

2. Cause of death

2.1. A post mortem examination was carried out by forensic pathologist Dr Karen Heath the following day and in a report dated 3 July 2008[1] Dr Heath gave the cause of death as

[1] Exhibit C2a

'combined effects of severe pulmonary emphysema, ischaemic heart disease and recent head and neck trauma', and I so find.

3. The involvement of Mr Palmer in Mr Rollbusch's injuries

3.1. The staff on duty in Makk House consisted of Ms Atkinson, Mr Laurente and Mr Mohmad. The evidence shows that at about 5am the three staff members commenced a ward round. They had reached the start of the northern corridor close to room G155 when they heard someone yell out. Mr Laurente stated that it sounded like Mr Palmer[2]. Ms Atkinson stated that she heard Mr Palmer yelling from the east end of the corridor and although it was hard to understand what he was saying, she knew it was Mr Palmer by the pitch and volume and sounded as if something was wrong. Ms Atkinson walked quickly towards Mr Palmer's room. Mr Palmer's room was immediately adjacent to Mr Rollbusch's room and there was a small alcove immediately outside the two rooms that gave access to the doors of each room. Ms Atkinson said that when she got to the alcove area, outside of Mr Palmer and Mr Rollbusch's rooms, she could see Mr Rollbusch lying face down in the entrance of his room. She could see blood on the floor which was coming from his head. She said that Mr Palmer was hovering around the alcove area in front of the two rooms. She immediately called for Mr Laurente and Mr Laurente went over to Mr Rollbusch to check to see if he had a pulse. While that was happening Ms Atkinson said she heard Mr Palmer say 'I think I have hit him too many times'. Mr Palmer repeated this about three times. She sat Mr Palmer down on a chair outside of his room in the alcove. She could see what she described as visible signs of blood on Mr Palmer's right hand. Mr Mohmad gave evidence to a similar effect. He also saw blood on Mr Palmer's hands[3]. Mr Laurente also noted blood on Mr Palmer's hands.

3.2. Ms Hull was the night nurse manager. She was stationed in another part of the facility. She was called soon after Mr Rollbusch was discovered by Ms Atkinson. She checked Mr Rollbusch on her arrival and said that there was a lot of blood around his head. She checked for a pulse and breathing and neither pulse nor breathing was present. She said that she saw red marks on Mr Palmer's hands that looked like blood. She said that she heard Mr Palmer saying words to the effect 'I'm in trouble' over and over again. She also heard him say 'I shouldn't have hit him so hard and I pulled him out of bed and

[2] Transcript page 84
[3] Transcript page 61

tried to strangle him'. Mr Laurente stated that the door to Mr Rollbusch's room was open when he arrived at the scene and that Mr Palmer was outside the door when he arrived[4]. Mr Laurente also checked Mr Rollbusch's pulse[5]. Mr Laurente's evidence corresponded with that of Ms Atkinson and Mr Mohmad. He said he also heard Mr Palmer's voice. He also saw Mr Rollbusch face down in blood[6]. Mr Laurente also said that he heard Mr Palmer say 'I should not have hit him, I hit him several times'[7].

3.3. As a result of these accounts attention naturally turned to the likelihood of Mr Palmer having been involved in the infliction of Mr Rollbusch's injuries. Both Mr Palmer and Mr Rollbusch had dementia at the time of this event. It goes without saying that Mr Palmer did not have the necessary cognitive capacity to make admissions that could be relied upon with any certainty. However, the following factors were clearly suggestive of an involvement by him in the infliction of Mr Rollbusch's injuries:

1) His presence in the immediate vicinity; and
2) The fact that not long before the discovery of his body, Mr Rollbusch had been observed in his bed alive; and
3) The presence of blood on Mr Palmer's hands.

The admissions made in the hearing of Ms Atkinson, Mr Mohmad and Mr Laurente have greater weight when considered in the light of those other circumstances, and Ms Hull's account of hearing Mr Palmer say 'I pulled him out of bed' is particularly significant in light of the forensic evidence that Mr Rollbusch had apparently been dragged along the floor by his upper body. This evidence will be described in more detail later in this finding.

4. <u>The post mortem examination</u>

4.1. In her post mortem report Dr Heath stated that death was due to the combined effects of severe pulmonary emphysema, ischaemic heart disease and recent trauma to the head and neck. She stated as follows:

> 'Circumstances surrounding the death suggest that the deceased may have been assaulted prior to death. On examination at autopsy there were numerous bruises, lacerations and superficial abrasions involving the head and neck, including a fractured nose. These

[4] Transcript page 95
[5] Transcript page 35
[6] Transcript page 85
[7] Exhibit C16

injuries were consistent with a recent assault. It is noted that the deceased was found face down on the floor. Some of the injuries found at autopsy may have resulted from a fall, however the extent of the facial injuries was more than would be expected from a simple fall alone'. [8]

4.2. Dr Heath also said:

'Although no lethal inflicted injuries were identified at autopsy, the trauma and resulting anxiety of an assault most likely contributed to death by resulting in exertion and catecholamine (adrenaline) release, placing additional strain on the heart and lungs and exacerbating the underlying severe heart and lung disease. In addition there was moderate blood loss from the injuries to the head and neck. Whilst the amount of haemorrhage was not excessive, in a person with severe underlying natural disease, the blood loss may have been significant and contributed to death'.

4.3. Under the heading 'Signs of Recent Injury', Dr Heath documented 35 items including bruises, abrasions and lacerations. The parts of the body affected were the head and neck, the trunk, the upper limbs and the lower limbs.

5. Blood stain analysis

5.1. Sergeant Veldhoen of the Forensic Response Section examined photographs of the scene compiled by Brevet Sergeant Tully, 124 images in all. He also examined a bed sheet that was seized from Mr Rollbusch's room. Sergeant Veldhoen has extensive qualifications in blood stain analysis and I accept him as an expert in this area. He evaluated all of the images and came to the following conclusions:

'1. A bloodshed event has taken place in the bed of the deceased resulting in him receiving a free bleeding injury;

This event has taken place after the removal of his nasal canula[9].

2. This bloodshed event has resulted in the deposition of a splatter pattern on the pillow and sheet of the bed. This pattern is most consistent with an impact pattern resulting from blows into a liquid blood source that was located in the vicinity of the pillow at the head of the bed. I cannot however, exclude a possible expirated blood stain pattern resulting from blood from an injury having been expelled from the nose or mouth.

3. The presence of friction ridge detail within the transfer blood stains on the bed railing indicates contact of a person's blood stained hand(s) with the hand rail. There is no evidence of the type of blood staining on the hands of the deceased.

4. The deceased's free bleeding injuries were confined to his head.

[8] Exhibit C2a

[9] Mr Rollbusch had oxygen therapy in his room and the nasal equipment attached to the oxygen supply had no signs of any blood on it and it was apparent that it had been removed before Mr Rollbusch sustained in the injuries to his face

5. The deceased's lower body has been in continuous contact with the floor producing two uninterrupted drag marks from where his hips and thighs have been in contact with the floor while his lower body has been dragged across the floor. This has also resulted in his incontinence pants being partially pulled down.

6. The deceased's head has been moved laterally after coming to rest. The inside of the base of the door has come into contact with a blood stained object, possibly the head of the deceased on opening the door.

7. Having reviewed the photographs of the injuries, in particular the blunt force trauma to the face of the deceased and having reviewed all of the scene photographs, I am unable to identify any blood stains that would indicate repeated impact with any surfaces within the room.' [10]

6. Conclusion in relation to the involvement of Mr Palmer

6.1. Counsel for the family of Mr Palmer correctly submitted that the admissions of Mr Palmer ought not to be relied upon to any large degree. It was submitted that a scenario other than Mr Palmer entering Mr Rollbusch's room and committing an assault against Mr Rollbusch in his bed is open on the evidence. There was considerable evidence about a practice within Makk House involving the closing and locking of patient's doors. The effect of the evidence was that the doors could be locked from the outside with a key, thus preventing anyone from entering the room unless they possessed a key. At the same time, the door could be opened from the inside, thus permitting the patient to exit the room at any time. The evidence was quite clear that the practice of closing the doors was regularly observed by staff and it was the evidence of each of the three staff members on the night that the practice was observed in relation to Mr Rollbusch's door.

6.2. Counsel for Mr Palmer placed some reliance on that evidence. Nevertheless, the fact of the matter is that when Mr Rollbusch was found, his door was open. However it came to be open, the fact is that at some point, a person other than Mr Rollbusch, would have been able to access the room. Dr Heath discounted the possibility that Mr Rollbusch's injuries could have been sustained simply by a fall. The finding of Sergeant Veldhoen that Mr Rollbusch's lower body was dragged along the floor suggests that another person lifted his upper body in order to drag him to permit his lower body and limbs to have contact with the floor in the manner described. There is no other explanation for the drag marks.

[10] Exhibit C8a

6.3. One might theorise that Mr Rollbusch fell off his bed, thus sustaining all of, or most of, the serious injuries that were subsequently found on his head and upper body and then somehow dragged himself towards the door of his room while maintaining his upper body clear of the floor in the process of doing so. That proposition is untenable when one considers Mr Rollbusch's extreme frailty. At the time of his death Mr Rollbusch weighed only 36 kilograms and was extremely ill. Even a well person would have some difficulty having sustained serious injuries to the face and head in dragging their lower body across the floor unaided with their upper body raised above the floor. It is clear that a third party was involved.

6.4. The presence of blood on Mr Palmer's hands, his proximity to the location and his admissions, for what they were worth, cause me to conclude that Mr Palmer was responsible for the infliction of at least the more serious of the injuries that were noted to Mr Rollbusch's body. In making that finding I apply the civil standard of proof while taking into account the principles in **Briginshaw v Briginshaw**[11]. In that case Dixon J said at 362:

> 'But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters, 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony or indirect inferences'.

Furthermore, I bear in mind that the Court must not make any finding or suggestion of criminal or civil liability[12], and the analysis of that principle in **Perre v Chivell**[13].

6.5. Further weight for my conclusion is to be found in the medical notes of Mr Rollbusch[14] which record that on 21 January 2008 Mr Rollbusch was struck repeatedly by Mr Palmer. Moreover, on 30 January 2008 Mr Rollbusch was sitting in a chair when Mr Palmer approached him swinging his fists and swearing and then punched Mr Rollbusch in the face. Mr Palmer was verbally abusive for some time after the incident and repeatedly stated 'he's a bastard if I see him again I will punch him in the jaw'[15].

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[11] **Briginshaw v Briginshaw** (1938) 20 CLR 335
[12] Coroners Act 2003 S25(3)
[13] **Perre v Chivell** (2000) 77 SASR 282
[14] Exhibit C11b page 65
[15] Exhibit C11b page 65

7. The circumstances in which Mr Rollbusch came to be admitted to Makk House

7.1. It appears from the records that Mr Rollbusch had been living with a carer or friend by the name of Melissa. A final separation summary from the Queen Elizabeth Hospital dated 1 May 2005[16] records that he was referred by his general practitioner for an opinion regarding his severe unresponsive chronic obstructive airways disease and management of his social issues. He had presented to his general practitioner one week previously with increasing shortness of breath and use of home oxygen, requiring oral prednisolone. He had no cough, fevers, sweats or abdominal pain but complained of difficulty sleeping at night. His friend Melissa, who he lived with and who cared for him, reported inappropriate behaviour, wandering and refusal to take medications. She felt that she was unable to care for him further and requested admission to hospital.

7.2. It appears that during the admission Mr Rollbusch was reviewed by occupational therapists, physiotherapists and social work who recommended that he would benefit from supportive care given his dyspnoea and his social situation. This was discussed with Melissa and Mr Rollbusch who were both happy for him to be placed in Brooklyn Supportive Care.

7.3. So it was that Mr Rollbusch entered the Brooklyn Supportive Care facility on 20 April 2005. He was to remain for only a couple of months.

7.4. A letter dated 3 August 2005 from a Mary Marone of Brooklyn Supportive Care is addressed to (it would appear) the Queen Elizabeth Hospital Emergency Department and is as follows:

> 'Dear Doctor,
>
> I have sent Mr Rollbusch into hospital for admission on the request of Dr Flynn (psychiatrist) from Western Team Mental Health. This man is not able to be managed in our facility at this stage due to his inappropriate sexual behaviour. Dr Flynn's plan is to have him sent to Howard House where there is an available bed.' [17]

7.5. A letter from the community mental health nurse, Western Community Team to Mr Rollbusch's general practitioner is in the following terms[18]:

> 'I reviewed Mr Rollbusch today… in discussion with Mary Marone it would appear that Mr Rollbusch showed some initial improvement but this has not been sustained. He was

[16] Exhibit C11 page 99
[17] Exhibit C11 page 59
[18] Exhibit C11 page 98

> reported today being highly offensive to female staff and residents in his usual sexually disinhibited and inappropriate manner. One of his targets is a younger, intellectually disabled resident who becomes highly distressed with his suggestive nature towards her and is unfortunately unable to make her lack of interest known to him.
>
> I discussed this issue with Mr Rollbusch today who continues to see this as only 'teasing' and believes their reactions are their problem and if individuals have an issue with his behaviour, he believes they should discuss with him in person rather than sending an intermediary to do so. I again attempted to convey to him that his behaviour or advances or (sic) inappropriate.
>
> I discussed Mr Rollbusch with Dr Flynn prior to my visit today and he suggests that you prescribe Olanzapine at 5mg nocte in an effort to improve this gentleman's grandiose presentation. It is interesting to note that Mr Rollbusch continues to say that he has a financial interest in the rest home, but cannot offer any formal documentation to support this. He refers to this as a gentleman's agreement and that without him being there the business would fold. I suggested to Mary that I would review this gentleman's progress in two weeks and recommend they continue with a firm, consistent approach to his behaviour. Mary will also look at some opportunities with community involvement with Mr Rollbusch as he is probably quite bored within the confines of his accommodation.'

7.6. That correspondence seems to have been superseded by a letter dated 3 August 2005 from the same community mental health nurse, this time to the Emergency Department at the Queen Elizabeth Hospital[19]. The letter is in the following terms:

> 'Thank you for reviewing this gentleman who is well known to the respiratory clinic with chronic obstructive airways disease/pulmonary disease and inappropriate behaviours. He was placed at Brooklyn Supportive Care Resthome from TQEH 20/4/2005.
>
> He was subsequently referred for a mental health review and seen by Dr Patrick Flynn, Senior Consultant Psychiatrist on 18th July 2005 please find enclosed assessment. I followed Mr Rollbusch up on 1st August and include my review. He has become increasingly sexually disinhibited and offensive to female staff and residents and has targeted in particular some younger intellectually disabled female residents. Over the last 24 hours his behaviour has escalated with him exposing himself and requesting inappropriate sexual attention. The proprietor of the rest home, Mary Marone is unable to continue to manage this gentleman at this time.
>
> I have discussed Mr Rollbusch with Dr Patrick Flynn who suggests he be sent to A&E for physical and psychiatric review and he has been placed on the waiting list for Howard House at Oakden Campus. He is unable to return to Brooklyn Supportive Care. Can you please liaise with Howard House with the earliest opportunity for transfer, providing Mr Rollbusch is medically clear'.

7.7. In the result Mr Rollbusch was admitted to Howard House on 4 August 2005[20]. An ACAT assessment was made on 25 August 2005 on the application of a social worker

[19] Exhibit C11 page 95
[20] Exhibit C11 page 140

employed at the Oakden facility. The assessment appears to have been carried out on 1 September 2005[21]. The assessment stated that Mr Rollbusch had frontal lobe dementia, would become rude, demanding and sexually disinhibited at times and required firm limit setting[22]. Under the heading 'Assessment Comments' the following appears:

> '73yo man presently residing in Clements House, Oakden Campus. Admitted to Howard House 4/8/05 via TQEH. Detained due to inappropriate sexual behaviour towards nursing staff and refusing treatment. Previously at Brooklyn Supportive Care for three months where there was increasing sexually disinhibited and offensive behaviour towards female staff and residents. He is unable to return to the facility and at present is not suitable for generic residential care due to the level of recent and past sexually inappropriate behaviour. Patient has severe COAD. Minimal family contact, social work Oakden Campus presently applying to Guardianship Board for administration and guardianship orders. Approval high permanent secure facility – Makk House ward NH – Oakden' (the underlining is as appears in the original).

7.8. On 7 September 2005 the same social worker from Oakden made application to the Guardianship Board for orders for Mr Rollbusch[23]. The application explained why a guardian was needed. It stated that Mr Rollbusch's relatives have had very little to no contact with him and that decisions may be required relating to longer term accommodation. It also stated that Mr Rollbusch did not wish to remain in a psychiatric facility. The document recommended the appointment of the Public Advocate as guardian because no appropriate family member could be contacted to be a guardian. Under 'living arrangements' the document stated that Mr Rollbusch did not wish to remain in a psychiatric facility. He wished to return to Brooklyn Supportive Care (not appropriate). Under the heading 'What is the person's view of his current or proposed accommodation' the document stated:

> 'Did not wish to remain in Clements House wished to return to Brooklyn Supportive Care. The supportive residential care facility unable to manage sexual behaviour. To be transferred to Makk House (all male facility) on 7/9/05.' [24]

7.9. The application[25] also contained the following explanation:

> 'Mr Rollbusch requires his financial affairs to be managed by an independent authority. Reliant on continuous oxygen when he arrived at rest home 3-4 months ago. He had numerous debts (unpaid rent, utility debts, credit). He declared himself bankrupt and the

[21] Exhibit C11 page 51
[22] Exhibit C11 page 50
[23] Exhibit C11 page 21
[24] Exhibit C11 page 36
[25] Exhibit C11 page 40

> manager of rest home assisted him by withdrawing only their care fees. Mr Rollbusch cannot walk two steps before going blue. Prior to living at Brooklyn Supportive Care he resided in a rental property with a woman (owed her $800 in rent – other debts totalling $9,000 (utilities, bank card, a pharmacy account requires payment, as will future accommodation payments and pharmacy payments). Mr Rollbusch reported to social worker he "shouldn't have to pay, that everything be free". Had delusional type beliefs about his finances – that he rescued Brooklyn Supportive Care from financial ruin'.

7.10. From all of the above I reached the following conclusion. All decisions concerning Mr Rollbusch's financial, medical and residential circumstances were taken by agencies of the State of South Australia. Counsel for the Minister for Health made much of the note referred to above in the ACAT assessment 'approval high permanent secure facility Makk Ward NH Oakden'. Counsel for the Minister for Health saw this as some form of authority on the part of the ACAT delegate for Mr Rollbusch's detention at Oakden. Clearly it does not have that effect. The ACAT assessment is merely a document against which Commonwealth Aged Care funding is approved or not approved as the case may be. In the present instance the document served no purpose other than to instigate an approval from the Commonwealth Department of Health and Ageing for a residential aged care subsidy to be provided to the facility at which Mr Rollbusch would be accommodated. The aged care assessment team and the Commonwealth Department of Health and Ageing are, and were, entirely agnostic as to the identity of the aged care facility. All relevant decisions with respect to the identity of the facility were made by functionaries of the State of South Australia, and most particularly, the social worker at Oakden who made the ACAT assessment and the Guardianship Board application.

8. Mr Rollbusch is detained at Oakden

8.1. On 7 September 2005 Mr Rollbusch was transferred from Howard House to Makk House[26]. A monthly weight graph appears in the notes which records Mr Rollbusch as weighing 60.8 kilograms on 25 October 2005[27]. His weight remained steady around that figure of 60 kilograms until 27 August 2006, a bit less than a year later, when it started to decline steeply. Four months later in December 2006 his weight was down to 50 kilograms. By May 2007 it was down to 47 kilograms and by September 2007 to

[26] Exhibit C11a page 77
[27] Exhibit C10a page 19

40.8 kilograms. Therefore his weight reduced by 20 kilograms, or one third of his total body weight, between August 2006 and September 2007 a little more than a year.

8.2. It appears that there was a multi-disciplinary case management team meeting to consider Mr Rollbusch's case in Makk House on or about 18 October 2005. An outcome summary of that meeting was prepared by Dr Flynn, Director of Psychiatry and recorded that Mr Rollbusch had then been in Makk House for one month[28]. It recorded that he was on continuous oxygen with a past history of depression, sexually inappropriate behaviour and a current episode of said behaviour towards a female staff member. I note that there was no particularisation of that current episode. There is nothing in the notes to indicate its seriousness or otherwise. The note recorded that his diet was poor and he refused most foods offered. It stated that he was not in touch with his family and his medical conditions included dementia and chronic obstructive airways disease. The document stated that Mr Rollbusch's sexual inappropriateness had been less of late. Under the heading 'Discharge Planning' the following appears:

> 'Given the difficulty encountered with Mr Rollbusch at Brooklyn Supportive Care it is best that he is managed in the Oaks at the moment. When a further deterioration of his general health occurs, there should be a reappraisal of his ongoing placement.' [29]

8.3. A letter to the Office of the Public Advocate on 1 December 2005 was written by Dr Fletcher Lane, senior medical practitioner at Oakden. The purpose of the letter was to inform the Public Advocate of Mr Rollbusch's current health status. The letter recorded that he had advanced obstructive lung disease which would continue to worsen and reach a terminal stage, it was being treated with continuous oxygen therapy and prednisolone, seretide and tiotropium. He had recently been unwell from a chest infection and had been on antibiotics. Mr Rollbusch also had a diagnosis of dementia that was based on a deterioration in his behaviour, notably sexual disinhibition along with deteriorating memory and poor judgment. It was suggested that his cognitive decline may be due in part to his lung disease and it was expected that both would worsen. He was on olanzapine to control his disruptive behaviour, but his behaviour was manageable in Makk House. The letter stated that there were no current health decisions that needed to be made, but that with time it was likely consideration would need to be given to an order to provide palliative care[30].

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[28] Exhibit C11a page 57
[29] Exhibit C11a page 58 - the last line of this note was the subject of evidence from Dr Flynn
[30] Exhibit C11a page 54

8.4. Between 8 September 2005 and the date of his death on 28 February 2008 there were some 912 calendar days. Over that period the progress notes record approximately 254 entries. There were more in the early part of the admission and less at the end. Good nursing practice would see one entry per shift with at least two entries per day, thus, approximately 1800 odd entries over that period. The fact that only 254 entries were made clearly reflects very poor note keeping and record keeping within Makk House and Oakden. Combined with Mr Rollbusch's alarming weight loss and the rather glib notation from Dr Flynn that he refused food, it is reasonable to infer that the standard of care provided to him within the Oakden facility was poor.

8.5. On 30 August 2007 Dr Lane, who was the principal medical officer in charge of Mr Rollbusch's general health and that of the other inmates at Oakden, made an entry in Mr Rollbusch's notes, noting that Mr Rollbusch may have reached the terminal stage of his illness. The note is as follows:

> 'Continues to deteriorate, very poor intake of food and fluid. This has been occurring for an extended period now but is now severe. Is not having enough intake to maintain life. Respiratory function has also become worse and is now severe/terminal. Poor cough. Is at risk of pneumonia which would most likely be terminal. Overall in very poor physical condition and may have reached a terminal stage. Not in any distress. In fact is quite calm. Has an order for palliative care. Plan: for palliation as needed. Not in need of morphine yet.'

8.6. It seems that in light of this development some effort was made to discuss with one of Mr Rollbusch's relatives, and with Mr Rollbusch, arrangements for his funeral. The arrangements contain a note that Mr Rollbusch is willing to leave pain management to Dr Lane and his only wish is not to be in pain 'at the end'. There is a note that the family wish staff to be with Mr Rollbusch when he dies[31].

8.7. There is no note in the progress notes by Dr Lane indicating a further review of Mr Rollbusch until 22 February 2008 when there is a brief note concerning the possibility of a urinary tract infection which was discounted. I would not describe that attendance as a proper medical review. However, five days later on 27 February 2008, Dr Lane carried out a review of Mr Rollbusch. That review noted further overall deterioration with very poor respiratory function. Dr Lane noted that Mr Rollbusch had had similar episodes in the past few weeks, however he had not been as unwell as this and he had deteriorated overall considerably. He said that palliative care was to be

[31] Exhibit C11b page 50-51

given as needed and that Mr Rollbusch did not yet need pain relief. Apart from medication orders there is no other evidence of any attention being paid to Mr Rollbusch by Dr Lane during this period, despite Dr Lane noting that Mr Rollbusch appeared to be in the terminal phase of his life on 30 August 2007, some six months earlier. It is notable that on 24 December 2007 Dr Lane ordered 5mg of olanzapine nocte and the notes record that every night between that date and his death on 28 February 2008, he was given that dose at that time. As was eventually conceded by Dr Flynn in his evidence, this level of care by Mr Rollbusch's only attending medical officer was unsatisfactory.

8.8. As an example of the poverty of progress notes in Mr Rollbusch's records there are only four progress notes for the whole of January 2008 and the two largest of those notes relate to the two assaults upon Mr Rollbusch by Mr Palmer. It is reasonable to infer that if Mr Palmer had not assaulted Mr Rollbusch on 21 January 2008 and 30 January 2008 there would have been no nursing entries for those days. It is notable that there is no nursing entry between the dates of those two assaults and no records of any follow-up medical review in respect of either of the assaults. In my opinion, this is reflective of a very poor standard of care indeed.

9. Decision to impose sanctions on Makk & McLeay Nursing Home

9.1. In late 2007 and early 2008 nursing homes were regulated under the Aged Care Act 1997 of the Commonwealth. The Commonwealth Department of Health and Ageing provided funding to operators of aged care homes. Under the Aged Care Act 1997, aged care homes were required to meet certain standards of care and accommodation and be accredited by the Aged Care Standards and Accreditation Agency in order to receive that funding. For some time prior to 2007 the Makk & McLeay wards of the Oakden campus had been accredited under the Aged Care Act 1997 to receive funding as operators of aged care homes. At the same time they had another function under the State health system, namely to provide mental health services to the elderly. Thus, Makk House performed a dual function.

9.2. In early December 2007 the Aged Care Standards and Accreditation Agency visited Makk & McLeay to review the standards of care and accommodation. In consequence of that visit, a Notice of Decision to Impose Sanctions under Section 67-5 of the Aged Care Act 1997 was sent to the Central Northern Adelaide Health Service as the entity

responsible for Makk & McLeay. The Notice stated that the delegate found non-compliance in a number of areas which had been identified as 'serious risk'. The delegate was particularly concerned with the issues of education and staff development, living environment and occupational health and safety. The delegate was satisfied that there had been non-compliance because in a serious risk report prepared by the Aged Care Standards and Accreditation Agency, the agency identified that residents were at serious risk because the home provided care for residents with highly volatile behaviours who regularly presented with extreme physical aggression and who attacked and assaulted staff and other residents. This required a prompt response from several staff by activating a duress alarm. The home had identified problems with the duress alarm system through a hazard notice in August 2007 and management had been slow to commence action to rectify the situation and, on 6 December 2007, the duress alarm had ceased to function. The Aged Care Standards and Accreditation Agency also found that there were insufficient experienced numbers of the staff to manage the volatile behaviours of the resident population in the high security area of Makk House that managed eleven ambulant residents who demonstrated the most physically aggressive behaviours and to respond to assist staff when residents became physically aggressive.

9.3. The delegate stated that a review of two residents' care files residing in the high security area of Makk House indicated excessive physical aggression on a daily basis. The delegate found that incident data did not reflect the level of physical aggression incidents, and that staff had informed the agency that they did not always complete incident reports in cases of physical aggression. The delegate found that the clinical nurse manager had said that the home lacked sufficient competent and experienced nursing staff in the high security area of Makk House, and needed another competent mental health registered nursing staff member allocated to that area. The delegate also found that five of nine representatives raised concerns about the knowledge and skills of agency staff in the appropriate management of the behaviour of residents in Makk House and their response to extremely aggressive incidents[32].

9.4. The accompanying review audit report prepared by the Aged Care Standards and Accreditation Agency found that of the 44 expected outcomes set by the legislation, Makk and McLeay failed to comply with 25. The audit found, amongst other things, that the home did not have an effective system for ensuring all staff were able to deliver

[32] Exhibit C30 – Tab 1

care in accordance with the accreditation standards, that nursing and care staff, particularly temporary staff, were not able to demonstrate consistent knowledge and skills to perform their roles effectively, that staff did not demonstrate knowledge of residents clinical care needs, that residents did not have regular pain assessments or re-assessments, that staff could not demonstrate that residents with challenging behaviours were effectively assessed, and that representatives were not satisfied with the home's management of challenging behaviours. Furthermore, the audit found that the home did not provide a safe physical environment consistent with residents' care needs[33].

9.5. So it was that on 13 December 2007 the Commonwealth delegate wrote to Mr Rollbusch. The letter was addressed to him at his residence, namely Makk and McLeay House. The letter recorded that the Aged Care Standards and Accreditation Agency had visited Makk and McLeay House on 12 December 2007 and identified serious concerns regarding the safety, health and wellbeing of residents and as a result of those findings, the Department had imposed sanctions on the operator of Makk and McLeay. The letter explained that the consequence of the sanction that had been imposed was that Makk and McLeay would not be eligible for funding new residents for a period of six months, however the letter stressed that Government funding for existing residents would continue to be paid. The letter advised of a meeting on 20 December 2007 at the nursing home when the operator would provide information to all residents, relatives and representatives about the situation[34]. While clearly Mr Rollbusch was in no position to understand or respond to that piece of correspondence, had he understood it, he may have taken some comfort in the assurance that Government funding for existing residents such as Mr Rollbusch himself would continue to be paid. Sadly of course, all of these events would have escaped the attention of Mr Rollbusch because his cognitive impairments meant that he was unable to understand such things and was generally unable to protect his interests and, indeed, his own safety. Those matters were the responsibility primarily of Makk House, the very institution that the Commonwealth delegate had found to be in breach of 25 out of 44 expected outcomes.

[33] Exhibit C30 – Tab 2
[34] Exhibit C11b – pages 52 and 53

9.6. On 28 December 2007 the Executive Director, Mental Health Services, Central Northern Adelaide Health Service, Learne Durrington, wrote to the Acting Manager of the Aged Care Standards and Accreditation Agency saying that the Department did not intend to challenge the findings of the Agency and that it regretted having found itself in the situation that it was in. The letter advised that the Central Northern Adelaide Health Service had appointed a nurse adviser on a full time basis and had also procured the services of aged care advisers, Carla Baron and Neil Baron. The letter advised of strategies that the Department intended to put in place to attempt to regain compliance with the Commonwealth standards and thus have the sanction referred to above lifted.

9.7. In my opinion, having regard to the notes of Mr Rollbusch which I have carefully reviewed and which I have discussed above, I am not surprised that Makk House was found to be in breach of so many expected outcomes under the Commonwealth legislative framework. Indeed, the fact of the imposition of the sanctions is entirely consistent with the very poor standard of record keeping in relation to Mr Rollbusch, and the fact that it was clear that although he had supposedly been under palliative care for some six months, no medical review of him was undertaken during that period until 21 February 2008. It is consistent also with the very serious failure to procure a medical review on either 21 January or 30 January 2008 after the assaults upon Mr Rollbusch by Mr Palmer.

10. Institutional knowledge of Mr Palmer's propensity for violence

10.1. Mr Laurente was a registered nurse who worked at Oakden. In fact he was one of the nurses who was on duty on the night of Mr Rollbusch's death. Mr Laurente stated that a couple of weeks before Mr Rollbusch's death there was an incident involving Mr Palmer. He said that he had just completed the handover of the day shift to the night shift and that Mr Palmer was really agitated. Mr Laurente said that he approached Mr Palmer and politely asked him to go to the other side of the ward to his room. Mr Laurente started to walk across to the other side of the ward and as he walked off he felt a blow to his left ear. He said that to his surprise Mr Palmer had punched him with his right fist. Mr Laurente described how he felt the knuckle connect with his head and said that it was quite a hard blow for an elderly person to inflict[35].

[35] Exhibit C16a

10.2. Mr Laurente also gave evidence that Mr Palmer had been in what Mr Laurente described as an isolation room up until a week or two weeks prior to Mr Rollbusch's death. Mr Laurente was uncertain about the length of time Mr Palmer had been allotted the isolation room, but when pressed gave a period of a week or two[36].

10.3. Mr Laurente said that the isolation room was a room that was modified by the installation of a doorway to provide Mr Palmer access to a toilet from the room, but without permitting him to gain access to the general areas where he could mix with other patients[37]. Mr Laurente described it as a room that was bigger than the normal room and permitted Mr Palmer to move around in a reasonable amount of space[38]. Mr Laurente said that he believed that the changes were made specifically to house Mr Palmer on account of his aggressive behaviours[39]. Mr Laurente said that Mr Palmer was moved from that isolation room to the room adjoining Mr Rollbusch shortly before Mr Rollbusch's death[40]. It was after Mr Palmer's release from the isolation room that Mr Laurente was assaulted as described in his statement[41]. Mr Laurente said he was concerned because Mr Palmer would then be able to walk around the ward, able to walk around the rooms and might be aggressive to other patients and staff[42]. Mr Laurente said that he raised his concerns about Mr Palmer having been moved into the general ward environment:

> 'I did, upon hearing that Mr Palmer is moving out to (sic) the isolation room, I did discuss it with the nurse manager what are the basis that this patient can be moved back or be moved to this place, because history of the patient's aggressiveness, but nothing.' [43]

Mr Laurente explained that Mr Palmer had been placed in the isolation room because of his aggressiveness:

> 'As I can recall that he was – the reason why he was put in the isolation room because he is so aggressive, behaviourally aggressive to the other patient, that's what I can remember. Because we don't normally put patient in the isolation room if he has been settled.' [44]

[36] Transcript page 108
[37] Transcript page 109
[38] Transcript page 110
[39] Transcript page 111
[40] Transcript page 112
[41] Transcript pages 113-114
[42] Transcript page 114
[43] Transcript page 115
[44] Transcript page 108

11. Concerns are expressed by Ms Olsson, Ms Meredith and the Barons

11.1. Ms Olsson was the nurse adviser who was appointed from Glenside to work at Oakden in the aftermath of the imposition of the Commonwealth sanctions. It was part of her role to advise on strategies needed to regain full Commonwealth approval for the facility and for the sanctions to be removed. She said that she started at Oakden on 5 January 2008 having been asked to go out there by Ms Learne Durrington who was then the Executive Director of Statewide Mental Health Services and Mr Chris Sexton who was the General Manager for Statewide Mental Health Services. She said that she was told that there had been a failure of the standards with the Commonwealth. As she had some experience in aged care standards she was an appropriate person for the task[45]. Ms Olsson gave evidence about her understanding as to the role that she would have at Oakden and how she felt she was misled. It was clear that Ms Olsson had a level of resentment about her role at Oakden and how it interacted with the role of Ms Julie Harrison who had also been sent out to the facility. Ms Olsson clearly had an axe to grind so far as Ms Harrison was concerned, however it is my opinion that this has not affected the gravamen of Ms Olsson's evidence about key events. It is unnecessary for me to make findings about the exact nature of the relationship between Ms Olsson and Ms Harrison.

11.2. In the result, Ms Olsson said it became apparent to her that she would have the role of a Director of Nursing[46]. She said that she understood that she would have a free hand in effecting such changes as she thought were necessary within the Oakden facility[47]. Ms Olsson said that one of the early actions she took was to do an audit of the nutritional status of the residents. She said that it became obvious fairly quickly that a number of residents had lost up to 10 kilograms within the first six months of admission[48]. Of course this is consistent with the weight chart for Mr Rollbusch which I have referred to previously. He clearly sustained a significant weight loss after his arrival at the facility.

11.3. Ms Olsson said that she noted that there had not been very many medical reviews of patients which she stated were the responsibility of Dr Lane. She said that she spoke to Dr Lane about this issue and he said that he got to the reviews when he could.

[45] Transcript page 344
[46] Transcript page 344
[47] Transcript page 345
[48] Transcript page 349

Ms Olsson said that there were a number of patients who had not had reviews recorded in their notes since early in 2007[49]. She said that she did not find Dr Lane to be particularly approachable. She asked him on several occasions to speak to residents' relatives who were concerned about medication and felt that their loved ones had been over-sedated. She said that she could not persuade Dr Lane to see any of the relatives. She said that he was often not in his office[50].

11.4. The above observations of Ms Olsson about the lack of evidence of medical reviews is consistent with the lack of medical reviews performed upon Mr Rollbusch, particularly during the last six months of his life. I have no hesitation in accepting that Ms Olsson was right to be concerned about that issue. There was clearly an insufficiency of appropriate general medical attention being paid to Mr Rollbusch and it would seem on Ms Olsson's evidence that the same deficits applied in respect of other residents.

11.5. Ms Olsson said that she raised the matter of Dr Lane's lack of co-operation with Ms Harrison who, as Service Director, should be in a position to 'hold him accountable'[51]. She said that Ms Harrison replied with words to the effect 'you know what Fletcher's like' which Ms Olsson took to be dismissive of her suggestion. She said that she also requested that Ms Harrison support her in obtaining psychiatric reviews, but that this attempt was also unsuccessful[52].

11.6. Ms Olsson said that she stayed behind on a number of nights to see how much the residents were eating and how much food was being returned to the kitchen. She said that she found that if a resident was a little bit difficult, for example by pushing away the nurse's hand, there would be responses on the part of staff to the effect 'so you're not hungry, you don't want it, ok' and the food would be returned to the kitchen[53]. This caused Ms Olsson to arrange for a specialist dietician to be brought in[54].

11.7. She said that when she raised her concerns with some of the nursing staff about the emaciated condition of residents and their weight loss, they responded that that is what happens with dementia patients[55].

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[49] Transcript page 349
[50] Transcript page 349
[51] Transcript page 349
[52] Transcript page 350
[53] Transcript page 350
[54] Transcript pages 350-351
[55] Transcript page 351

11.8. Ms Olsson was aware of Mr Palmer. She knew that he had vascular dementia and was aware of his aggression[56]. She said that she thought that Mr Palmer should have been 'specialled' but that that was not a possibility because of financial constraints[57]. Ms Olsson had a recollection of Mr Palmer being in the separate area described by Mr Laurente, but her evidence was somewhat vague on that subject, a circumstance that I attribute to the passage of time[58].

11.9. Ms Olsson made comments about the attitude of the nursing staff generally. She said that the staff spent a lot of their time in the nursing station preparing documentation rather than being out on the ward. She described the staff as disenfranchised and depressed. She gave as an example of their propensity to stay in the nurses' station that if they heard a noise coming from the residents' area she would sometimes see the nurses not coming out to see what was going on, but simply to yell out words to the effect of 'stop that' from within the nursing station[59].

11.10. Ms Olsson said that she had a discussion with Ms Harrison about Mr Palmer and his aggression and as a result of that they both agreed that it would be a good idea for Mr Palmer to go into what she described as the room with the ensuite, which I take to be a reference to the isolation room described by Mr Laurente[60].

11.11. Ms Olsson said that she had seen Mr Rollbusch when she had been doing her rounds and was aware that he was being palliated. She said that she asked if there was any chance that he could go off to a general facility such as the Daw Park Hospice because she was concerned about the nursing standards[61]. She said that Ms Harrison responded by saying that Mr Rollbusch had a right to remain as a resident at Oakden and the matter went no further[62]. Ms Olsson said that after a reasonably short amount of time she left the Oakden facility. In fact she gave evidence that she left the facility around 15 February to 20 February 2008[63]. She said that she left because she could not achieve any of the goals that needed to be achieved and felt that the management directorate team had become hostile towards her because she supported the Barons[64]. She said that

[56] Transcript pages 354 - 355
[57] Transcript page 356
[58] Transcript page 356
[59] Transcript page 357
[60] Transcript page 361
[61] Transcript pages 361 - 362
[62] Transcript page 362
[63] Transcript page 380
[64] Transcript page 364

she and either the Barons or Ms Meredith decided that they would go and talk to the Commonwealth Department of Ageing to raise the issues they were concerned about. She said that when they arrived at a meeting that had been arranged, Ms Durrington and Mr Sexton were also present. She said that she felt that her concerns were not taken into account by the Commonwealth representatives at that meeting[65]. She said that she and Ms Meredith then decided to go to the Health and Community Services Complaints Commissioner who at that time was Ms Sudano. Ms Sudano advised them that she did not have sufficient resources to deal with the issue[66].

11.12. Counsel for the Minister for Health in these proceedings challenged Ms Olsson by suggesting that a number of her ideas were in fact incorporated in improvement plans that were prepared by Ms Harrison for the purposes of re-obtaining full Commonwealth accreditation[67]. Ms Olsson acknowledged that her input was reflected in the improvement plans, but it was her contention that change was not happening sufficiently quickly.

11.13. Ms Meredith is a psychologist with extensive experience in mental health services in the public sector. She was recommended in late 2007 by Ms Harrison to undertake behavioural assessments of 21 residents who had been identified as exhibiting behavioural concerns at the Oakden facility[68]. Ms Meredith was appointed for a six week period and commenced on 3 January 2008. She was aware of the accreditation failure and that the behavioural assessments were to assist in supporting efforts to regain accreditation. In the result, Ms Meredith completed only 12 of the 21 assessments and one of those was an assessment of Mr Palmer. Ms Meredith said that she observed the ward and had multiple conversations, where possible, with the residents and also spoke to family members[69]. She realised that it would take longer than the assigned six week period to complete all of the assessments. She said that she became increasingly traumatised by what she was seeing on the ward and that she had a duty of care to the residents to articulate her observations, so she prepared what she described as a report titled Recommendations to Management dated 21 January 2008[70]. In the report she made comments about the values, beliefs and attitudes of the staff members. She

[65] Transcript page 364
[66] Transcript page 365
[67] Exhibit C30 – Tab 5 and Tab 7
[68] Exhibit C21 page 2
[69] Transcript page 173
[70] Exhibit C21b

believed that the staff appeared to have almost no training in how to manage elderly people with a mental health impairment. She regarded the physical environment as 'appalling' and stated that with the exception of one or two people there was an almost complete absence of clinical leadership on the ward. She commented that the documentation was 'impoverished' and that the way in which patients were referred to in notes was 'judgmental, critical and that people were discussing dementia clients as if they were deliberately doing something wrong'[71].

11.14. Those observations are certainly true of Mr Rollbusch's notes. There are many instances in those notes which in my opinion suggest that the author had the view that Mr Rollbusch ought to have known better and was somehow aware of what was regarded as his poor behaviour. To write in that way about a person with severe cognitive impairment is to exhibit a complete failure to understand the condition. Little wonder that Ms Meredith became so concerned in such a short period of time.

11.15. Ms Meredith recommended that every single person on the ward needed to have an immediate review with an experienced geriatrician[72]. She was also very concerned about medication management[73]. Ms Meredith provided both the report[74] and the assessments in relation to those clients she had assessed to Ms Harrison.

11.16. Ms Meredith's assessment of Mr Palmer[75] recommended that Mr Palmer's episodes of hitting or lashing out at other residents may be reduced if he was given one to one attention, regular occupational or sensory stimulation and adequate supervision when walking around the ward. Ms Meredith noted in the assessment that on the evening of 29 January 2008 she observed Mr Palmer walking on the ward and she noted that he was asking for his sister and swearing at care staff who were behind him[76]. Before Ms Meredith reached him he hit another resident on the face as he passed. He then continued towards another resident identified by Ms Meredith in the report as 'Mr R' who was grunting and Mr Palmer said 'will you fucken shut up'. Ms Meredith said that she intercepted, took his hand and said 'Peter, I think that man might be in a bit of pain' and he then looked at her and said 'really can we go and have a chat please'. In other

[71] Transcript pages 185 - 186
[72] Transcript pages 186-187
[73] Transcript page 187
[74] Exhibit C21b
[75] Exhibit C21d
[76] The reference to the date of this incident and the involvement of a 'Mr R' is suggestive of the person being Mr Rollbusch. This was the day prior to Mr Palmer's assault on 30 January 2008. This act of aggression is not recorded elsewhere.

words she avoided a further confrontation. But shortly after this another care worker of non-caucasian appearance passed by and Mr Palmer shouted 'that asshole took her away I know he's got her' and then expressed racist views, a habit that was well known and regularly exhibited by Mr Palmer.

11.17. Ms Meredith prepared a report which was an overview of her observations and her assessment. It was dated 15 February 2008 and is a thoughtful and considered document[77]. In that report she noted that the environment was very poor and that one of the units was malodorous. She said that doors would bang loudly and frequently. She said the environment would lead to disorientation, boredom, frustration, noise and disruption, each of which would have the tendency to elicit behavioural disturbance and psychological distress. She noted that the Nursing Director and Clinical Nurse Manager were largely absent from the two wards and that staff did not have adequate clinical supervision. She regarded the nursing workforce as having underdeveloped skills and poor morale and work satisfaction. She was critical of staff training. She noted that work practices were 'task focussed' and organised around the convenience of staff. She noted that staff would move rapidly through routine care activities and then take meal and coffee breaks in groups which at times left 20 residents in the care of one or two staff members. She noted that there was a disproportionately high rate of incidents involving aggression towards staff in the two units. She said that casenotes indicated that a number of residents with challenging behaviours had received no medical or psychiatric reviews since arriving at the nursing home. She noted that in some cases increases in levels of PRN medication were authorised by psychiatric staff on the basis of telephone consultation with a registered nurse without a prior or subsequent examination of the resident. She said that staff and relatives expressed high levels of dissatisfaction at the lack of availability of psychiatric consultants and the interpersonal approach and level of expertise demonstrated by the medical officer (Dr Lane) at the facility. A number of relatives indicated their concern that medication was administered against their expressly stated wishes. She said that 69% of the residents at the facility were moderately to severely malnourished. She noted that medications including Oxazepam and Clonazepam were administered in the absence of medical or psychiatric assessment to rule out medical basis for the behaviour the medication was intended to address.

[77] Exhibit C21c

11.18. Ms Meredith noted that documentation in the casenotes was often subjective or judgmental. She said that some residents' actions were on occasion described as deliberate, and at least one staff member claimed to interpret intention by saying that 'patient was fully aware he was doing the wrong thing and continued to do so'. Ms Meredith said that type of language increased the likelihood that unhelpful judgments and attitudes about residents would be developed and promulgated to new or visiting staff.

11.19. Ms Meredith said that she noted that some staff frequently approached and talked to residents from behind which is known to be inappropriate with dementia sufferers. She said that some staff would talk rapidly to residents, not allowing them time to absorb or comprehend the information that was provided. She noted that some staff were observed to undertake care needs while talking to one another rather than attempting to engage with the resident, or in other instances staff would watch television while undertaking care needs (such as feeding a resident from the side).

11.20. She referred to aggressive behaviour and cited the example of a particular resident who I infer was Mr Palmer. She said:

> 'He was observed to wander around the ward despite an identified significant risk of falls, watched by staff, and sometimes to approach other residents (particularly those who made verbal utterances) and hit them. Staff responded only after aggression had occurred, often by shouting (from behind and at a distance) to "stop that".'

11.21. In her report Ms Meredith recommended that care plans be redeveloped and regularly updated and that the updates should ensure that material that is no longer relevant to the resident be removed. This is relevant to the care plans to be found in Mr Rollbusch's notes. There are a number of care plans each supposedly updated, but all very similar. A number of them contain a statement that Mr Rollbusch liked to have his door open at night. Yet the evidence was that there was a policy and a practice within the home that doors would be locked from the outside at night. Why was it then that Mr Rollbusch's care plan included the advice that he liked to have his door open at night? I was able to find no explanation for this anomaly. Counsel for the Minister for Health dismissed the inclusion of those words in the care plan as being of no particular moment. While it may be that those words did not result in Mr Rollbusch's door being left open on the night of his death, it is a matter of considerable concern that they would appear in the

care plan at all given the clear policy of the facility in relation to doors at night. The glibness of counsel for the Minister for Health's dismissal of the subject is regrettable.

11.22. Ms Meredith corroborated Ms Olsson's evidence about the visit to the Health and Community Services Complaints Commissioner[78].

11.23. I also heard from Carla Baron who was one of the nurse advisers who had been called in to assist in the re-accreditation process. She is now retired and gave her occupation as independent aged care consultant. She said that she and her partner Mr Baron were independent aged care consultants and they were listed on a panel established by the Commonwealth Government. The panel was set up so that approved providers of aged care facilities could choose an adviser from the panel to assist in achieving re-accreditation after sanctions had been imposed. It was in this capacity that the Barons were approached by the South Australian Mental Health Service following the sanctions that were imposed by the Commonwealth Government[79]. Ms Baron was also an external assessor with the Aged Care Standards and Accreditation Agency at the time, working not only in South Australia but throughout the Commonwealth[80]. She and her partner had extensive experience in the area and she was well positioned to assess the state of Oakden in December 2007 and January 2008. She said that she and Mr Baron and a third member of their team started at the facility on 18 December 2007. The term of appointment was as long as the term of the sanction that had been imposed, namely six months[81]. Ms Baron was clearly not impressed with what she found. She gave as an example the so-called palliative care room which was being used for storage and had bags of old clothing in it including clothing of deceased former residents[82].

11.24. She said that she and her team had difficulties with members of Oakden's staff on an ongoing basis. When the Barons would ask for something to be done, they would be met with a response that 'this is a mental health facility and we do things differently here'. She saw this as the staff using the Barons' discipline of aged care as a pretext for suggesting that they were not an appropriate authority. By way of example, Ms Baron said that they observed what she described as appalling medication management practices which would have been unacceptable whether in a mental health

[78] Transcript page 190
[79] Transcript page 433
[80] Transcript page 434
[81] Transcript page 435
[82] Transcript page 438

facility or any other facility and when they raised the matter the staff would respond by saying 'no that's how we do it in mental health'[83]. She said that she and her team did gain support from Sharon Olsson, but that they never 'got over staff resistance'[84]. She said there was never cooperation from staff and they went to centre management to say that they were not getting support. She said that their approach to management did not yield any effective outcome. Ms Baron said that the staff of the facility had a very poor approach to behaviour management of residents. She said that the staff did not have requisite knowledge of what might be triggering behavioural issues and in those circumstances it was not possible to prevent such behaviours from recurring[85]. She said that she was concerned that the medication management was deficient and yet had not been found to be an issue of non-compliance in the Commonwealth sanctions. She gave as an example an instance where a registered nurse crushed medication and put it into a full cup of coffee and handed it to a resident. Ms Baron observed that if the resident chose not to drink the coffee at all, or only drank half of it, there would only be half a dose of medication given and that that was poor practice. The staff member when tackled on the issue said words to the effect 'that's the way we do it here'[86].

11.25. On the question of the number of staff Ms Baron was of the opinion that the staff numbers at the facility were more than adequate. She said they had great numbers of staff compared to most places the Barons visited. She said that the difficulty was not the numbers of staff, but the knowledge and skill base of the staff and the difficulty with staff attitudes. She said there was a lack of management and a lack of leadership[87].

11.26. Ms Baron gave as an example that in most nursing homes staff would not be taking lunch at the same time as the residents were having their own meal time. She said that is what occurred at Oakden because staff would go off to lunch whenever they wanted and when she raised the matter with managers she was told that they did not wish to upset the staff. She said that the one room in the facility that was actually 'not too bad' was the staff lounge[88]. She commented that management did not get out and about within the ward sufficiently[89]. She referred to the meeting that she and Ms Olsson attended with the South Australian delegate of the Commonwealth Department of

[83] Transcript page 440
[84] Transcript page 442
[85] Transcript page 444
[86] Transcript page 445
[87] Transcript page 447
[88] Transcript page 449
[89] Transcript page 450

Health at which she stated that she did not believe that they were getting upper management cooperation. This was the meeting that Ms Olsson gave evidence about also. Ms Baron's account of the event was consistent with that of Ms Olsson. It was her impression that the Commonwealth would not insist on the State facility doing the things that the Barons regarded as necessary to improve the situation at Oakden[90]. Accordingly, the Barons decided to resign from the appointment and this they did on or about 8 February 2008[91].

11.27. Ms Baron said that following the departure of she and her team, the Oakden facility obtained the assistance of senior members of staff of the organisation known as ACH, a provider of aged care facilities. She met with the representatives of ACH and advised them of her reservations[92]. She said that her understanding was that ultimately ACH assisted, and as a result the facility obtained its re-accreditation[93].

11.28. Ms Baron and her team provided an evaluation to the Commonwealth Department of Health and Ageing[94]. In that document which was provided in or about February 2008 to the Commonwealth Department, they made the following observations:

> 'We believe that our appointment as advisers did not substantially assist the approved provider due to reluctance on their part to understand non-compliance and their obligations under the Aged Care Act 1997 and this was one of the reasons for our withdrawal from the situation.'

The report stated that it was the opinion of the advisers that the sanction imposed by the Commonwealth was seen as an inconvenience that had to be tolerated and that persons responsible for actions greatly hampered progress to the point where there was a real concern that residents' health and safety were at risk.

12. Ms Harrison, Mr Sexton and Mr Skelton

12.1. I make it quite plain that I make no criticism of any of Ms Harrison, Mr Sexton or Mr Skelton. To the extent that criticisms were made of them in the evidence of the Barons or Ms Olsson, I regard those criticisms as being attributable to the state of the facility which had developed over a period of many years. Mr Skelton, Ms Harrison and Mr Sexton happened to be persons occupying those particular roles of Nursing

[90] Transcript page 453
[91] Transcript page 453
[92] Transcript page 485
[93] Transcript page 486
[94] Exhibit C32b

Director[95], in the case of Mr Skelton, Manager of Statewide Mental Health Services in the case of Mr Sexton and Manager of the Campus in the case of Ms Harrison. There is no question that the Oakden facility was in a deplorable state in 2007 and early 2008. I have every reason to believe that it had been in a deplorable state for many years prior to that. It would be wrong to visit responsibility for the institutional failings upon any one of the individuals concerned.

12.2. Significantly Mr Skelton conceded that, in retrospect, Mr Rollbusch could have been discharged from the facility depending on what his family wanted to do, but he stated that the option of discharge was not considered[96]. This evidence is of significance having regard to the contention of counsel for the Minister for Health that there was no other facility in the State that Mr Rollbusch could have been housed at even in his extremely frail state in the weeks preceding his death. I will come to that issue in due course.

13. Ms Meredith's patient assessments were never placed in the casenotes

13.1. Ms Meredith expected that the assessments that she performed on twelve patients, including Mr Palmer, would be placed in each patient's medical record. She said that at Ms Harrison's request the assessments were handed to Ms Harrison. The evidence at the Inquest shows that they never made their way into the individual medical records. In particular, Mr Palmer's assessment was never placed in his medical record. The investigating police officer had to request copies of the assessments from Ms Meredith as they could not be found in any Oakden record. Needless to say Ms Meredith's assessments of the individual patients should have been placed on the patient records of the individuals concerned. Mr Skelton, the Nursing Director stated that he did not see the results of the behavioural assessments[97] and that they never came to him[98]. They were not shown to other nursing managers[99]. Ms Harrison's evidence was that she required the assessments herself in order to see whether any 'themes' emerged from them that required her attention at an organisational level. It was then her intention to pass them to either Mr Skelton, Ms Olsson or the Barons[100] but she could not recall to

[95] Transcript page 280
[96] Transcript page 304
[97] Transcript page 295
[98] Transcript page 296
[99] Transcript page 316
[100] Transcript pages 649, 675

whom she gave them[101]. Ms Olsson said that she never saw the assessments and should have seen them, and that they should have been circulated[102]. Ms Baron could see no utility in them being located centrally[103] and it was implicit in her evidence that they should have been placed on the individual case files. The clear evidence at the Inquest was that they should have been placed in the individual case files[104]. Ms Harrison ultimately agreed that the individual case files were the appropriate place for the assessments[105].

13.2. Counsel for the Minister for Health never attempted to offer any explanation for this failure. At first glance their absence from the files might appear to have a sinister connotation. Having considered the matter and reflected upon it, I am satisfied that the absence of these important documents from the individual patient records (and from Oakden's general records given the investigating officer's inability to find them, except from Ms Meredith herself) was attributable to incompetence and mismanagement of the facility generally. It was consistent with the generally inept and sloppy state of the facility in all respects. By that I refer to the facility's low standards in respect of record keeping, staff behaviour, staff skills, management and the physical environment.

14. Counsel for the Minister for Health's contention that there was nowhere else Mr Rollbusch could have been accommodated at any relevant time

14.1. The Court became aware of research into the frequency and nature of resident to resident aggression in nursing homes in Australia published in the Journal of the American Geriatrics Society in November 2017. Professor Ibrahim is a Professor in the Health, Law and Ageing Research Unit, Department of Forensic Medicine, Monash University and is an author of the report that emerged from the study. The Court commissioned an opinion from Professor Ibrahim into the circumstances of this case. Professor Ibrahim's curriculum vitae is to be found in Exhibit C34. It is extremely impressive. He is also an Adjunct Professor, Australian Centre for Evidence Based Aged Care, LaTrobe University, Faculty of Health Sciences. He has extensive clinical experience and continues in an active role as a practising consultant physician in geriatric medicine. He is the Clinical Director of Sub-Acute Services and a practising

[101] Transcript page 654
[102] Transcript page 379
[103] Transcript page 469
[104] Transcript pages 317, 379, 469, 525, 597
[105] Transcript page 655

consultant physician in aged care medicine, Ballarat Health Service. He is extremely well qualified to express an opinion in this case and I have no hesitation in regarding him as an expert.

14.2. It was Professor Ibrahim's view that Mr Rollbusch was not receiving appropriate care in the Oakden facility. He noted that Mr Rollbusch had lost considerable weight and was being palliated without a formal diagnosis. Professor Ibrahim posed the question that if Mr Rollbusch was being palliated, why did he need to remain at the Oakden facility. Professor Ibrahim noted that Mr Rollbusch was predominantly bed bound and did not appear to be creating problems with staff or any other resident[106].

14.3. It was also Professor Ibrahim's view that Mr Palmer's care needs were not being met. He noted that there were seven episodes documented of behaviours requiring a report in the 3-4 weeks leading up to the final event. Professor Ibrahim noted that none of the assaults carried out by Mr Palmer were things that he would have wanted to have done when he was younger and not suffering from dementia. Professor Ibrahim noted that Mr Palmer himself was a victim in this tragic episode and that his behavioural needs had not been met because, although he had repeated episodes of outburst, there were no documented regular reviews by a senior medical practitioner to improve his management by asking 'what are we doing to help this man who is obviously upset on a number of occasions'[107]. Professor Ibrahim said that there appeared to be an acceptance that this is the way it is and he regarded that as a failure[108]. Professor Ibrahim expressed the opinion that there was not sufficient information in the medical records and notes to get a full picture of the relationship between Mr Rollbusch and Mr Palmer. He did note that there had been incidents prior to the one on 30 January 2008 and said that this suggested that the combination of the two men was not a good combination. He said that the institution should want to be separating them. He said that it would be necessary to decide who should stay and who should go, and that would involve speaking to the families. Then, if there was no alternative but to keeping them both in the same facility, there would need to be decisions about how to manage the interaction between the two. He said that ought to have been front and centre in decision making but it did not happen[109]. He said that if Mr Palmer had never interacted with

[106] Transcript page 577
[107] Transcript page 581
[108] Transcript page 581
[109] Transcript page 585

Mr Rollbusch prior to 28 February 2008 then it would be reasonable to consider their care separately and make judgements separately, but in view of the history that clearly existed, it was necessary to consider their care collectively[110]. He commented that he would have thought that Mr Rollbusch would have been the easier person to move to another facility to palliate him because it did not appear that he was exhibiting behavioural issues. He was predominantly bed bound and therefore more vulnerable[111].

14.4. Professor Ibrahim was critical of the decision to place the two men in rooms next door to each other because it was more likely that they would come into contact with one another. Professor Ibrahim noted that the outer locking doors were fine so far as they went because they were intended to allow the individual resident to come and go as they pleased, and yet protect them from intrusive people who would enter their safe space. However, he noted that outer locking doors do not prevent resident to resident aggression. He said that the outer locking doors gave no guarantee because people were not in their rooms all the time. He was asked to comment about sensor mats and commented that they are not a suitable solution. He said that the high piercing alarm that a sensor mat emits is very disturbing for residents as it is more likely to make them angry. In any event, there was no evidence of the employment of sensor mats in this case.

14.5. Professor Ibrahim said that Australia does not have a central database of resident to resident aggression and in the absence of reports every year from the Commonwealth Department of Ageing about the number of such incidents and what their pattern is, and their distribution, it is difficult to formulate recommendations to prevent resident to resident aggression. He said that his report recommended the mandatory reporting of such episodes regardless of the cognitive status of the persons involved[112].

14.6. Because Professor Ibrahim expressed the opinion that Mr Rollbusch would have been more appropriately accommodated in another facility, counsel for the Minister for Health requested an adjournment before he cross-examined Professor Ibrahim. The basis of the request was that, on his instructions, there was nowhere else that either Mr Palmer or Mr Rollbusch could have been accommodated at any relevant time[113]. He said that this went beyond mere family preferences and asserted that not only was

[110] Transcript pages 585 - 586
[111] Transcript page 586
[112] Transcript page 591
[113] Transcript page 605

Mr Rollbusch properly in Oakden on his client's instructions, but further that there was nowhere else for him to go[114]. Accordingly, an adjournment was granted so that counsel for the Minister for Health could make good that contention.

14.7. When the hearing resumed six months later, counsel for the Minister for Health called Dr Flynn, psychiatrist. Dr Flynn was a visiting medical officer in his speciality of psychiatry at the Oakden Campus from 1992 to 2010. He said that due to a personal illness there was some irregularity with his attendance at the Oakden Campus in the period 2005 to 2007 and he was absent from work during the first half of 2008[115]. In his evidence-in-chief he acknowledged that during the period 2005-2007 he was off on sick leave on numerous occasions. He acknowledged that during the times when he was absent on sick leave he was not always replaced, and indeed that there were occasions when satisfactory arrangements to cover for him were not made[116]. Dr Flynn could not remember when he last saw Mr Rollbusch. He hazarded a guess that it would probably have been in late 2007, although there was no entry in the casenotes to verify that. Indeed, the only entry in the casenotes made by Dr Flynn was an entry in 2005 early in Mr Rollbusch's admission[117]. In the end Dr Flynn acknowledged that he really did not remember seeing Mr Rollbusch late in 2007[118]. He acknowledged that his understanding of Mr Rollbusch came from the casenotes, including the care plans. He acknowledged that he put considerable faith in these for the purposes of his opinions about Mr Rollbusch. It was clear from his evidence that his reliance on the notes for that purpose informed his evidence at the Inquest. It was also clear that during the period that he was a visiting medical officer, he relied heavily on the notes and not on his direct interactions with Mr Rollbusch. He said that Mr Rollbusch's 'situation was regularly discussed with me' but he had no independent recollection of those discussions and certainly none of them was noted[119]. By way of an example of Dr Flynn's lack of knowledge of Mr Rollbusch, he was not aware that Mr Rollbusch was a 'two staff assist' towards the end of his life[120]. Dr Flynn was aware of the assault by Mr Palmer upon Mr Rollbusch on 30 January 2008, but was not aware of the more

[114] Transcript page 605
[115] Exhibit C38
[116] Transcript pages 772-773
[117] Transcript pages 782-783
[118] Transcript page 783
[119] Transcript pages 775-776
[120] Transcript page 774

serious assault that preceded it on 21 January 2008, nor of any other incidents of altercations between the two men[121].

14.8. Furthermore, Dr Flynn was not aware of the issues within the facility concerning nutrition which were obviously impacting upon Mr Rollbusch[122]. Dr Flynn was asked if he knew how often the medical officer, Dr Lane, would see the patients. He said that Dr Lane would 'probably see Mr Rollbusch most days' but he ultimately conceded that he simply did not know and acknowledged that at most Dr Lane may have sighted Mr Rollbusch most days[123].

14.9. Having regard to these matters it is apparent to me that Dr Flynn relied heavily upon the casenotes for the purposes of his evidence and for the purposes of his statement[124]. At best, he had only a hazy recollection of Mr Rollbusch in truth and his evidence relied heavily upon the documentation which, as I have already noted, was entirely lacking in appropriate detail and thoroughness. In truth, Dr Flynn was in no better position to express opinions about Mr Rollbusch than was Professor Ibrahim. Indeed, Professor Ibrahim's expertise in the area of aged care and dementia care is greater than that of Dr Flynn.

14.10. Taken at its highest, Dr Flynn's evidence did not amount to a proper basis for the submission made by counsel for the Minister for Health that there was no other place that Mr Rollbusch could have been housed and that Mr Rollbusch was appropriately placed in Makk House until his death. Indeed, Dr Flynn's evidence fell so far short of that aspiration of counsel for the Minister for Health that it was difficult to see how the contention ever came to be advanced in the first place, let alone why it was necessary to adjourn the Inquest for six months to enable the attempt at proof to be made.

14.11. In his evidence-in-chief Dr Flynn was taken to the notation he made in respect of Mr Rollbusch on 18 October 2005 being a record of the multi-disciplinary case management review meeting. I have referred to the document previously[125]. Dr Flynn was asked by counsel for the Minister for Health about the sentence he wrote:

> 'When a further deterioration of his general health occurs there should be an appraisal of his ongoing placement'.

[121] Transcript page 805
[122] Transcript page 787
[123] Transcript page 778
[124] Exhibit C38
[125] Exhibit C11a page 58

Asked what Dr Flynn intended to convey by that, he responded that he was referring to 'some abatement and greater stability in Mr Rollbusch's behaviour and clinical condition moving forward to the point that he may have been able to be discharged from Oakden into possibly another facility such as a geriatric nursing home'. His counsel then asked him whether from his reading of the file such an improvement ever took place and he responded that it did not[126].

14.12. It is notable that counsel's question was phrased on the basis of Dr Flynn's reading of the file. Clearly it was apparent even to counsel for the Minister for Health that Dr Flynn's evidence was based on his understanding of the case after reading that file, and not from a sound understanding based on firsthand knowledge of the case.

14.13. The response that Dr Flynn gave to the question about what he intended to convey by the words 'when a further deterioration of his general health occurs there should be an appraisal of his ongoing placement', was surprising referring as it did to abatement and greater stability in behaviour and clinical condition moving forward. Those are factors more indicative of improvement than deterioration. Indeed, in answer to questions from the Court later in his evidence, he conceded that his intention was in fact to convey that when Mr Rollbusch's physical condition deteriorated to the point where his sexual disinhibition was not a threat any longer, there should be a re-appraisal of his placement[127]. He conceded that he expected that there would be a further deterioration in Mr Rollbusch's general health which likely would result in sexual disinhibition not being a major problem in his management[128]. He acknowledged that it was likely that in fact that was exactly what happened. Mr Rollbusch's sexual disinhibition was unlikely to be a major issue in his ongoing management[129].

14.14. Dr Flynn described Makk House as a 'ward of last resort' for the management of people with longstanding entrenched psychiatric problems and severe behaviour disturbances or psychosis[130]. Dr Flynn acknowledged that there were inherent risks involved in the patient population at Makk House, consisting as it did of a ward of men who, although elderly, were generally quite robust and mobile. The risks were that they would interact with each other, they had little judgment, they resented having their private space

[126] Transcript page 761
[127] Transcript page 798
[128] Transcript page 799
[129] Transcript page 799
[130] Transcript page 747 - It is absolutely clear that Mr Rollbusch never suffered from any form of psychosis. His behaviour was related to his dementia

invaded and there were incidents and altercations that occurred quite regularly[131]. He said that this was one of the reasons why Makk House had a very high patient/staff ratio compared to general nursing homes[132]. In his evidence-in-chief Dr Flynn said that Mr Rollbusch's 'sexually inappropriate behaviour' most definitely would have precluded him from a transfer to McLeay House because there was a mix of male and female patients on that ward, the implication presumably being that the female patients would have been vulnerable to Mr Rollbusch's supposed predations[133].

14.15. Dr Flynn described the punch to the face that Mr Rollbusch received from Mr Palmer on 30 January 2008 as an unfortunate event, but that it was expected because incidents of that nature happened, and they happened not infrequently in Makk House[134]. Dr Flynn also described the incident as a sudden altercation that occurred between the two men and happened on the spur of the moment[135]. Dr Flynn described the assault on Mr Rollbusch on 30 January 2008 as a 'low level incident' and said that episodes of aggression and aggressive behaviour were common within the Makk House setting. It was for that reason that the incident would not have stimulated discussion about placing Mr Rollbusch elsewhere[136]. He said that incidents between patients occurred regularly including altercations, difficulties and injuries[137]. He repeated that Makk House was a 'facility of last resort' where people with behavioural and psychiatric problems and dementia issues could be managed most safely[138].

14.16. Dr Flynn's attention was directed to the question of Mr Rollbusch being on olanzapine and he acknowledged that that there was a likelihood and a good chance that the olanzapine would have restricted Mr Rollbusch's mobility[139]. Dr Flynn's attention was drawn to the fact that from 24 December 2007 until his death on 28 February 2008, Mr Rollbusch was receiving 5 milligrams of olanzapine at 2100 hours every evening. He acknowledged that he could not see any good reason for Mr Rollbusch to have been on the olanzapine and acknowledged that it was neither good medical practice nor good treatment. He said that it was likely to render Mr Rollbusch fairly immobile and not to

[131] Transcript page 753
[132] Transcript page 754
[133] Transcript page 763
[134] Transcript pages 763-764
[135] Transcript page 768
[136] Transcript page 771
[137] Transcript page 766
[138] Transcript page 767
[139] Transcript pages 783-784

be a physical threat to anybody[140]. He acknowledged that the olanzapine would probably have sedated Mr Rollbusch and slowed him down, and that Mr Rollbusch 'wouldn't have been probably robust enough to be resistive enough to cause physical damage to staff attending him'[141].

14.17. Dr Flynn was invited to look through the notes to familiarise himself with Dr Lane's reviews of Mr Rollbusch[142]. Dr Flynn acknowledged that on 30 August 2007 Dr Lane had recorded that Mr Rollbusch was not having enough oral intake to maintain life[143] and was in overall very poor physical condition and he may have reached a terminal stage[144]. Dr Flynn said 'it reads like he is in the terminal phase of a terminal illness' and acknowledged that Mr Rollbusch was likely to be frail and not very mobile[145]. Dr Flynn was invited to find the next evidence of a review by Dr Lane and acknowledged that there was no review until February 2008[146]. He accepted that the documentation did not indicate regular reviews by Dr Lane and that during this period Mr Rollbusch was extremely unwell and unlikely to be mobile[147].

14.18. Dr Flynn acknowledged that the use of olanzapine nightly for the two months prior to Mr Rollbusch's death did not represent good medical management. He acknowledged that it was not satisfactory that Dr Lane apparently did not see Mr Rollbusch at all between August 2007 and February 2008 when he was in the terminal phase of his life[148], that it was unsatisfactory that there was no record of Dr Lane having reviewed Mr Rollbusch on or about 24 December 2007 when Dr Lane instituted the regular nocte administration of olanzapine and that there should have been[149]. Rather revealingly, Dr Flynn acknowledged that Dr Lane 'was not always as assiduous in documenting issues to do with patient contact and patient care'[150]. He acknowledged that the continuance of the olanzapine during that period should have been reviewed weekly or fortnightly[151].

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[140] Transcript page 790
[141] Transcript pages 790-792
[142] Exhibits C11a and C11b
[143] Transcript page 787
[144] Transcript page 788
[145] Transcript page 788
[146] Transcript page 788
[147] Transcript page 789
[148] Transcript page 793
[149] Transcript page 793
[150] Transcript page 793
[151] Transcript page 794

14.19. Having made all of the concessions referred to above, Dr Flynn conceded that it was possible that Mr Rollbusch could have been placed in McLeay House at least in the early months of 2008[152]. He agreed with the proposition that if there was a perception at any point that Mr Palmer was a threat to Mr Rollbusch, that could have been managed by placing Mr Rollbusch in McLeay House without any significant threat to the staff and the security of McLeay House[153]. He acknowledged that he had not been aware prior to cross-examination of the earlier incident involving Mr Palmer assaulting Mr Rollbusch. Dr Flynn acknowledged that the earlier incident raised his level of concern about the possibility that it would happen again if the pair were kept in close proximity[154].

14.20. Dr Flynn acknowledged that he would have expected far more nursing entries within the notes of Mr Rollbusch during January 2008 than the two relating to the assaults on him between 21 January and 30 January 2008[155]. Finally he acknowledged that he would expect an entry every day at least, especially given the high ratio of staff to patients in Makk House. He acknowledged that there were large gaps in Mr Rollbusch's progress notes and that those gaps were hardly reflective of an abundance of nursing staff. He acknowledged that there ought to have been a nursing note per shift and that in fact the notes were a wholly inadequate reflection of the nursing care that was provided to Mr Rollbusch during the period in question[156]. Dr Flynn acknowledged that a general practitioner review should have been conducted on Mr Rollbusch following the assault on 21 January 2008 and the assault on 30 January 2008[157].

14.21. Dr Flynn acknowledged that sexually disinhibited behaviour is not particularly uncommon in persons with frontal lobe dementia and that such persons are regularly managed in ordinary nursing homes[158]. After some prevarication he finally conceded that Mr Rollbusch's sexually inappropriate behaviour must have been physical in nature to warrant him having been placed in Makk House in the first place[159]. Dr Flynn

[152] Transcript page 802
[153] Transcript page 803
[154] Transcript page 805
[155] Transcript page 806
[156] Transcript page 807
[157] Transcript pages 808 - 809
[158] Transcript page 817
[159] Transcript page 818

said that there would have been no financial implications for Mr Rollbusch's family if he had been moved from Makk House to McLeay House[160].

14.22. I conclude from all of this that Mr Rollbusch's confinement in Makk House in 2005 could only have been justified on the basis of physical manifestations of sexually inappropriate behaviour. There was a terrible paucity of evidence to justify the conclusion that he exhibited any such signs. The highest point the evidence on the notes reaches is that he exposed himself in front of a younger intellectually disabled female while in the Brooklyn Supportive Care Facility and requested inappropriate sexual attention[161]. Disturbing as that may have been[162], it falls far short of the records of physical sexual inappropriateness that one would have hoped to have seen on Mr Rollbusch's files to justify his confinement in Makk House, a 'ward of last resort'. It is far from clear that he ought ever to have been placed in Makk House in the first place.

15. Professor Ibrahim resumes his evidence

15.1. After hearing from Dr Flynn, Professor Ibrahim was called to complete his evidence. It was his opinion that Mr Rollbusch could have been moved from Makk House[163]. He said that palliation would usually occur in a medical setting with mental health support rather than the other way around[164].

15.2. Professor Ibrahim said that dementia is essentially a progressive neuro-degenerative condition and the patient loses brain function with each month that goes by. He said therefore that patients with very aggressive behaviour tend to settle with time because as time goes by they do not have the mental or cognitive ability to plan and sequence and do things[165].

15.3. On the subject of Mr Rollbusch's 'inappropriate sexual behaviour', Professor Ibrahim said that it was not clear to him from the records what exactly the sexually inappropriate

[160] Transcript page 819
[161] Exhibit C11 page 95
[162] Nothing I say about Mr Rollbusch exposing himself in front of younger intellectually disabled females and requesting inappropriate sexual attention is intended as minimising the seriousness of that behaviour. I am sure that it would have been very distressing for the young people involved. They could not have known that Mr Rollbusch did not himself appreciate or understand the impact his behaviour would have had on them. They could not have understood that he could not help exhibiting such behaviour because of his dementia. The matter is one of context: certainly Mr Rollbusch needed to be separated from the younger vulnerable females. But surely that did not necessitate his confinement to what Dr Flynn described as the 'ward of last resort' for people whose behaviour could not be managed anywhere else.
[163] Transcript page 836
[164] Transcript page 838
[165] Transcript page 839

behaviour was and how it was so extreme that it could not have been managed elsewhere[166]. He said that the remarks contained in the records tended to be in a generic form that repeated and lacked detail and merely summarised what was said to be sexually inappropriate behaviour[167]. In any event, Professor Ibrahim said that he would expect that as Mr Rollbusch's physical condition deteriorated, his ability to do anything that harmed himself or others would similarly diminish and the risk that he posed if any would be substantially less than when he first entered[168].

15.4. Professor Ibrahim said that as Mr Rollbusch progressively declined, his physical function declined so much that it did not matter what was going on in his mind, he would not be a danger to others[169]. He remarked that the records of the use of restraint in Mr Rollbusch's notes suggested very little, if anything, to the effect that Mr Rollbusch required any unplanned intervention at any time. This again was an indication that he was relatively stable[170]. Professor Ibrahim said that if a patient were exhibiting behaviours that were problematic for staff he would expect something to appear in the restraint document. He said that there was virtually nothing in the restraint document in respect of Mr Rollbusch other than the use of bed side rails, which were implemented as a result of Mr Rollbusch's own requests. He said that he saw none of the typical patterns of medical and nursing practice that would suggest Mr Rollbusch was creating havoc that would mean that he would have to stay in Makk House and could not be housed elsewhere[171]. He said that if there were substantial problems, he would expect them to be documented on the day they occurred and to see a pattern that repeats and that there was simply nothing to that effect in the notes[172]. He said that it would be highly unusual that such behaviour would be occurring without any documentation whatsoever[173].

15.5. Professor Ibrahim was shown some notations that suggested that Mr Rollbusch's family were accepting of his situation and happy with his end of life care[174]. Professor Ibrahim remarked in a sense these matters were beside the point because Mr Rollbusch had a

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[166] Transcript page 840
[167] Transcript page 842
[168] Transcript page 841
[169] Transcript page 844
[170] Transcript page 845
[171] Transcript page 846
[172] Transcript page 846
[173] Transcript page 847
[174] I place little evidentiary weight on these notations for two reasons. Firstly, Mr Rollbusch was estranged from his family. Secondly, the notes are so poorly kept, inadequate and unreliable, that it is not safe to rely on them for this purpose.

guardian appointed in the Public Advocate it was actually a matter for the guardian to make these decisions. That did not happen[175].

15.6. On the subject of the sparsity of the progress notes for Mr Rollbusch, Professor Ibrahim remarked that on any approach 'this is not a normal pattern of work practice'[176]. Professor Ibrahim remarked that if Mr Rollbusch had complex mental health issues and was so sexually disinhibited as to be creating a concern, a monthly psychiatric or medical review would have been acceptable and a fortnightly review would have been more likely. He said that if staff were being assaulted he would expect a review weekly. Of course the notes revealed nothing of the sort[177].

15.7. The question of Mr Rollbusch having a right of tenure in the facility by virtue of the Commonwealth aged care regime was the subject of much emphasis by counsel for the Minister for Health in this case. It was pointed out that Mr Rollbusch's right to a bed for life, which the Commonwealth regime undoubtedly afforded him, was a justification for him continuing to be housed in Makk House. Professor Ibrahim noted that the right of tenure did not erect an insuperable barrier to Mr Rollbusch being moved from Makk House[178]. He pointed out that the question of where Mr Rollbusch should be and remain was one for the Public Advocate, not for anyone else[179]. Professor Ibrahim contended that particularly after Mr Rollbusch was assaulted, that neither his right of tenure nor his palliative care needs outweighed the risk to his safety and that he could have been moved at that point.

15.8. It was put to Professor Ibrahim by counsel for the Minister for Health that there would have been difficulties encountered in attempting to find alternative accommodation for Mr Rollbusch. Professor Ibrahim conceded this and that it is rare that other facilities would welcome such patients with open arms. But crucially he said:

> 'What I did not see was any effort taken or any consideration given to doing that, based on the pattern behaviour documented in the notes for Mr Rollbusch, he did not present as a problematic resident. It was two and half years after his initial move with sexual disinhibition. So my question back to Dr Flynn would have been what has his behaviour been in the last 3 months? What have been the incidents that compel you to think that he

[175] Transcript page 849
[176] Transcript page 852
[177] Transcript page 853
[178] Transcript page 857
[179] Transcript page 867

> can't be moved….keeping him there with no effort to explore – so I saw no documentation of exploring any other option.'

15.9. It was suggested that moving Mr Rollbusch could not have been initiated without his consent and Professor Ibrahim responded that yes it would have required not Mr Rollbusch's consent, but that of the Public Advocate, his guardian. Professor Ibrahim pointed out that the Public Advocate was not made aware of the situation and did not attempt to make enquiries, thus the Public Advocate was not informed that Mr Rollbusch was being palliated and was not informed of the assault and was not making any efforts to make itself aware[180].

16. Mr Rollbusch could have been moved to McLeay House

16.1. Whatever difficulties may have been involved in finding private sector nursing home accommodation for Mr Rollbusch because of his lack of means, it cannot be suggested that the same would have applied to a possible move to McLeay House. Indeed, Dr Flynn conceded that there would have been no financial implications in that. The fact of the matter is that no consideration was given to such a move even after the assaults on Mr Rollbusch had occurred and further assaults were clearly foreseeable. Even earlier than that, it is plain to me that it is absurd to suggest that his supposedly inappropriate sexual behaviour would have represented any danger to any female patient in McLeay House because Mr Rollbusch, at least since August 2007, was two thirds of his former weight, extremely frail, and at least in Dr Lane's assessment, in the terminal phase of his life.

16.2. There was no evidence before me as to whether there was a vacant bed in McLeay House and so I cannot reach a firm conclusion on that matter. What is abundantly apparent is that the subject was simply never considered. I find that it should have been considered. McLeay House was not a different facility for the purposes of the so-called right of tenure issue.

16.3. In conclusion I have no hesitation in accepting Professor Ibrahim's evidence. I intend to recommend that this State adopt a register of resident to resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents. I intend to recommend that the Minister for Health raise with his counterparts the proposition that such registers should be duplicated across the other States and

[180] Transcript page 883

Territories, or better still that there be the adoption of a National register at the Commonwealth Government level.

17. Letter from the Public Advocate to Counsel Assisting dated 5 July 2018

17.1. In response to an enquiry from Counsel Assisting about whether and to what extent the Public Advocate was notified of decisions regarding Mr Rollbusch, the present Public Advocate provided certain information in a letter dated 5 July 2018[181].

17.2. The Public Advocate said that there were no documents on the Office of the Public Advocate's file with regard to palliative care for Mr Rollbusch. Indeed after 1 December 2005 there was no indication on the Office of the Public Advocate's notes that Dr Lane or any other staff member of Makk House had made contact with the Public Advocate in relation to any further deterioration in Mr Rollbusch's health or his decline to a palliative status. The Public Advocate advised that alternative accommodation of a client from Makk House would be sought if the assessment by a treating team suggested that a person was able to be moved to a mainstream facility. Of course no suggestion to that effect was made by Mr Rollbusch's 'treating team' although I have found that it should have been.

17.3. The letter from the Public Advocate said that the Public Advocate expects to be notified of an assault of a person for whom the Public Advocate is guardian. The Public Advocate would expect the fact of the assault would be reported to the police and family members also. The Public Advocate was not informed of the assaults upon Mr Rollbusch, nor were the police or members of Mr Rollbusch's family.

17.4. The Public Advocate said that it is now impossible so say what action, if any, would have been taken in 2008 if the Public Advocate had been notified of the assault upon Mr Rollbusch. The Public Advocate went on to say:

> 'It is however very unlikely that any action would involve the transfer of Mr Rollbusch to another facility'.

Considerable emphasis was placed upon that passage in the letter from the Public Advocate by counsel for the Minister for Health. I do not regard that sentence as being particularly persuasive written as it is ten years after the event and without a proper understanding of the full circumstances involving the assaults and the circumstances in

[181] Exhibit C37

which Mr Rollbusch was then placed. The fact of the matter is that the Public Advocate had been told little or nothing about Mr Rollbusch since December 2005. It knew nothing of his severe weight loss, the lack of medical reviews, psychiatric and general medicine, the administration of olanzapine, or any other of the many significant circumstances that transpired which have been mentioned previously in this finding. If theoretically the Public Advocate had either been informed of those things or taken a greater interest in Mr Rollbusch's welfare and sought to acquaint itself with what was happening to him, it may have taken a different view at the time. At the very least, it may have precipitated a discussion about the appropriateness of Mr Rollbusch remaining in Makk House with robust ambulant patients such as Mr Palmer who had shown a propensity for violence upon Mr Rollbusch in circumstances where Mr Rollbusch himself was predominantly bed bound and extremely frail and nearing the end of his life. I place little weight upon the opinion of the present Public Advocate that it would be unlikely that any action would have been taken that would involve Mr Rollbusch's transfer.

18. The smidgen contention

18.1. In his closing submissions, counsel for the Minister for Health said this:

> 'Mr Rollbusch died as a consequence of physical illness plus the assault by Mr Palmer and which obviously precipitated his death perhaps a smidgen earlier than it might have otherwise taken place. But the assault did not arise as a consequence of any failure of the system in place at Makk House to ensure the safety of residents during the night time.' [182]

18.2. While it may be true that the assault did not arise as a consequence of any failure of the 'system in place' at Makk House to ensure the safety of residents during the night time, in the sense that there was a system of locking doors, the fact of the matter is that I have found that Mr Rollbusch was assaulted by Mr Palmer and was dragged across the floor by Mr Palmer. It is conceivable that the door was opened by Mr Rollbusch himself, and that he then returned to bed thus affording Mr Palmer the opportunity to gain access. It is also possible that some other person, including a staff member, failed to lock the door despite the fact the three staff on duty on the night all asserted that the door was locked. I find it difficult to imagine that Mr Rollbusch would have opened the door himself and then returned to bed. I find it completely implausible that Mr Rollbusch's injuries arose as a result of a fall. I find it equally implausible that

[182] Transcript page 973

Mr Rollbusch managed to somehow drag his lower body across the floor while keeping his upper body in an elevated position until he came to rest.

18.3. In my opinion it is inappropriate for counsel for the Minister for Health to have submitted that Mr Rollbusch's death was precipitated 'perhaps a smidgen earlier than it might have otherwise taken place' by the assault upon him by Mr Palmer. As I have previously stated, forensic pathologist Dr Heath[183] stated that the extent of the facial injuries was more than would be expected from a simple fall alone. She said that the cause of death was the combined effects of severe pulmonary emphysema, ischaemic heart disease and recent trauma to the head and neck. She said that although the inflicted injuries were not lethal, the trauma and resulting anxiety of the assault most likely contributed to death. She also noted that the amount of haemorrhage, although not excessive, may have been a significant and contributing factor in a person such as Mr Rollbusch with severe underlying natural disease. There is nothing in her report to support the contention that Mr Rollbusch would have died at or about the time that he was assaulted by Mr Palmer regardless of the assault. He may have lived another day or another week or longer. To trivialise the assault by the use of the expression 'smidgen' is extremely unfortunate. I reject the submission and expressly disassociate myself from any suggestion that the assault upon Mr Rollbusch ended his life only a 'smidgen' earlier that it otherwise would have ended.

19. Dementia in relatively young men with sexual disinhibition

19.1. This case has disturbing similarities with the case of John Arthur Burns[184]. Both of these men were relatively young when their dementia triggered sexual disinhibition. In Mr Rollbusch's case it is far from clear to me that his sexualised behaviour was sufficiently serious to warrant his placement in the 'ward of last resort' for people whose behaviour could not be managed elsewhere. In Mr Burns' case he was placed in a general facility, but was heavily medicated from a very early point. Again, it was far from clear that his behaviour could not have been managed in some other way.

19.2. It may be that these men constitute a cohort that is anomalous in the aged care system, and not well managed. I propose to forward this finding and that of John Arthur Burns to the Commonwealth Minister for Senior Australians and Aged Care to consider in the

[183] Exhibit C2a
[184] Inquest 24/2010

context of the proposed Royal Commission into Aged Care recently approved by the Commonwealth Government.

20. Recommendations

20.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

20.2. I recommend that this State adopt a register of resident to resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents, and that it apply regardless of the residents' cognitive status.

20.3. I further recommend that the Minister for Health raise with his counterparts the proposition that such registers should be duplicated across the other States and Territories, or better still that there be the adoption of a National register at the Commonwealth Government level.

Key Words: Nursing Care; Aged Care; Oakden

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 28th day of September, 2018.

State Coroner