CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 9th, 10th, 11th, 12th, 22nd, 23rd and 24th days of August 2022 and the 20th day of September 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Colin Norman.

The said Court finds that Colin Norman aged 66 years, late of 62 Woolnough Street, Exeter, South Australia died at Exeter, South Australia on or about the 6th day of January 2018 as a result of an unascertained cause. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Colin Norman was born on 16 March 1951 and died at the age of 66, on or about 6 January 2018. He liked to be known, and was known, as 'Joe' or 'Joe Cool'.

1.2. Mr Norman suffered from right hemiparesis and dysarthria and lived with an acquired intellectual disability as a result of a traumatic brain injury sustained on 25 October 1984.[1] He was a chronic alcoholic who was diagnosed with cirrhosis of the liver in 2012 but continued to drink heavily every day. He ambulated by use of a powered wheelchair. His general state of health was poor.

1.3. Mr Norman lived in his own home with the assistance of disability support workers who were rostered to attend twice each day. Their duties included cooking and cleaning, administering medications, assisting Mr Norman to get out of bed and into his wheelchair and assisting him to get out of his wheelchair and into his bed. HomeCare+ was the organisation responsible for providing that care.

[1] Exhibit C11, pages 6, 12

1.4. Mr Norman was found deceased on the floor of his bedroom by disability support worker Jonathon Sutton at about 5pm on Sunday 7 January 2018. He was last seen alive by a care worker on the previous morning. It is not known how long Mr Norman had been on the floor or how long he had been deceased.

1.5. Mr Norman was wearing only a soiled white t-shirt. Around his neck hung a portable telephone and a care alert pendant. It is not known whether the care alert pendant was operational at the time of Mr Norman's fall and any subsequent lie, or whether any attempt had been made by Mr Norman to activate it. The telephone had not been used.

1.6. The evidence establishes that Mr Norman had not received personal care since Mr Sutton assisted him to bed at about 7pm on Friday 5 January 2018.

1.7. The care worker who attended on the morning of Saturday 6 January 2018 was sent away by Mr Norman before attending to any of his duties, including assisting Mr Norman to transfer from his bed to his wheelchair. Mr Norman remained in his bed when that carer left.

1.8. HomeCare+ was next required to have a carer attend Mr Norman that same afternoon, but for reasons which were explored during the inquest, failed to roster a carer for that shift.

1.9. A carer was rostered to attend on the Sunday morning but failed to attend.

1.10. A focus of this inquest was why Mr Norman was not provided with care over the weekend of 6 and 7 January 2018.

1.11. Issues considered included:

- whether HomeCare+ had adequate policies and procedures in place to ensure that support workers knew when they were required to attend a shift, attended that shift and performed their duties in accordance with the client's support plan;
- whether HomeCare+ had appropriate procedures in place regarding the refusal of care services by a client, to ensure that appropriate action was taken in response;
- whether the failure to provide Mr Norman with essential care services was a failure of governance, or an issue with compliance; and
- the role that the failure to provide care played in the cause of Mr Norman's death.

1.12. The discovery of Mr Norman deceased

1.13. Jonathon Sutton provided a statement to police[2] at about 5:39pm on Sunday 7 January 2018. He was then interviewed[3] on 10 January 2018 by Elizabeth Frankish, then the Human Resources Manager at HomeCare+. Through his counsel Mr Sutton also provided a more detailed statement,[4] sworn on 5 August 2022, and he was called to give evidence at the inquest.

1.14. Mr Sutton attended Mr Norman's residence for his shift at 5pm on Sunday 7 January 2018. He unlocked and entered the house, finding Mr Norman's bedroom door shut, which was unusual unless Mr Norman was sleeping.

1.15. In the bedroom Mr Norman was lying on the floor beside his bed, apparently deceased. One of the footplates of the wheelchair was on Mr Norman's chest and his head was in between the footplates.[5] He was cold and stiff, and there were ants on and near his body. At 5:03pm Mr Sutton called for an ambulance.

1.16. In his interview with Ms Frankish, Mr Sutton said he was not sure whether Mr Norman had slipped down (out of his wheelchair) or whether he was trying to get in.[6]

1.17. In his oral evidence Mr Sutton provided further information in relation to the positioning of Mr Norman's body in relation to the wheelchair. He described moving one of the footplates to check for a heartbeat. Regarding his comment to Ms Frankish as set out in the paragraph above, Mr Sutton explained that if Mr Norman was going to slip down out of his wheelchair '*that was probably where he would have ended up*'. Mr Sutton described the position of Mr Norman's body as '*more like in a foetal position*' and stated that Mr Norman was '*sort of wedged under the footplates of the wheelchair) a little bit*'.[7] Mr Sutton drew a diagram depicting what he saw when he entered the bedroom.[8]

1.18. Mr Sutton said the temperature of the house was no different from normal. He noticed that the area around the nightstand was '*in a bit of a mess*'. He could not

[2] Exhibit C12, page 42
[3] Exhibit C12, page 39
[4] Exhibit C12
[5] Exhibit C12, page 45
[6] Exhibit C12, page 39
[7] Transcript, pages 44-47
[8] Exhibit C12a

recall whether the fruit and cordial bottle he had left on the nightstand on Friday were still there.

1.19. During his interview, Mr Sutton was asked to speculate about whether Mr Norman had left his bedroom over the weekend following Mr Sutton's attendance on the Friday night. He did not think Mr Norman had left his bedroom, as if he had been up on the Saturday he would have had something to drink and he would have spilt it, but the floors were clean and there was no alcohol spilled on the floor.[9] Nothing had moved from where he left it on Friday.

1.20. SAAS Paramedic Andrew Bastian declared life extinct at 5:18pm. He reported that Mr Norman was pale and cold and rigor mortis was present. It was also noted that there were no entries made in the carers' logbook over the weekend.

1.21. SAPOL Probationary Constable McElroy[10] attended with Senior Constable Bayne. Probationary Constable McElroy was told by the paramedics that Mr Norman was deceased, and he saw Mr Norman lying on the bedroom floor. The bedsheets were folded to the side and there was a blanket near the head end soiled in faeces. The brakes of the wheelchair were activated.

1.22. Probationary Constable McElroy said Mr Norman's head was positioned by the foot end of the bed. He was laying on his back, with both legs bent at the knee, his right leg under the bed and his left knee elevated and leaning on the side of the bed.

1.23. Significantly, Probationary Constable McElroy observed that Mr Norman's head was held up, pressed against the base of the wheelchair forcing his chin to his chest. His left arm was braced on top of the left footrest of the wheelchair. His right arm was bent, and his right hand was resting on his stomach. Unfortunately, Probationary Constable McElroy did not take any photographs of the premises, or of the body of Mr Norman. Neither did he have a body worn camera as he had not yet been trained in its use.

2. <u>Colin Norman's dependence on care services</u>

2.1. Mr Norman's 1984 traumatic brain injury left him significantly disabled with right hemiparesis and dysarthria, as well as an acquired intellectual disability. He resided

[9] Exhibit C12, page 40
[10] Exhibit C5

for some time at the Julia Farr Centre, and in 1990 returned home with daily carer support provided by HomeCare+. At the time of his death Mr Norman had been a client of HomeCare+ for more than 20 years.

2.2. HomeCare+ is a division of the Paraplegic and Quadriplegic Association of SA Incorporated (PQSA), an independent not-for-profit organisation. The Chief Executive Officer, Mr Peter Stewart, provided two affidavits[11] and also gave oral evidence at the inquest.

2.3. Mr Norman's care by HomeCare+ was funded by the SA Department for Communities and Social Inclusion. The 2017 Client Service Agreement between the Department and HomeCare+ on 28 June 2017 stipulated that HomeCare+ was to provide Mr Norman with 40.5 hours per week of support with personal care, meal preparation, domestic and household tasks, as well as 4 hours for therapy such as physiotherapy and podiatry.[12] The Client Service Agreement required the provision of 5.75 hours of care on each Saturday and Sunday.

2.4. William Davidson was an employee of HomeCare+ and at the time of Mr Norman's death in January 2018 was the Client Services Officer (known within HomeCare+ as CSO) responsible for the coordination and management of Mr Norman's care services. He provided an affidavit[13] and gave oral evidence at the inquest. He first worked with HomeCare+ as a support worker and then as a Client Administration Officer (also known as CAO) from 2013 to March 2016. He then left HomeCare+ but returned in July 2016 as full time permanent CSO, with Mr Norman assigned as one of his clients. After Mr Norman's death, in September 2018 he changed roles to a Rostering Coordinator.

2.5. At the time of Mr Norman's death, Mr Davidson managed the team of support workers who provided care to Mr Norman. The team included Jonathon Sutton, Wally Shevsov, Greg Edwards and Kailo Karpeh, all of whom gave oral evidence at the inquest.

2.6. Mr Sutton commenced working with Mr Norman in approximately 2016 and was typically rostered to work four or five shifts with him each week.[14]

---

[11] Exhibits C19 and C19a
[12] Exhibit C19, Client Service Agreement, page 303
[13] Exhibit C19
[14] Exhibit C12, page 7

2.7. Mr Edwards commenced working with HomeCare+ as a support worker in February 2014 and from July 2014 typically worked three to four shifts per week with Mr Norman.[15]

2.8. Mr Shevsov worked as a support worker with HomeCare+ from September 2016 and commenced working with Mr Norman in October that year, normally for two to four shifts each week, including Saturday morning or Saturday evening, and sometimes both.[16]

2.9. Mr Karpeh commenced working with HomeCare+ as a support worker in June 2016[17] and his employment ceased on 24 May 2018.[18] Mr Karpeh worked with Mr Norman on six occasions from November to December 2017.[19]

2.10. Ms Elizabeth Frankish[20] was the Human Resources Manager of PQSA from July 2007 to January 2020. Ms Frankish was responsible for conducting PQSA's internal investigation into Mr Norman's death, which included interviews with Mr Davidson, Mr Karpeh, Mr Sutton and Mr Edwards.

2.11. Support plan

2.12. Part of Mr Davidson's role was to review and update Mr Norman's support plan every 12 months. The November 2017 review had been commenced but not completed at the time of Mr Norman's death.

2.13. Mr Davidson commenced the review and update of the plan in consultation with the HomeCare+ registered nurses. In preparation, Mr Davidson conducted a team meeting on 15 November 2017 with Mr Norman's support workers.[21]

2.14. The minutes record that there were '*no problems supporting Mr Norman unless the support workers are late*', although that did not accord with the memory of some of the witnesses who gave oral evidence during the inquest. Mr Sutton stated that Mr Norman '*wasn't too bad*' about lateness as he did not have a real grasp of the

[15] Exhibit C14, page 5
[16] Exhibit C13, page 6
[17] Exhibit C16f, page 1
[18] Exhibit C16c
[19] Exhibit C16f, page 2
[20] Exhibit C17
[21] Exhibit C7i, Minutes of meeting

time.[22] Mr Shevsov did not have a memory of Mr Norman complaining about late attendance but noted that in the morning he tried never to be late.[23] It was Mr Edwards who recalled that Mr Norman '*wasn't good*' with lateness. He said that while he was never late himself, Mr Norman complained to him on more than one occasion that the worker who attended the night before had been late.[24]

2.15. The minutes referred to issues with Mr Norman transferring safely onto his double bed from his wheelchair. It appears that consideration was being given to a bedside commode as Mr Norman was not always able to get to the toilet during the night in the absence of a support worker. It is apparent from the minutes that there were concerns in November 2017 regarding Mr Norman's ability to safely navigate the transfer to and from his bed. Following the meeting, steps were taken by Mr Davidson to acquire for Mr Norman a height adjustable hospital bed, which had not arrived by the time of Mr Norman's death.

2.16. During the meeting Mr Sutton suggested the inclusion in the support plan of behaviour guidelines to assist new workers. In evidence Mr Sutton stated that Mr Norman had new workers '*fairly regularly*' and not everyone knew how to deal with his more challenging behaviours.[25] Those instructions were added to the support plan following this meeting.

2.17. Mr Norman's support plan contained detailed instructions about how to assist Mr Norman to transfer in and out of his wheelchair safely. There was also a medication plan, a mobility and transfer plan, a communication plan, a personal hygiene and skin care plan, a bladder plan, a bowel plan, a nutrition and hydration plan, a domestic cleaning plan, a shopping plan, instructions about what to do in the event of a fall, and a mealtime safety and management plan. The support plan also set out in some detail the morning and evening routine for support workers to follow when attending upon Mr Norman.

2.18. The minutes of the meeting on 15 November 2017 also suggest that those caring for Mr Norman were concerned that more needed to be done to ensure his safety.

[22] Transcript, page 15
[23] Transcript, page 98
[24] Transcript, page 137
[25] Transcript, page 14

2.19. The support plan, when considered in the context of the evidence of those who cared for Mr Norman, reflects the fact that that Mr Noman depended heavily on the provision of care from his support workers for almost all aspects of his daily living. Although Mr Norman could leave the house independently once in his wheelchair, and was still capable of managing his own finances, he required a high level of support.

2.20. Falls

2.21. Mr Norman had a long history of falls with many instances documented. The medical records indicate that on 9 April 2009 Mr Norman had a fall while transferring from his wheelchair to the toilet at home while intoxicated.[26] He was located the following morning by a disability support worker and was taken by ambulance to the Royal Adelaide Hospital. A CT scan showed an intracerebral haemorrhage[27] which was not thought to have caused any new neurological deficit. Mr Norman was admitted to the Brain Injury Rehabilitation Unit of the Hampstead Rehabilitation Centre on 16 April 2009 and was discharged home on 9 June 2009.[28]

2.22. On 5 June 2012 Mr Norman was admitted to the Royal Adelaide Hospital with a fractured right neck of femur following an unwitnessed fall from his wheelchair.[29]

2.23. The medical notes also refer to Mr Norman having recurrent falls in the fortnight preceding 15 June 2012,[30] a fall out of his manual wheelchair while trying to pick an item up off the floor on 8 July 2012,[31] a fall transferring to the toilet on 30 April 2014[32] and a fall on 26 May 2017 while trying to transfer from his wheelchair to his bed.[33]

2.24. There are several notes recorded on CareLink, the electronic customer management system used by HomeCare+, indicating that Mr Norman fell to the floor on 20 April 2015 and 29 July 2015. The minutes of the meeting on 15 November 2016 also suggest that it was not unusual for support workers to find Mr Norman on the floor.[34]

---

[26] Exhibit C11, pages 12, 23
[27] Exhibit C11, page 6
[28] Exhibit C11, page 117
[29] Exhibit C10, page 94
[30] Exhibit C10, pages 94, 96
[31] Exhibit C10, pages 89-90
[32] Exhibit C10, page 11
[33] Exhibit C10, pages 85-86
[34] Exhibit C7(i), the minutes read 'Colin can get on his knees to assist support workers to get him off the floor'

2.25. Mr Davidson's evidence was that Mr Norman had had a number of falls, often while he was by himself.[35] In his statement Mr Davidson said that Mr Norman needed assistance with transfers to and from his bed and shower chair, but that he could self-transfer to the toilet at times.[36] Mr Davidson recalled Mr Norman using his care alert pendant to call the ambulance service.[37] On 5 April 2017 Mr Davidson advised the HomeCare+ operations manager via email that Mr Norman had fallen out of his wheelchair after self-transferring.[38]

2.26. Mr Norman's support workers were also aware that Mr Norman was prone to falling if he attempted to self-transfer. However, there was evidence from them that he could successfully self-transfer on occasion.

2.27. Mr Shevsov attended one morning to find Mr Norman already in his wheelchair still wearing his night clothes, suggesting that he had successfully transferred from his bed to his wheelchair unaided. On another morning he found Mr Norman in his wheelchair in his day clothes.[39] Mr Norman told him that the previous worker had failed to attend the night shift.[40] Mr Shevsov could not recall whether he took any action in relation to that potential failure to attend a shift, and speculated that Mr Norman might not have been telling the truth.[41]

2.28. Mr Shevsov recalled in evidence that he attended Mr Norman's house for an afternoon shift and found him on the floor intoxicated. He called an ambulance and noted that the officers who attended appeared to be on a first name basis with Mr Norman.[42]

2.29. On 5 May 2017 Mr Shevsov filed an incident report relating to an occasion when he arrived at 8:40am (late) to find Mr Norman '*half-dressed, long underpants around his ankles*', in his wheelchair watching television. On this occasion Mr Norman told him to '*F-off*' saying he was expecting Greg.[43] It appears likely that Mr Norman had successfully transferred from his bed to his wheelchair independently on this occasion.

---

[35] Transcript, page 197
[36] Exhibit C15, page 9
[37] The medical records (Exhibit C10) at page 85 contain a Patient Clinical Record referring to this incident and the use of the call alert for SAAS assistance - This is the only record located relating to Mr Norman using the care alert pendant
[38] Exhibit C15, page 131 (email to Sue Houston 4 April 2017)
[39] Transcript, page 88
[40] Transcript, page 118
[41] Transcript, page 119
[42] Transcript, page 117
[43] Exhibit C13, page 64

2.30. Mr Edwards said there were maybe six times over the three and a half or so years he worked with Mr Norman when he arrived in the morning and Mr Norman was in his wheelchair. He had found him in his wheelchair in his nightclothes. He described an occasion when it was clear, due to the state of the toilet, that Mr Norman had been up during the night and then gone back to bed.[44] There was also an occasion when he arrived to find that Mr Norman had fallen and was on the floor.[45] Unsurprisingly, he regarded Mr Norman as vulnerable to failure if he tried to self-transfer.

2.31. Mr Sutton considered it difficult and dangerous for Mr Norman to attempt to transfer from his wheelchair to his bed without assistance.[46] Nevertheless, there were occasions when he had clearly done so. Mr Sutton recalled an occasion when he arrived in the morning to find Mr Norman still in his day clothes from the night before and he assumed Mr Norman had not gone to bed the previous night.[47] He also described finding Mr Norman in the morning in his wheelchair and still in his night clothes.[48] Mr Sutton believed that it would have been less dangerous for Mr Norman to attempt to transfer independently from his bed to his wheelchair, because that transfer would occur in the morning when he was sober. However, his view was that even when sober it would not have been '*completely safe*' for Mr Norman to attempt this transfer independently.[49]

2.32. It is clear, and I find, that those responsible for providing care to Mr Norman plainly understood that Mr Norman was at risk of falling should he attempt to transfer in or out of his wheelchair without assistance. They also understood that assisting him with transfer into bed in the evening and out of his bed and into his wheelchair in the morning reduced his risk of falling.

2.33. One of the aims and purposes of provision of morning and afternoon/evening care to Mr Norman was to provide Mr Norman with assistance for these transfers.

---

[44] Transcript, page 132
[45] Transcript, page 134
[46] Transcript, page 34
[47] Transcript, page 35
[48] Transcript, pages 34-36
[49] Transcript, page 36

2.34. Refusal of care services

2.35. It was well-known to HomeCare+ that Mr Norman sometimes asked support workers to leave when they attend a rostered shift.[50] It was clear from several witnesses that he could do so in an aggressive way.

2.36. It is also clear on the evidence that there were occasions when Mr Norman was not assisted by his care worker from chair to bed or from bed to chair, according to plan. It was, or must have been, obvious to the management and staff of HomeCare+ that if Mr Norman refused care and sent his carer away there would be a risk that he would attempt to self-transfer, exposing him to a risk of injury.

2.37. It is not clear on the evidence whether any of the previous occasions of Mr Norman self-transferring occurred because the shift was simply not attended by any person, as occurred on the afternoon of Saturday 6 January 2018 and the morning of Sunday 7 January 2018, although on the evidence this remains a possibility.

2.38. The communication book which was in evidence[51] covered the period from Mr Norman's death back to 11 July 2017. The example of 12 and 13 October 2017 demonstrates that the lack of a record in the communication book of a particular attendance by a support worker does not necessarily indicate that no support worker attended. On 12 October 2017 there is no entry in the communication book for the afternoon shift. On 13 October 2017, the note for the morning shift includes '*Joe didn't go to bed last night*'. On 13 October 2017 Mr Shevsov filed an incident report regarding his attendance for his shift at 5:30pm on the previous day. Mr Shevsov wrote the following:

> 'Knocked Joe's sitting room.
>
> Joe responded enter.
>
> I entered.
>
> Joe told me to fark off.
>
> Reasoned with Joe if I leave he will sleep in his [powered wheelchair]. Joe repeated F-off. Rang HC+, spoke with Amanda. Told to go outside for half an hour & come back again. Came back half hour later. Reasoned with Joe if I leave he will sleep in his PWC, which usually works. Joe again repeated F-off. Rang HC+ & spoke to Amanda again. Took out rubbish bins on street side. Then left Joe's residence.'

[50] Transcript, page 17
[51] Exhibit C7a

2.39. Mr Shevsov's note indicates that for him, reasoning with Mr Norman usually worked, and Mr Norman would be persuaded to allow Mr Shevsov to assist him with transferring.

2.40. In Mr Sutton's experience, when asked to leave, which was quite frequent and normal, the best approach was to leave for a little while and come back, which would usually work, although sometimes it took a few tries. On occasions Mr Sutton saw that there was no note in the communication book and he attributed this to Mr Norman having not let the support worker come in for their shift. An example is to be found in the communication book on 8 December 2017, where Mr Sutton recorded, '*Joe didn't go to bed last night*' and there is no note in the communication book regarding the previous evening's shift.

2.41. Mr Davidson made the point that it was ultimately Mr Norman's choice whether he wanted a service that day and that Mr Norman was entitled to ask support workers to leave. He stated though, '*I think most times [Mr Norman] allowed the worker to stay*'.[52]

2.42. I acknowledge that it was Mr Norman's right to refuse care. This must nevertheless be seen in the context that HomeCare+ and its employees knew that there might be adverse consequences if he should then attempt to self-transfer after not receiving the assistance which HomeCare+ was contracted to provide.

2.43. Mr Norman's support plan did not include any instructions about what should be done if Mr Norman asked a support worker to leave, either at the commencement of the shift, or at some stage prior to the completion of the shift. It became clear during the inquest that the lack of specified obligations led to a state of uncertainty which was not conducive to provision of care of the highest standard.

2.44. During the course of the inquest it was suggested to a number of witnesses that there should have been guidance within the support plan about what to do if a client refused a shift. Ms Frankish agreed that the support plan should have contained this information.[53] Mr Gavin Watson, HomeCare+ Operations Manager, stated that in his view it would not be unreasonable to include that information in a support plan. He

[52] Exhibit C15
[53] Transcript, page 473

also considered that it would not be unreasonable not to include this information.[54] When asked if it would be helpful to include guidance in the support plan in relation to the refusal of care, he responded '*potentially*'. The CEO, Mr Stewart agreed, unequivocally, that if a client is in the habit of refusing care, the support plan should contain guidance about what to do.[55] Unfortunately, that was not what HomeCare+ had in place at the time of Mr Norman's death.

2.45. In his oral evidence Mr Davidson stated that he did not consider including this kind of information in Mr Norman's support plan.[56] Mr Davidson was aware that Mr Norman sometimes told support workers who arrived for shifts to leave his house and he understood that this was more common in the evening as Mr Norman would have been drinking alcohol during the day. Mr Davidson understood that if Mr Norman refused care there was an informal procedure in place which required the support worker to call the HomeCare+ office and speak to a CAO. The CAO would tell the worker to leave the house for a period of time, 15 or 30 minutes, and then go back and try again with Mr Norman.

2.46. Mr Davidson stated that there was an '*unwritten protocol*' in place that support workers were meant to leave, wait a period of time and go back, and report to the office. Mr Davidson expected the support workers to call the office on each and every occasion Mr Norman told them to leave a shift. Mr Davidson also expected that an incident report would be completed in these circumstances.[57]

2.47. Mr Sutton understood that the '*unwritten protocol*' required him to leave, stay away for five or ten minutes, and then come back. He did not call the office each time this occurred, and he did not fill out an incident report each time this occurred '*because it happened so frequently*'.[58]

2.48. Mr Shevsov stated that he would always call the HomeCare+ office if Mr Norman refused care.[59] This is what Mr Davidson would always tell him if he spoke to him.[60]

[54] Transcript, page 525
[55] Transcript, pages 581, 584
[56] Transcript, page 191
[57] Transcript, page1 91
[58] Transcript, page 18
[59] Transcript, page 87
[60] Transcript, page 93

However, the advice he received depended on which person he spoke with at the office.[61]

2.49. In his oral evidence Mr Watson told the Court that there was an expectation that staff would notify the office if the client asked them to leave a shift early.[62] He believed that the staff would learn of that expectation through team meetings and during the induction process.[63] Mr Watson stated that the frequency of team meetings varied depending on the needs of the client. He stated that they might be as often as every 6 weeks, or only once every 12 months.[64]

2.50. However, Mr Sutton only recalled attending about half a dozen team meetings relating to various clients, maybe a few more. He recalled attending about one every six months. He thought he attended '*a few*' team meetings regarding Mr Norman's care. He believed that team meetings tended to be convened if there was a particular issue with a client.[65]

2.51. Mr Edwards could only recall attending one team meeting in relation to Mr Norman,[66] which was the meeting on 15 November 2017.

2.52. The support workers in Mr Norman's team all had a different understanding of what this informal procedure or '*unwritten protocol*' required them to do.

2.53. The support worker position description[67] specifically states that a client cannot be left unattended for any reason whist on a rostered shift unless requested to do so by the responsible CSO. Mr Watson's interpretation of this document was that a support worker must call the CSO each time a client refuses care. Mr Watson expressed surprise at the suggestion that Mr Norman's support workers would leave him unattended during the shift, for example to go to the bottle shop or run other errands.[68]

2.54. However, the requirement set out in the position description was clearly not enforced. Mr Sutton gave evidence of leaving Mr Norman unattended to do things for Mr Norman or at his request[69] and the communication book records many examples of

[61] Transcript, page 95
[62] Transcript, page 522
[63] Transcript, page 522
[64] Transcript, page 528
[65] Transcript, pages 26-27
[66] Transcript, page 136
[67] Exhibit C12, page 23
[68] Transcript, page 523
[69] Transcript, page 61

others doing the same. There is no reason for this Court to criticise an arrangement whereby paid carers could attend to necessities such as shopping.

2.55. I find that there was no formal policy or procedure in place at the time of Mr Norman's death to guide employees about the appropriate process to follow if Mr Norman refused care. There was a need for such formal policy or procedure, whether it was of broader application or confined to Mr Norman's individual circumstances, and recorded in his support plan. The '*unwritten protocol*' was ill-defined and was an inadequate means of ensuring that support workers acted appropriately when a client refused care. It failed to address and attempt to avert the known risk to Mr Norman which arose when he was left to self-transfer from bed to his wheelchair or from his wheelchair to his bed. A formal policy or procedure would have provided staff, including Mr Shevsov and the CAO with whom he spoke when Mr Norman refused his care for the last time, with a clearer understanding of what was required.

3. Saturday morning 6 January 2018

3.1. Mr Shevsov was the last support worker to see Mr Norman alive.

3.2. Mr Shevsov made a statement by telephone to police at about 10pm on Wednesday 31 January 2018. He had previously provided an account to Ms Frankish on 10 January 2018.[70] Through his legal representatives, Mr Shevsov also provided a more detailed statement, sworn on 5 August 2022[71] and he gave oral evidence at the inquest.

3.3. Mr Shevsov's account[72] was that he was rostered to attend a shift with Mr Norman at 7:30am on Saturday 6 January 2018. He arrived at around 7:45am,[73] knocked on Mr Norman's door and called out to him. When he entered the bedroom, Mr Norman said to him, '*What are you doing here?*'. Mr Shevsov told him he had a rostered shift. Mr Norman replied, '*I don't want you here*'. Mr Shevsov said, '*Are you sure you don't want me here, are you sure?*' Mr Norman replied, '*Yes, go*'.

3.4. Mr Shevsov then left and called the HomeCare+ office. He stated that the person he spoke to told him that if the client did not want him there, he could leave.

[70] Exhibit C13, page 77
[71] Exhibit C13
[72] Exhibit C13, page 10
[73] This is consistent with the arrival time provided to Police on 31 January 2018 at Exhibit C13, page 82

Mr Shevsov then left. He did not notice anything to be out of the ordinary with Mr Norman.

3.5. Mr Shevsov did not go back and check again to see if Mr Norman would change his mind and accept care, although, as has been referred to, he had done that before when he had been told to.[74]

3.6. Mr Shevsov received a call from Joanna Boland the following day, informing him that Mr Norman had been found deceased. Mr Shevsov recounted the events of Saturday to Ms Boland, who completed an incident form.[75] The account in the form is generally consistent with Mr Shevsov's affidavit but does not include Mr Shevsov asking Mr Norman if he was sure that he wanted him to leave.

3.7. This detail is also absent from the account Mr Shevsov provided to Ms Frankish on 10 January 2018 and from the account Mr Shevsov provided to police on 31 January 2018.[76] In these two accounts Mr Shevsov states that after Mr Norman told him that he did not want him there, Mr Shevsov asked the question '*You don't want me here?*' and Mr Norman responded '*Yes*'. In oral evidence Mr Shevsov stated that he could not recall exactly what he said after Mr Norman said, '*I don't want you here*'.[77]

3.8. Mr Shevsov also filled out his own incident report relating to 6 January 2018 following his interview with Ms Frankish on 10 January 2018. In this report Mr Shevsov recounted that after Mr Norman said that he did not want him there, he said, '*You want me to go?*' and Mr Norman said '*Yes, go*'.[78]

3.9. The differences on this point do not require resolution. I find that Mr Norman told Mr Shevsov that he did not want him there and that Mr Shevsov confirmed with him that he did not want him there.

3.10. Diana Churches, the CAO to whom Mr Shevsov spoke provided two affidavits.[79] Unfortunately Ms Churches was not asked to provide an account of her conversation with Mr Shevsov until 8 August 2022 and by then, unsurprisingly, she said she had no independent recollection of the conversation. The only record of it was a screenshot

[74] Exhibit C13, page 10
[75] Exhibit C13, page 76
[76] Exhibit C13, page 83
[77] Transcript, page 96
[78] Exhibit C13, page 81
[79] Exhibits C20 and C20a

of a CareLink note made by Ms Churches on 6 January 2018 which reads '*Client asked SW to leave shift*'.

3.11. Ms Churches stated that while it was relatively rare for clients to refuse a service, it was '*a more common experience for Mr Norman, who would fairly frequently ask his support workers to leave*'.[80] Ms Churches stated that she was unaware of any specific policy that applied when a client refused services. She could not recall any particular practice she would follow in response to a call such as the one from Mr Shevsov. However, Ms Churches could not recall an occasion on which she asked a support worker to leave without first having instructed them to leave the client for a period of time and then try again with the client to see if they would accept the service. Ms Churches could not recall receiving any particular training about what to do in the event that client refused a service, as she would have learned this '*on the job*'.[81]

3.12. There being no evidence from Ms Churches to the contrary, I accept Mr Shevsov's evidence that when he called the office, he was told that he could leave, and was not instructed to leave, wait, and return.

3.13. Why did Mr Norman refuse care on Saturday morning?

3.14. Mr Shevsov gave different accounts of the time at which he arrived for his shift. This gave rise to a question of whether he arrived late.

3.15. In his incident report dated 10 January 2018, Mr Shevsov wrote that the time of the incident was, '*appox (sic) 0850 am*'. He also wrote in his description of the incident '*At about 0850 I knocked at Joe's bedroom door*'.[82] In his interview with Ms Frankish he estimated that he arrived at the shift anywhere between 7:45am to 7:55am.[83] In his statement to police on 31 January 2018 he stated that he arrived at 7:45am.[84]

3.16. There is no time recorded on the CareLink note made by Ms Churches. In his oral evidence Mr Shevsov attributed the inconsistency to an error in the incident report. He stated that '*he never turned up at 8:50*'[85]. Mr Shevsov was then taken to an earlier

[80] Exhibit C20, page 3
[81] Exhibit C20a
[82] Exhibit C13, page 81
[83] Exhibit C13, page 13
[84] Exhibit C13, page 82
[85] Transcript, page 100

incident report he completed on 23 May 2017[86] in which he had written '*I entered Joe's place at 8:40am*'. Notwithstanding the time on that document, Mr Shevsov maintained that the error was probably the time he recorded twice in the incident report as 8:50am.[87]

3.17. Mr Shevsov also told the Court that he tried to arrive before 8am for his morning shifts with Mr Norman. When asked why, he replied '*Well I presume I have to because he might not like it or whatever, but that's how I understood. But I knew he told me a few times he doesn't want me there early*'.[88] This is consistent with the evidence of Mr Edwards that Mr Norman '*wasn't good*' with lateness, and that his preferred time for a morning shift was usually 8am.[89]

3.18. If Mr Shevsov attended the shift at 8:50am it might be inferred that this would have displeased Mr Norman and may have contributed to his decision to refuse the shift. Although the later time was the earliest account of the time of his attendance given by Mr Shevsov, there was nothing about his demeanour as a witness, or the content of his evidence, which led me to conclude that he was being untruthful. Neither was there anything to assist me to conclude that one or other of the times he gave was correct, or otherwise. I make no finding as to the time of his attendance.

3.19. <u>Relationship between Mr Shevsov and Mr Norman</u>

3.20. Counsel assisting, Ms Roper, submitted that the likely state of the relationship between Mr Shevsov and Mr Norman could provide an explanation for Mr Shevsov being told to leave.

3.21. In his affidavit, Mr Shevsov stated that at some stage prior to January 2018 he decided to cease working with Mr Norman and advised Mr Davidson accordingly. In oral evidence Mr Shevsov explained that he did not want to work for Mr Norman any more due to the unhygienic nature of his home, Mr Norman's smoking and drinking, and his aggressiveness. He explained that at that time he had other issues in his life that were stressful. He recalled that there were '*quite a few times*' when Mr Norman swore at him and asked him to leave.

---

[86] Transcript, page 64
[87] Transcript, page 111
[88] Transcript, page 98
[89] Transcript, page 135

3.22. Mr Sutton stated in his evidence that Mr Norman told him that he hated Mr Shevsov.[90]

3.23. Mr Davidson conceded that he knew that Mr Norman '*wasn't 100% happy with Wally*'. It was his evidence that Mr Norman was happy to have Mr Shevsov until he could find someone else to cover the shifts.

3.24. Mr Shevsov stated that he told Mr Davidson '*at least once*' or '*numerous times*' that he wanted to stop working with Mr Norman. Mr Shevsov recalled that Mr Davidson's response was to tell him to ring HomeCare+ and let them know.[91] Mr Shevsov was told by someone in the office that another worker needed to be found to take on shifts with Mr Norman before he could stop doing his shifts.[92] Mr Shevsov clarified that he was told that he was the person responsible for finding another worker.[93] He expressed the view that he thought it was '*a bit odd*' that it was his responsibility as a support worker to find another worker to cover the shift, rather than being the job of someone who worked in the office.[94] However, once he ascertained Mr Karpeh's willingness to take over, he informed a lady from HomeCare+.[95]

3.25. Mr Davidson provided support for this account from Mr Shevsov. He was asked if he ever said to Mr Shevsov '*If you don't want to work shifts with Joe call the office*' and responded '*that's standard procedure*'.[96] However, Mr Davidson said he had no recollection of Mr Shevsov telling him that he wanted to stop working shifts with Mr Norman.[97] He conceded that he was '*not 100% sure*' that Mr Shevsov did not tell him that he did not want to work with Mr Norman any more.[98] Mr Davidson stated that if Mr Shevsov had made it known that he did not want to work with Mr Norman any more, he would have removed him from all shifts on Mr Norman's roster.[99]

3.26. I queried Mr Davidson whether there may been some timeframe that Mr Shevsov gave him that he was willing to work with Mr Norman and Mr Davidson.

---

[90] Transcript, page 16
[91] Transcript, pages 75-76
[92] Exhibit C13, page 9
[93] Transcript, page 74
[94] Transcript, page 77 - Mr Shevsov also described this as 'a bit unusual or strange' at Transcript, page 84
[95] Transcript, page 75
[96] Transcript, page 217 - I note that this advice was consistent with the Enterprise Agreement
[97] Transcript, page 202
[98] Transcript, page 217
[99] Transcript, page 214

Mr Davidson acknowledged that it would not have been easy to fill Mr Shevsov's shifts without Mr Shevsov working for a couple of weeks.[100]

3.27. Mr Davidson, on the other hand was firm in his evidence that it was his understanding that Mr Shevsov was willing to continue to work with Mr Norman but was no longer available to do the Saturday afternoon shift.[101] Despite this, Mr Shevsov remained on the permanent roster to work the Saturday afternoon shift until 5 January 2018.[102]

3.28. Further, Mr Davidson provided contradictory responses on the question of whether he was aware that Mr Shevsov wanted to work less shifts with Mr Norman. At one point Mr Davidson acknowledged that he was aware that Mr Shevsov wanted to 'c*ut back on the shifts*' with Mr Norman.[103] He then stated that for family reasons Mr Shevsov was looking to '*relinquish some shifts*'.[104] However, later in his evidence Mr Davidson stated that he had no recollection that Mr Shevsov wanted to work less shifts with Mr Norman.[105]

3.29. Mr Shevsov's evidence was that a shadow shift was arranged with Mr Karpeh at some unspecified time after he had told Mr Davidson that he did not want to work with Mr Norman any more.[106] Records show that Mr Karpeh worked a shadow shift on 16 November 2018.[107] Mr Shevsov understood that the shadow shift was arranged with a view to Mr Karpeh taking over all of his shifts with Mr Norman.[108]

3.30. After the shadow shift, Mr Shevsov attended a further ten or eleven shifts with Mr Norman.[109] On Wednesday 29 November 2017, Mr Karpeh covered Mr Shevsov's regular evening shift.[110] Support worker Andrew McCaskill covered Mr Shevsov's evening shifts on Thursday, 21 December 2017 and Wednesday, 27 December 2017. Mr Edwards covered Mr Shevsov's morning shift on Saturday, 30 December 2017, and Mr Sutton covered his evening shift on Thursday, 4 January 2018.[111] In my opinion these shift changes are consistent with the evidence of Mr Shevsov that he no

[100] Transcript, pages 202-203
[101] Exhibit C15, page 16 and Transcript, pages 158, 202
[102] Transcript, page 157
[103] Transcript, page 190
[104] Transcript, page 201
[105] Transcript, page 201
[106] Transcript, page 83
[107] Exhibit C7a page 38; Exhibit C7f
[108] Transcript, page 82
[109] Exhibits C7f and C7a While there is an entry in the timesheet regarding Mr Shevsov's attendance on 7 Dec 2017, there is no equivalent entry in the Communication Book
[110] Exhibit C7g
[111] Exhibit C7g

longer wished to work with Mr Norman from at least the time of the shadow shift on 16 November 2017, and that he had made this known to Mr Davidson.

3.31. Mr Davidson agreed that it was possible that the shadow shift was arranged in preparation for Mr Karpeh to take over some of Mr Shevsov's shifts.[112] He also stated that he wanted to add other support workers to Mr Norman's team.[113]

3.32. I agree with the submission of counsel assisting, Ms Roper, that it cannot be the case that Mr Karpeh was being introduced to Mr Norman's support team only to cover Mr Shevsov's Saturday night shift. Mr Karpeh's availability to work Saturday nights was a matter that Mr Davidson did not learn of until Friday 5 January 2018. The first occasion on which Mr Shevsov was removed from the Saturday evening shift on the roster was for Saturday 6 January 2018.

3.33. There is a clear inconsistency between the evidence of Mr Shevsov and Mr Davidson as to whether Mr Shevsov told Mr Davidson he no longer wanted to work any shifts with Mr Norman. I prefer Mr Shevsov's evidence on this topic. It was generally consistent whilst Mr Davidson's was not. The independent evidence of the shift changes makes it plain that Mr Shevsov took action to effect what he says was his expressed intention to cease working with Mr Norman.

3.34. Also, it might be expected that if Mr Shevsov just had a particular difficulty with Saturday evening shifts, that would have been reflected in the roster of shift changes. It was not.

3.35. Further, Mr Davidson was inconsistent in his evidence regarding what he would have done if Mr Shevsov had told him that he no longer wanted to work shifts with Mr Norman. At one point he agreed that he would have told Mr Shevsov to call the office. At another, he firmly stated that he would have removed Mr Shevsov from all shifts. Later, he agreed that he might have asked Mr Shevsov for some time to cover his shifts.

3.36. Finally, I cannot find that Mr Davidson would have removed Mr Shevsov from all shifts forthwith had Mr Shevsov made it known he no longer wished to work with Mr Norman. That is not consistent with the action Mr Davidson told the Court that he

[112] Transcript, page 188
[113] Transcript, page 204

took in response to Mr Shevsov's apparent unwillingness to work the Saturday night shift.

3.37. The possibility of a misunderstanding between Mr Shevsov and Mr Davidson remains, however. As previously mentioned, Mr Davidson conceded that he was aware that Mr Shevsov wanted to *reduce* the number of shifts he worked with Mr Norman.[114] Further, Mr Davidson agreed that Mr Norman had said to him words to the effect of '*Wally's OK but find someone else*' and that he would have been looking for someone else to cover those shifts.[115] The weight of evidence indicates that Mr Davidson thought that Mr Shevsov and Mr Norman were willing to tolerate each other for a period to allow another worker to be located.

3.38. In my opinion, there is clear evidence that by Saturday 6 January 2018 the relationship between Mr Shevsov and Mr Norman had deteriorated. Mr Shevsov was dissatisfied with the conditions of his work with Mr Norman and his abuse of him and, as I have found, he had told Mr Davidson that he no longer wished to work with him. This is to be distinguished from telling Mr Davidson that he was not prepared to work with him on any occasion again. I accept Mr Sutton's evidence that Mr Norman told him that he hated Mr Shevsov. On Mr Davidson's own evidence, Mr Norman told him that he wanted Mr Davidson to find someone else. As conceded by Mr Davidson, continuing to send Mr Shevsov to shifts with Mr Norman rendered him more vulnerable to expressions of discontent.[116] As suggested by counsel assisting, I agree that Mr Davidson was aware that Mr Shevsov and Mr Norman were tolerating each other at best. By extension, the state of their relationship also made it more likely that Mr Norman would send Mr Shevsov away and refuse his assistance, as he had done on previous occasions. If this did not occur to Mr Davidson, it should have.

3.39. By 6 January 2018, more than seven weeks had passed since the first shadow shift worked by Mr Karpeh with Mr Norman, and still Mr Shevsov was being rostered to work with Mr Norman. Ms Roper submitted that the rejection by Mr Norman of Mr Shevsov upon his attendance on that Saturday morning was predictable and preventable. That characterisation was challenged by Ms Veale on behalf of HomeCare+. Ms Veale is certainly correct to say that Mr Norman's behaviour was not predictable and he would send away people, even those he reportedly liked, for a

[114] Although he denied this at Transcript, page 201
[115] Transcript, page 188
[116] Transcript, page 211

variety of reasons. I also bear in mind Ms Veale's submission that it was not practically possible to always send workers Mr Norman liked, given that he liked very few of his workers. I note that Mr Sutton for example, not only said that Mr Norman hated Mr Shevsov, but that he would say that about '*pretty much everyone*'.[117]

3.40. Mr Davidson may not have known the full extent of the deterioration of the relationship between Mr Norman and Mr Shevsov. However, he conceded that he became aware that the relationship was not going very well about a month before Mr Norman's death, perhaps longer.[118]

3.41. In my opinion, once seven weeks had passed from Mr Shevsov telling Mr Davidson that he no longer wished to work with Mr Norman, Mr Davidson and HomeCare+ should have been aware of an increased risk that Mr Norman would refuse care from Mr Shevsov and should not have been continuing to roster him for shifts with Mr Norman. In the circumstances, I consider that HomeCare+, through Mr Davidson, should have acted more swiftly to remove Mr Shevsov as one of Mr Norman's support workers.

3.42. That is not to say that on that particular morning Mr Norman might not have sent away a different support worker. It must be remembered however that Mr Shevsov's experience, if told to leave in the evening, and if told by HomeCare+ to go outside and wait and then go back in, was that he could reason with Mr Norman about the fact that he would have to sleep in his wheelchair and that Mr Norman would relent. It is also the case that Mr Shevsov did not recall Mr Norman ever sending him away in the morning prior to this occasion.[119]

3.43. The fact that Mr Norman was not provided with care on Saturday morning, including by assisting him from his bed to his wheelchair, cannot be attributed conclusively to the actions of Mr Davidson or Mr Shevsov or Ms Churches. Mr Shevsov took appropriate action by informing HomeCare+ that care had been refused. Mr Shevsov was given instructions simply to leave, which was contrary to the usual instructions he received. As previously observed, there was no formal policy in place at HomeCare+ relating to the refusal of care services.[120] Consequently, on this occasion the advice

[117] Transcript, page 19
[118] Transcript, page 198
[119] Exhibit C13, page 77
[120] Transcript, page 191

given was inconsistent with the '*unwritten protocol*', a process that was understood to be the best approach to ensure that Mr Norman received care.[121] This was a process which respected Mr Norman's right to refuse service, but acknowledged the common experience of his support workers that Mr Norman would relent and accept care. Ms Churches' statement was to the effect that she was not aware of the '*unwritten protocol*' and on the basis of the evidence, particularly because it was unwritten, HomeCare+ cannot persuasively assert that she was.

3.44. There is no evidence of any attempt being made by HomeCare+ to contact Mr Norman to ascertain the reason for his refusal to accept care from Mr Shevsov, or to check on his welfare. Mr Norman had a telephone. The risk to his safety if he should attempt to self-transfer was known to HomeCare+. I also note that an extremely high temperature was forecast for Saturday 6 January 2019; it reached 41ºC.[122] There ought to have been action taken by HomeCare+ following the telephone call from Mr Shevsov. The only action taken by Ms Churches on behalf of HomeCare+ was to instruct Mr Shevsov to leave and make a note on the CareLink system to record the bare fact of the refusal of care.[123]

3.45. Mr Shevsov then followed the inappropriate and inadequate instructions provided to him. Ms Churches did not act in accordance with the unwritten protocol. She did not even know about it. There was no written protocol. In the absence of a clear policy guiding Ms Churches, responsibility for the lack of such action rests with HomeCare+.

3.46. I also observe that the unwritten protocol, according to which Mr Shevsov would have been asked to wait for a time before going in and again attempting to persuade Mr Norman to accept care, was hardly unreasonable from the standpoint of the support worker or HomeCare+, as the support worker would be paid in any event for the full duration of the scheduled shift.[124]

---

[121] Transcript, page 18

[122] Transcript, pages 508 (Frankish); 592 (Stewart)

[123] I note that Ms Frankish stated in oral evidence that this note ought to have included details as to the advice given to Mr Shevsov, and that an incident report should have been completed: Transcript, page 467 Mr Stewart also stated that he would have expected an incident report to have been filed and acted upon: Transcript, page 571

[124] Transcript, page 595

4. Saturday evening 6 January 2018

4.1. Prior to Friday 5 January 2018, Mr Shevsov was on the fortnightly roster to provide care to Mr Norman on Saturday morning and Saturday evening on 6 January 2018.[125] The roster was prepared on a fortnightly basis and Mr Shevsov had the permanent Saturday evening shift in week one of the fortnight.[126]

4.2. It was Mr Shevsov's evidence that at some stage after the shadow shift worked by Mr Karpeh, he suggested to Mr Karpeh that he could take over the Saturday evening shifts with Mr Norman. Mr Shevsov stated in his affidavit that Mr Karpeh told him that he was happy to take over that shift.[127] Mr Shevsov then told HomeCare+ that he had found a worker interested in taking over the shift.[128]

4.3. In his oral evidence, Mr Karpeh could not initially recall a conversation with Mr Shevsov about taking over his Saturday night shifts with Mr Norman.[129] He later conceded that he must have done so.[130]

4.4. In his affidavit, Mr Davidson stated that Mr Shevsov told him that he had spoken with Mr Karpeh and Mr Karpeh wanted more shifts. Mr Davidson recalled Mr Shevsov telling him that Mr Karpeh would take over Mr Shevsov's Saturday afternoon shift.[131]

4.5. Accordingly, I accept Mr Shevsov's evidence that he and Mr Karpeh discussed the Saturday evening shift and that Mr Karpeh expressed an interest in taking over the shift. It was after that discussion that Mr Shevsov informed Mr Davidson he had found a worker, and Mr Davidson spoke with Mr Karpeh.

4.6. I note that Mr Karpeh recalled speaking to Mr Shevsov about the Saturday shift with Mr Norman after he had spoken to Mr Davidson.[132] However, I consider it likely that Mr Karpeh was mistaken about this. It was Mr Karpeh's evidence that he did not ever speak with Mr Shevsov on the telephone.[133] Mr Shevsov and Mr Karpeh could not have worked together on Saturday morning as Mr Shevsov was rostered on to work with Mr Norman. Consequently, any discussion between Mr Shevsov and Mr Karpeh

[125] Transcript, page 157
[126] Ibid
[127] Exhibit C13, page 9
[128] Exhibit C13, page 10
[129] Transcript, page 392
[130] Transcript, pages 413-414
[131] Exhibit C15, page 16
[132] Exhibit C16e page 3
[133] Transcript, page 419

about the Saturday shift with Mr Norman must have occurred prior to the conversation between Mr Karpeh and Mr Davidson at about 12:30pm on Friday 5 January 2018.

4.7. Conversation between Mr Davidson and Mr Karpeh on Friday 5 January 2018

4.8. On Friday 5 January 2018 there was a conversation between Mr Davidson and Mr Karpeh in relation to Mr Shevsov's Saturday night shift. Their accounts of the conversation are at variance, but there is significant common ground that during this call Mr Karpeh expressed an interest in taking over the Saturday night shift on an ongoing basis.[134] The time of the shift was changed to commence at 4:30pm to better suit Mr Karpeh.[135]

4.9. Mr Davidson recalled that during this conversation Mr Karpeh told him that his football commitments no longer precluded him from taking the Saturday night shift.[136] Mr Karpeh said that he was out with his son at a shopping centre when he spoke with Mr Davidson. He thought that they initially spoke about something else and then Mr Karpeh asked Mr Davidson for extra shifts. Mr Davidson then offered him the shift on Saturday night with Mr Norman. Mr Karpeh recalled that Mr Davidson said that the person who usually did the shift was Wally (Shevsov) and that Wally wanted to give the shift out permanently, but that he had to check with him first. Mr Karpeh said that he was willing to do the shift because he no longer played soccer on Saturdays.[137]

4.10. Mr Karpeh initially stated that he was '*very hesitant*' to take the shift,[138] but he agreed to do it. He explained that he was hesitant because he did not know whether the shift being offered to him was Saturday week one in Mr Norman's roster, or Saturday week two. He played amateur soccer on one of those Saturdays.[139] Mr Karpeh gave evidence that the call ended with Mr Davidson stating, '*I'll call you back to confirm the shift*'.[140] Mr Davidson agreed that he told Mr Karpeh that he would call him back to confirm the shift.[141]

---

[134] Transcript, page 395
[135] Transcript, pages 160-161; It is noted that Mr Karpeh could not recall the reason for the change in shift time (396)
[136] Exhibit C15, page 17
[137] Exhibit C16e, page 3
[138] Transcript, page 265
[139] Transcript, page 426
[140] Transcript, page 266
[141] Transcript, page 242

4.11. The HomeCare+ telephone records[142] do not assist with the timing of the call, or in identifying who initiated the call. Outgoing calls were made to Mr Karpeh's number at 2:53pm (12 seconds), at 3:57pm (27 seconds) and at 4:26pm (21 seconds).

4.12. In his affidavit Mr Davidson stated that he believed that Mr Karpeh must have called him.[143] However, in his oral evidence Mr Davidson asserted not just the contrary belief, but that he had a record establishing that he called Mr Karpeh. Mr Davidson stated, '*I know I called him...because I had a record of it at the time*'.[144] He later clarified that he simply had a note confirming the time of the conversation, which was 12:30pm, rather than a note stipulating who it was that made the call.[145]

4.13. In Mr Karpeh's interview with Ms Frankish he stated that he could not recall whether he called Mr Davidson on Friday 5 January 2018, or whether Mr Davidson called him.[146] The time of 12:30pm was put to him, but he was not asked whether that time accorded with his memory. In his oral evidence, Mr Karpeh originally stated that Mr Davidson called him. However, once reminded of what he had told Ms Frankish, he stated that he would stick with his previous answer.[147] Mr Karpeh recalled that the conversation was in the afternoon or evening and stated that it must have been on the Friday.[148]

4.14. The 12-second call showing in the records as having occurred at 2:53pm is too short to be the conversation deposed to by Mr Davidson and Mr Karpeh.[149]

4.15. The HomeCare+ landline was used again to call Mr Karpeh at 3:57pm and that call was of 27 seconds duration. A third call of 21 seconds duration was made from the HomeCare+ landline to Mr Karpeh at 4:26pm. The evidence does not establish whether any of those calls were answered. Further, the evidence does not establish which of these calls, if any, were made by Mr Davidson. There is no record of a telephone call from the HomeCare+ landline to Mr Karpeh on 5 January 2018 at

[142] Exhibit C15, pages 172-180
[143] Exhibit C15, page 17
[144] Transcript, page 225
[145] Transcript, page 230
[146] Exhibit C16e page 1; Transcript, page 393
[147] Transcript, page 393
[148] Transcript, page 266; Transcript, pages 419-410
[149] Exhibit C15, pages 172-180

around 12:30pm. Mr Davidson stated that he very rarely used his personal mobile telephone for work.[150]

4.16. Mr Davidson however recalled that he called Mr Shevsov after speaking with Mr Karpeh. There is a record of a call from the HomeCare+ landline to Mr Shevsov at 12:29pm on Friday 5 January 2018. The duration of that call was 7 minutes and 13 seconds.

4.17. Mr Shevsov could not recall when or how he first became aware that Mr Karpeh would be taking over his Saturday evening shift permanently, however it was his clear understanding that the Saturday morning was to be his last shift with Mr Norman.[151] Mr Shevsov was taken to the telephone records which indicated that a call was made to his mobile telephone from HomeCare+ at 12:29pm on Friday 5 January 2018.[152] Mr Shevsov could not recall who he spoke to or what they spoke about. He agreed that it was possible that this conversation was with Mr Davidson and that the conversation related to the change of worker for the following day.[153] Mr Davidson believed that he was the person who made this call to Mr Shevsov,[154] although he had no independent recollection of doing so.[155]

4.18. Having regard to that evidence, I conclude that Mr Davidson and Mr Karpeh must have had a conversation just prior to 12:30pm on Friday 5 January 2018 regarding the Saturday evening shift with Mr Norman. Mr Karpeh was aware that Mr Davidson was looking to fill the Saturday evening shift with Mr Norman on an ongoing basis.[156] During that call, Mr Karpeh agreed that he was available to attend the shift and he was at the least aware it was possible that the shift was the next day and not the Saturday a week hence. Mr Davidson told Mr Karpeh that he would call him back to confirm the shift once he had spoken to Mr Shevsov.

4.19. There is no suggestion that Mr Davidson ever spoke with Mr Karpeh to confirm the shift.

---

[150] Transcript, page 226
[151] Transcript, page 78
[152] Exhibit C13, page 72
[153] Exhibit C13, page 10
[154] Transcript, pages 231-232
[155] Exhibit C15, page 17
[156] Transcript, pages 232, 393-394

4.20. At some stage prior to 5:30pm on the afternoon of Friday 5 January 2018 Mr Davidson amended the fortnightly roster to remove Mr Shevsov's name and replace it with Mr Karpeh's name.[157] Mr Davidson also amended the starting time to 4:30pm.[158]

4.21. The only remaining area of contention regarding this conversation relates to Mr Karpeh's assertion that Mr Davidson was confused about whether the shift to be covered was Saturday evening in week one or two of the roster.

4.22. In his interview with Ms Frankish, Mr Karpeh initially stated that Mr Davidson told him that he needed to check with Mr Shevsov to confirm that he wanted to give the shift out permanently.[159] He later stated that Mr Davidson was not sure whether the shift available was the first or second Saturday in the roster.[160] Mr Karpeh stated that Mr Shevsov was also confused about this. On 10 January 2018 Mr Karpeh provided Ms Frankish with the following explanation for not returning Mr Davidson's calls that afternoon:

> 'No I did not call back because, when me and Bill spoke, Bill actually wasn't actually sure if even if it was the first Saturday or every second Saturday'.

4.23. Some support can be found for Mr Karpeh's evidence on this topic in the email Mr Davidson sent to Mr Karpeh at 5:28pm on Friday 5 January 2018. The email, with the subject heading 'Joe Cool', read as follows:

> 'Hi Kailo, Wally has handed in Joe's Saturday week one bed shift. I have put you in the shift on a regular basis. Could you call the office please, **to confirm** you can attend, thanks Bill'.[161] (emphasis added)

4.24. In this email Mr Davidson confirms the two facts that Mr Karpeh stated needed to be confirmed prior to him being allocated the shift – the shift was the Saturday week one bed shift and Mr Shevsov had confirmed that he no longer wanted that shift.

4.25. During cross-examination Mr Davidson denied that he was confused about whether the shift was in week one or week two, but conceded he was *'stressing his memory here*'.[162]

---

[157] Transcript, page 168
[158] Transcript, page 169; Exhibit C7h
[159] Exhibit C16e, page 1
[160] Exhibit C16e, pages 5-6
[161] Exhibit C15, page 181
[162] Transcript, pages 232, 236-237

4.26. I prefer Mr Karpeh's evidence on this topic. His recollection was clear and it was provided at a time when Mr Karpeh was unaware of the consequences of failing to attend the shift, as he did not know that Mr Norman had passed away. It cannot be suggested that he fabricated an account to explain his failure to attend due to the tragic circumstances. Further, it was Mr Karpeh's evidence that this confusion about week one or two led (in part) to him not returning the calls from HomeCare+ on Friday 5 January 2018.

4.27. Mr Davidson's attempts to confirm the shift

4.28. In oral evidence Mr Davidson recalled making two calls to Mr Karpeh to confirm the shift after their initial conversation.[163] Further, the handover document Mr Davidson left for the CAOs included a note that Mr Davidson had left a mobile message for Mr Karpeh to confirm that he could cover the shift.[164] That handover note read:

> 'Colin Norman, Saturday 6/1/18 1630 – 1930 left mobile message for Kailo Karpeh **to confirm** that he will cover the shift on a regular basis. Please follow up. Thank you, Bill.'[165] (emphasis added)

4.29. It is clear, and I find, that Mr Davidson left at least one message on Mr Karpeh's mobile phone on Friday 5 January 2018 relating to the shift with Mr Norman. The content of that message, the time at which it was sent, and the form in which it was received by Mr Karpeh are more complex issues as, at the time of giving evidence, Mr Karpeh no longer had possession of the mobile telephone he had on 5 January 2018.

4.30. As a result, the only evidence before the Court of what was recorded on Mr Karpeh's phone comes from the transcript of Mr Karpeh's interview with Ms Frankish. However, in an unexpected turn of events, Mr Karpeh challenged the accuracy of the transcript[166] of the recording of his interview with Ms Frankish on 10 January 2018. Mr Karpeh stated that despite the content of the transcript, he could not recall showing Ms Frankish his phone, or receiving a message on his phone reading '*message is from Homecare+ call back urgently*'.[167]

---

[163] Transcript, page 236
[164] Exhibit C15, page 182
[165] Exhibit C15, page 182
[166] Exhibit C16b
[167] Transcript, page 272

4.31. By way of background, the account Mr Karpeh provided to Ms Frankish was the only account Mr Karpeh provided at a time proximate to the death of Mr Norman. Also, as I have alluded to, Mr Karpeh was not aware until the end of the interview that Mr Norman had died. Mr Karpeh did not make a statement to a SAPOL coronial investigator until about 3:50pm on Tuesday 14 September 2021.[168]

4.32. Prior to the commencement of Mr Karpeh's cross-examination the Court was informed that, contrary to earlier advice, the audio recording of Mr Karpeh's interview with Mr Frankish may in fact be available. Mr Karpeh was stood down and the audio recording was produced.

4.33. Mr Karpeh returned to give evidence on 22 August 2022 having been provided with the opportunity to listen to the recording to refresh his memory. Some amendments were made to the transcript with its accuracy agreed upon by all parties and Mr Karpeh. A new version of the transcript was tendered.[169]

4.34. Having refreshed his memory from the recording, Mr Karpeh was able to recall showing Ms Frankish the missed call message folder on his phone containing missed calls from the HomeCare+ landline. He stated that he did this so that Ms Frankish could see for herself how his phone recorded a missed call message. He wanted her to see that he was not lying.[170]

4.35. It is apparent from the transcript that after being handed the phone Ms Frankish looked at the missed call messages from HomeCare+ from 5 January 2018. Ms Frankish then stated:

> 'So if we went to the 5th so it does say HomeCare+, somebody's left a message, HomeCare+ urgent to give them a call back, 3:04 HomeCare+, message provided, 'hello please call HomeCare+ regarding a 1 hour shift from 6 to 7. This message provided by Telstra.' [171]

4.36. Mr Karpeh explained that Ms Frankish would have been looking at a message that had been left as an audio message but converted to text.[172]

4.37. There was a lack of clarity in the evidence as to how many messages were present on Mr Karpeh's phone at the time at which Ms Frankish viewed it. Ms Frankish was

[168] Exhibit C16f
[169] Exhibit C16e
[170] Transcript, page 347
[171] Exhibit C16e, page 4
[172] Transcript, page 352

unable to recall how many messages she viewed, but assumed from the content of the transcript that there were two messages received on 5 January 2018.[173]

4.38. Mr Karpeh conceded that there was more than one message on his phone from HomeCare+ on 5 January 2018. In relation to the message regarding the one-hour shift, Mr Karpeh initially thought that this message related to another day as he had already spoken with HomeCare+ about this shift prior to Friday.[174] Mr Karpeh stated that he saw these messages when he turned his phone on late on 5 January 2018.[175] His phone had been off in the afternoon as the battery was flat.[176]

4.39. In any event, it is clear the message relating to the one-hour shift was not the message left by Mr Davidson, as the shift with Mr Norman was a three-hour shift.

4.40. I find that Mr Davidson left one or two messages on Mr Karpeh's mobile telephone on the afternoon of 5 January 2018. Given the content of the handover note, which refers to a message being left asking Mr Karpeh to call the office, it is most likely that Mr Davidson left the message '*urgent to give them a call back*'. It is unclear whether this message correlates with the call made from the HomeCare+ landline at 2:53pm, 3:57pm or 4:26pm.

4.41. It is also clear, and I find, that Mr Karpeh did not return these calls on the Friday.

4.42. I also find that there was no communication between Mr Karpeh and HomeCare+ on Saturday 6 January 2018 regarding the shift with Mr Norman.[177]

4.43. I accept Mr Karpeh's evidence that he did not believe that he was expected to attend the Saturday evening shift with Mr Norman, at least unless it was confirmed.

4.44. Mr Davidson maintained during his evidence that he believed that the shift was confirmed with Mr Karpeh. It was his evidence that he was 100% certain that the shift was confirmed, and that Mr Karpeh would attend.[178]

[173] Transcript, page 438
[174] Transcript, page 357
[175] Transcript, page 358
[176] Transcript, page 359
[177] Transcript, page 425
[178] Transcript, page 232

4.45. However, Mr Davidson's actions following his conversation with Mr Karpeh are inconsistent with a concrete belief that the shift was confirmed:

- Mr Davidson called Mr Karpeh on at least two occasions in an attempt to speak with him about the shift with Mr Norman the following day;
- When Mr Davidson was unsuccessful in his attempts to speak with Mr Karpeh, he sent him an email to confirm the shift;
- Mr Davidson left a handover note to the CAOs asking them to follow up with Mr Karpeh relating to the shift on 6 January 2018.

4.46. Mr Davidson conceded that calling Mr Karpeh back after speaking with Mr Shevsov probably did not make sense given his asserted belief that the shift was already confirmed. He could not provide an explanation for this other than to say that perhaps he was being overcautious.[179]

4.47. I do not suggest that Mr Davidson was being deliberately untruthful in his evidence, on this topic or more generally. However, I find that following his conversation with Mr Karpeh, Mr Davidson must have had at least some doubt in his mind regarding the status of the shift, given the actions he then took. When these actions are considered together with Mr Karpeh's evidence it is clear, in my opinion, that the evening shift with Mr Norman on Saturday 6 January 2018 had not been confirmed during the conversation between Mr Davidson and Mr Karpeh, on Friday or at any later stage.

4.48. Several factors contributed to the failure of HomeCare+ to ensure that Mr Norman's Saturday afternoon care shift was attended by a support worker:

- Although Mr Davidson called and left a message or messages for Mr Karpeh, Mr Karpeh did not return the calls, either on the Friday or Saturday;
- Mr Davidson did not follow the shift change procedure;
- Mr Davidson's handover note asking CAOs to follow up on the question of confirmation of change of shift was not acted upon.

[179] Transcript, page 235

4.49. The shift coverage procedure at HomeCare+

4.50. The formal shift coverage procedure in place at the time of Mr Norman's death was tendered.[180] Mr Davidson understood that this procedure applied to changes to regular shifts as well as cover shifts.[181] He accepted that clause 5.6.2 of this procedure required him to contact Mr Norman and to obtain his consent prior to changing the time of the Saturday shift and that he did not do so.[182] Clause 5.6.2.4 required him to document that all relevant parties had been contacted.

4.51. Clause 6 required that if he was unable to contact the client to inform him of the shift change, he was required to leave a note for the next shift to inform Mr Norman. Mr Davidson did not do so.

4.52. Mr Davidson failed to comply with the shift coverage procedure in the following ways:

- He did not obtain Mr Norman's approval to change the shift time;
- He did not note the process involved in the change of shift time;
- He did not inform Mr Norman of who was attending the shift;
- He did not include in the handover a note requesting that a staff member follow up with Mr Norman to notify him of the shift change;
- He entered Mr Karpeh's name onto the roster in circumstances where the shift had not been confirmed.

4.53. It is not possible to say whether compliance with this policy would have altered the outcome for Mr Norman. However, it may have done so.

4.54. It was Ms Frankish's evidence that the fact Mr Karpeh's name was prematurely entered onto the roster[183] meant that the CAOs would not have seen the handover note left by Mr Davidson as a priority. In her view, they would have considered the shift filled.[184]

[180] Exhibit C7e
[181] Transcript, page 170
[182] Transcript, page 171
[183] Transcript, page 449
[184] Transcript, page 484

4.55. Further, it is clear from the statement of intent that this procedure was designed to ensure that all shifts were covered by an appropriately trained support worker '*of the client's choosing*'. This was not a mere technical failure to comply with procedure, but a failure also to comply with its spirit.

4.56. According to Mr Sutton, Mr Norman hated Mr Shevsov. Mr Sutton did not pass that information on to Mr Davidson. It was Mr Davidson's evidence that he never sought feedback from Mr Norman about the performance of individual support workers.[185] Mr Davidson stated in his oral evidence that he would '*always have conversations with support workers about how they feel about their work with a client*'.[186] He could not recall ever speaking with the support workers to ascertain whether Mr Norman had provided them with feedback about the quality of the service they were receiving from other support workers.[187] In these circumstances, the failure to consult Mr Norman about the change of support worker had the potential to bring about a scenario in which the support worker who arrived was sent away in an aggressive manner, leaving Mr Norman without much needed care.

4.57. It was Mr Davidson's evidence that he tried to call Mr Norman to confirm that the shift change was okay with him, but he did not answer.[188] Mr Davidson accepts that there is no record of this outgoing call to Mr Norman in the call records. Further, in his interview with Ms Frankish, Mr Davidson did not mention that he attempted to call Mr Norman about the change in shift. Rather, he stated that he called Mr Shevsov straight after he spoke with Mr Karpeh.[189] The first mention by Mr Davidson that he attempted to call Mr Norman in relation to the shift change was in his affidavit dated 5 August 2022. I am not in a position to make a finding as to whether or not he did. It remains the case that he did not leave a handover note asking the next shift to do so.

4.58. <u>The Enterprise Agreement</u>

4.59. Further documents tendered regarding the shift coverage procedure were the Enterprise Agreement,[190] the Support Worker Position Description,[191] the Client

[185] Transcript, page 183
[186] Transcript, page 185
[187] Transcript, page 183
[188] Exhibit C15, page 19; Transcript, page 174
[189] Exhibit C15, page 190
[190] Exhibit C7c
[191] Exhibit C16k

Administration Officer Position Description,[192] and the Client Services Officer Position Description.[193] Each position description reflects the Enterprise Agreement in relation to the shift coverage responsibilities of support workers.

4.60. Clause 13.4.2 of the Enterprise Agreement reads as follows:

> 'To ensure employee flexibility when an employee is aware in advance that they will not be able to attend a rostered shift, the employee will be responsible for varying any shifts they are rostered for but unable to attend, except in cases of acute illness or emergency'.

4.61. Clause 13.4.3 reads:

> 'It is the responsibility of 'the employee' changing the shifts to advise 'the employer' of shift changes prior to the shift commencing'.

4.62. Mr Davidson agreed that there was an expectation by HomeCare+ that if a support worker could not attend a rostered shift that they would, in the first instance, attempt to find someone to cover their shift, as provided by the Enterprise Agreement.[194]

4.63. Mr Davidson agreed that if Mr Shevsov did not want to do a Saturday night shift with Mr Norman the expectation was that he would find someone from Mr Norman's support worker team to do that for him.[195] It was Mr Davidson's evidence that this expectation was part of the support workers training, but that it was not always enforced.[196]

4.64. Mr Davidson expressed the view in his oral evidence that it would not be fair for the onus to be on the support worker to find someone to cover a regular shift on an ongoing basis.[197]

4.65. Ms Frankish was involved in negotiating the Enterprise Agreement.[198] In her view, Clause 15.4 of that agreement had the effect of shifting the responsibility for covering rostered shifts to the support worker unless there is a case of illness or emergency.[199] Mr Stewart, CEO, conceded that the burden of covering shifts ought to rest with the administration staff rather than the casually employed support workers.[200] It was

[192] Exhibit C15, page 24
[193] Exhibit C15, page 29
[194] Transcript, pages 219-221
[195] Transcript, page 221
[196] Transcript, page 220
[197] Transcript, page 223
[198] Transcript, page 497
[199] Transcript, page 497
[200] Transcript, page 547

Mr Stewart's belief that this clause of the Enterprise Agreement would have been instigated by HomeCare+. He did not envisage that requiring the administrative staff to bear this burden would create an undue problem for their workload.[201] Mr Stewart took no issue with a suggestion for a recommendation that the Enterprise Agreement be renegotiated with a view to HomeCare+ filling shifts when workers advise that they are no longer able to or wish to do them.

4.66. The shift coverage procedure in place at the time of Mr Norman's death placed the onus on Mr Shevsov to find coverage for his shifts with Mr Norman in circumstances where he no longer wished to work for him. Had that onus been with HomeCare+ as it should have been, whether through Mr Davidson or the administrative staff or some other arrangement, Mr Shevsov's shifts may have been filled more promptly.

5. Sunday 7 January 2018

5.1. Mr Edwards stated in his affidavit that on the evening of Saturday 6 January 2018 he went to bed feeling unwell. He woke up in the afternoon of the following day, Sunday 7 January 2018, still feeling unwell. Realising he had missed his morning shift with Mr Norman by several hours, he did not think it necessary to contact HomeCare+ to inform them he failed to attend.[202]

5.2. In oral evidence Mr Edwards confirmed that he simply did not wake up on the Sunday until approximately 3pm and by then it was his expectation that someone else would attend Mr Norman around two hours later.[203] He acknowledged that he breached the company's policies and procedures, as well as the employee Enterprise Agreement with respect to unplanned sick leave.[204] Mr Edwards stated that this was the first time he had slept in and missed a shift and he was deeply distressed by this.[205]

5.3. I accept the evidence of Mr Edwards as to the events of 7 January 2018 and his subsequent remorse.

---

[201] Transcript, page 577
[202] Exhibit C14, page 7
[203] Transcript, page 141
[204] Exhibit C14, page 7
[205] Transcript, page 141

6. The Homecare+ internal investigation

6.1. Ms Frankish conducted an internal investigation into Mr Norman's death to determine any areas of concern and to provide recommendations to address any concerns identified.[206] That process involved conducting interviews with Mr Sutton, Mr Shevsov, Mr Edwards, Mr Karpeh and Mr Davidson.

6.2. As a result of the investigation Mr Karpeh was issued with a first and final warning, Mr Edwards was issued with a formal written warning and Mr Davidson was issued with a formal written third warning. Ms Frankish concluded that Mr Davidson's performance was unsatisfactory in that he failed to comply with the shift coverage procedure by entering Mr Karpeh's name into the roster prematurely.

6.3. No wrongdoing was identified on the part of Mr Sutton or Mr Shevsov.

6.4. There was a particular focus in the investigation on the conduct of Mr Karpeh. In preparing my findings I have not embarked upon an assessment of the fairness of Mr Karpeh's treatment during the investigation, or his later dismissal, although submissions on that issue were made on behalf of HomeCare+ by its counsel Ms Veale and on behalf of Mr Karpeh by his counsel Ms Scanlon.

6.5. Ms Frankish stated that Mr Karpeh's first and final warning was due to his failure to return calls to HomeCare+. She stated that there was an expectation that support workers return calls to HomeCare+ and that if they wanted to pick up shifts, that was how they got them.[207] It was Ms Frankish's view that it was reasonable to expect support workers to take calls outside of rostered work hours.[208]

6.6. There did not appear to have been any consideration of why it might have been that Mr Karpeh did not return the calls from HomeCare+ on Friday, or why it was that there was no attempt to contact him on Saturday.

6.7. Ms Frankish stated in her oral evidence that Mr Karpeh was given a first and final warning for failing to return calls from HomeCare+, both in the context of the conversation he had had with Mr Davidson, and because of '*priors*'.[209] Ms Frankish

[206] Exhibit C17, page 9
[207] Transcript, page 441
[208] Transcript, page 441
[209] Transcript, page 505

expressed the view that there was a failure to follow procedures in relation to these '*priors*'.[210]

6.8. Ms Frankish stated that at the time of Mr Norman's death, HomeCare+ relied '*wholly and solely*' on trust to ensure that support workers attended their rostered shifts.[211] The level of trust placed in support workers is apparent from these remarks of Ms Frankish to Mr Karpeh during the interview on 19 January 2018:

> '...We do not have supervisors - we do not have people watching every move you make - we do not have someone standing at the front door watching the clock to make sure you come in. We trust you and that is why we employ you…' [212]

6.9. This serves to emphasise the failure of HomeCare+ to have in place a system to check and see that support workers were attending. As Ms Frankish conceded, the only way in which HomeCare+ would necessarily find out if that did occur was if a client complained.[213]

6.10. It must have been evident to HomeCare+ that simply trusting in the casual workforce was a risky and predictably fallible way of ensuring that clients were always attended by support workers as required by the Client Service Agreement. At the time of Mr Norman's death, HomeCare+ was working with the supplier of the CareLink platform to develop a system of electronically monitoring attendance by support workers at their shifts.[214]

6.11. In her evidence Ms Frankish conceded that she ought to have interviewed the CAOs working on Saturday 6 January 2018. The aim of Ms Frankish's investigation was to consider what went wrong with the systems at HomeCare+. However, the investigation did not identify or attempt to ascertain the cause of the failure by the CAOs to follow up on the shift change as requested by Mr Davidson in the handover note. In her oral evidence, Ms Frankish was strident in her defence of the failure of CAOs to act upon this handover note. In her view, the note was ambiguous and implied that the follow up was not urgent in nature.[215] This assertion does not withstand scrutiny; there was a complete failure to act on the handover note, not a failure to act urgently. The handover note warranted attention. The failure to act

[210] Transcript, page 508
[211] Transcript, page 458
[212] Exhibit C17, page 61
[213] Transcript, page 458
[214] Ibid
[215] Transcript, pages 484-491

upon it is but one indicator of the need to have a system in place to ensure that workers attend shifts, and that shift coverage procedures are followed.

6.12. Neither Ms Churches nor Mr Shevsov completed an incident or concern report regarding Mr Norman's refusal of care on 6 January 2018. Ms Churches also failed to record the details of the advice she provided to Mr Shevsov. Ms Frankish quite properly conceded that these steps ought to have been taken.[216]

6.13. There was some evidence to suggest that there may have been a note on CareLink relating to what instructions a CAO should provide in the event that Mr Norman refused care. No note has been produced.

6.14. Ms Frankish did not mention such a note in her affidavit and did not recall it until she was referred to an email that she sent to Peter Stewart on 10 January 2018 updating him on the progress of her investigation.[217] In this email, Ms Frankish provided a synopsis of her interviews with Mr Karpeh, Mr Edwards, Mr Sutton and Mr Shevsov. She stated in her email that the following exchange occurred when she spoke with Mr Shevsov:

> 'Q. Where (sic) you aware that there is a directive alert on CareLink that if the client asked you to leave you were to leave, call the office then try again in about 15-30 minutes?
>
> A. Didn't realise it was a directive, but that had happened a couple of times in the past, but not this time.' [218]

6.15. In the transcript of Mr Shevsov's interview there is no mention of a directive or alert on CareLink, or to whom it would apply.

6.16. Once directed to this email, Ms Frankish stated she recalled this CareLink alert or directive. It does appear that she was aware of such a note at the time she drafted the email to Mr Stewart. It is reasonable to conclude that there must have been a note of some sort on CareLink relating to Mr Norman and what advice should be given if he refused care. However, as to the detail of that note, and how a CAO might become aware of it, this Court has no reliable evidence.

6.17. Ms Frankish stated that if her '*memory served her correctly*', an alert would come up to say '*check something*'. However, Ms Frankish was unable to assist the Court any

[216] Transcript, pages 467-468, 492-494
[217] Transcript, page 471
[218] Exhibit C17, page 48

further in relation to CareLink, or what needed to be done in order to access this note. I make no criticism of Ms Frankish in this regard as CareLink was not a program she used in her day-to-day work at HomeCare+.[219]

6.18. I have concluded that the evidence of Ms Frankish on this topic falls short of establishing, on the balance of probabilities, that Ms Churches ought to have been aware of a CareLink note and acted upon it.

6.19. Ms Frankish agreed that there ought to have been a procedure in place to guide CAOs about what should be done if a client refused care.[220] The development of such a policy was clearly considered at the time of Ms Frankish's investigation, as evidenced by an email she sent to Ms Hendry from the Department of Communities and Social Inclusion on 7 February 2018.[221]

6.20. The procedure considered by Ms Frankish was as follows:

- Where a Client Services Officer becomes aware that a client has refused a shift they will:
  - instruct the worker to remove themselves but stay at the property;
  - call the client and confirm that they don't want the shift, enquire why. Note reason in One Note.
- If the client still refuses the shift the admin worker will:
  - call the worker and instruct them to return to the client and resume the shift.

6.21. Ms Frankish could not recall whether the procedure she outlined in that email was implemented, but that she hoped that it was.[222] Mr Stewart gave evidence that this policy was not implemented and that at the time of the inquest there was no such policy in force at HomeCare+.

6.22. Ms Frankish retired in January 2020.

6.23. The Court heard evidence from Mr Gavin Watson and Mr Peter Stewart as to the actions taken by HomeCare+ since the retirement of Ms Frankish.

---

[219] Transcript, page 476
[220] Transcript, page 487
[221] Exhibit C17, page 38
[222] Transcript, page 481

6.24. In addition to being the Operations Supervisor, Mr Watson was also the manager of Mr Davidson at the time of Mr Norman's death. Mr Watson's evidence was that Mr Davidson had received two formal warnings prior to the death of Mr Norman. The issues identified resulting in those warnings included difficulties managing the administrative aspects of the role, possibly including the failure to respond to incident reports in a timely manner, and issues with updating support plans in a timely manner.[223]

6.25. During his evidence Mr Watson mentioned that when he first commenced with HomeCare+ 16 years ago, support workers would have 10 days of unpaid training prior to their commencement, which at that time was deemed necessary to get a support worker up to the standard required.[224] He recalled that the training decreased over the years and that support workers now undertake one and a half days of induction training. Mr Watson explained that over time HomeCare+ has reduced the amount of training '*to be competitive with all other providers*'. Mr Watson expressed the view that the initial training was '*far better and more rounded than the opportunities of the training that are provided to the workers now*'.[225]

6.26. Mr Stewart also gave oral evidence on the topic of the training of support workers. When he commenced with PQSA, the duration of the training program was five days. Mr Stewart states that in 2014 self-paced pre-learning packages were developed in response to the observation that prospective support workers were not completing the full five days of training, and therefore did not commence work with PQSA. The duration of the training program was decreased to three days.

6.27. In 2017 there were further changes to the support worker induction program. An e-learning program of eight hours duration was introduced which employees were initially expected to complete in their own time, but for which they were paid. The on-site training program was reduced to two days and support workers were paid for their time.

6.28. From 2020, PQSA allowed support workers to complete this training in their first week of employment.

[223] Transcript, page 515
[224] Transcript, page 534
[225] Transcript, page 541

6.29. On the evidence, although the duration of training has changed, its nature has also. Mr Watson gave evidence that approximately 60-70% of new support workers come to the organisation already having obtained relevant certificate qualifications.[226] Mr Stewart's second affidavit describes further in person training and competency assessments with Registered Nurse Consultants in more complex personal care areas, which include in-home assessments, as well as ad hoc further training and competency assessments in client specific tasks and support needs. Support workers also complete e-learning modules on an ongoing refresher basis.

6.30. <u>HomeCare+ response to the death of Mr Norman and Ms Frankish's investigation</u>

6.31. In his affidavit, Mr Watson sets out the response of PQSA to Ms Frankish's recommendations. One of those recommendations related to the implementation of the CareLink SMS module to confirm shift details with support workers, which was under way prior to the death of Mr Norman[227] and has now been introduced. Mr Watson said that this system provides greater certainty to office staff and support workers as to who will be covering a vacant shift. It is to be hoped that in the future this system will prevent confusion such as that which culminated in Mr Norman's Saturday evening shift not being attended by a support worker.

6.32. HomeCare+ has also introduced the CareLink Go application which enables support workers to view their roster in real time on their phone and provides a system for workers to log in and out of each shift. At the time Mr Watson gave evidence this system did not have the capacity for monitoring through '*geo-fencing*', which would allow a support worker's presence at a client's home to be confirmed in real time.[228]

6.33. In oral evidence Mr Watson stated that HomeCare+ was about to undertake an upgrade of CareLink Go.[229] Mr Watson stated, with some trepidation, that this update *should* enable real time monitoring through geofencing, enabling the support workers' location to be determined at the time they log in.[230]

6.34. Mr Watson explained that if the situation with Mr Norman were to arise at the time he gave evidence, prior to the successful upgrade, HomeCare+ would not know until the

[226] Transcript, page 564
[227] Exhibit C18, page 11
[228] Exhibit C18, page 15
[229] Transcript, page 544
[230] Transcript, page 544

next weekday of a failure of workers to attend over the course of a weekend.[231] Even with the upgrade, Mr Watson stated that the situation that arose with Mr Norman could still occur. Whilst the upgrade would assist with auditing to ensure that a worker was where they ought to have been when they logged into a shift, it would not provide a real time alert to HomeCare+ that would then enable immediate action.[232] Mr Watson identified a number of logistical issues that he foresaw with a system that provided an alarm or alert if a support worker failed to log in for an allocated shift at the appointed location. Mr Watson agreed he would give serious consideration to implementing an application that would enable HomeCare+ to be alerted in real time if a support worker failed to attend a rostered shift but said he would defer to the leadership team on that issue.

6.35. Mr Watson gave evidence that HomeCare+ was attempting to recruit a '*senior mobile support worker*'. Based on Mr Watson's description of this position, it appears that this appointment would provide a level of supervision of support workers, assisting to ensure that support workers are performing their tasks appropriately.[233]

6.36. In his evidence, Mr Stewart stated he understood that the update to CareLink would in fact allow for real time notification if a support worker did not log in for a rostered shift. However, he acknowledged that Mr Watson was much more au fait with CareLink than he was. Mr Stewart stated that a real time alert for failure of a support worker to log in at a shift was something he would like to see in place, and if the technology were available, he would consider it a high priority for HomeCare+ to implement.[234]

6.37. <u>A proposed procedure to govern refusals of care</u>

6.38. Mr Stewart acknowledged that HomeCare+ should have responded differently when Mr Norman refused care on 6 January 2018.

6.39. However, Mr Stewart, in his oral evidence, stated that he had not introduced a policy or procedure to govern refusals of care since the death of Mr Norman. Mr Stewart

[231] Transcript, page 547
[232] Transcript, page 550
[233] Transcript, page 560
[234] Transcript, page 609

explained that it was difficult to have a procedure to cover every eventuality and expressed a view that there should be a plan for each individual client.[235]

6.40. Mr Stewart supported the implementation of the following procedure:

- If a client refuses a care service or asks the support worker to leave before completion of a rostered shift, the worker must leave the room and call the office;
- The Client Administration Officer who receives that call must fill out an incident report at the time of the call;
- If the incident occurs during business hours, the CAO must then call the Client Services Officer to advise them that the client has turned away the support worker;
- If the incident occurs outside of business hours, the CAO must notify the Senior CAO;
- The CSO or the Senior CAO should then attempt to contact the client to ascertain why care was refused, unless there is a particular plan in place for that client stipulating otherwise, and that plan is deemed appropriate by the CSO or Senior CAO given the circumstances existing at the time care is refused;[236]
- If the client can be contacted, specific inquiries will be made to ascertain why the service was refused, and those reasons documented. An offer will be made to have the support worker return to complete the shift or, if practicable, to arrange for a different support worker to attend; [237] and
- If the client cannot be contacted, the on-call supervisor or Senior CAO must be notified.

6.41. It was not suggested that a procedure be implemented in the precise terms set out above. It is acknowledged that this is a complex issue that merits close consideration.

6.42. Mr Stewart agreed that it was important for all disability service providers to have a policy in place to cover the situation when a client refuses care, whether that policy is general or specific to individual clients.

[235] Transcript, page 601
[236] Transcript, page 604
[237] Transcript, pages 606, 610-611

7. Cause of death

7.1. Dr Neil Langlois, a Senior Specialist Forensic Pathologist at Forensic Science South Australia, who is also an Associate Professor of the University of Adelaide, conducted a post-mortem examination, comprising a full autopsy. His report was tendered[238] and he gave oral evidence, the principal topics being the cause of death and whether a time of death could be ascribed for Mr Norman.

7.2. The major pathological findings included a cirrhotic and fatty liver, left ventricle chamber dilated with fibrosis, bruises and abrasions in keeping with falls, and a gliotic region brain, in keeping with a history of previous head injury.

7.3. In his report Dr Langlois cited the cause of death as chronic alcoholism. He stated that it is recognised that sudden death can occur in chronic alcoholics when they have no detectable alcohol in the blood, commonly in the presence of fatty change of the liver. The mechanism is unclear.

7.4. No alcohol was detected in the blood specimens taken from Mr Norman during the autopsy.

7.5. In his oral evidence Dr Langlois stated that the explanation for sudden death in alcoholics with no detectable alcohol in their blood is '*elusive but nonetheless it definitely happens*'. He stated that death from alcohol withdrawal is '*almost a negative finding*' in that there are no other pathological findings to account for the death. Based on the information he had at the time of the post-mortem examination, he formed the view that the probable cause of death was withdrawal from alcohol.[239]

7.6. Dr Langlois was later provided with the two affidavits of Probationary Constable McElroy,[240] containing further information about the position of Mr Norman's body.

7.7. In relation to the observation made by Probationary Constable McElroy that Mr Norman's chin was forced to his chest, Dr Langlois stated that this position could have obstructed the airway and therefore caused asphyxia of the person, a phenomenon known as '*postural asphyxia*'.[241] Due to the absence of photographs, it

[238] Exhibit C2a
[239] Transcript, pages 306-311
[240] Exhibits C5 and C5a
[241] Transcript, pages 298, 308

was not possible for Dr Langlois to assess the degree to which the neck was flexed. He said:

> 'If there is a very flexed neck and the chin is very much on the chest it would support postural asphyxia and if the neck was not of course then it would definitely exclude this particular form of postural asphyxia'.

7.8. Dr Langlois reviewed the photographs taken at the post-mortem examination and noted a parchmented abrasion on the right side of Mr Norman's chest. A parchmented appearance may be associated with an abrasion sustained at or around the time of death.[242]

7.9. This parchmenting, in combination with the description of Probationary Constable McElroy, raised in the mind of Dr Langlois the possibility that Mr Norman had been on his back with his neck markedly flexed and his head slightly to the right, putting his chin to the area of parchmented skin on the chest. However, while this position would be '*in keeping with*' postural asphyxia, he could not say whether postural asphyxia resulted.[243]

7.10. Dr Langlois noted that without photographs a diagnosis of postural asphyxia, by reference to abnormal flexing of the neck, is difficult to make. Police body worn camera footage might have provided enough information, however without a visual record, Dr Langlois was unable to determine whether the position of Mr Norman's body resulted in postural asphyxia or was otherwise relevant to the cause of death.

7.11. Dr Langlois agreed that it would be ideal for attending police to take photographs of the deceased in situ and to utilise a body worn camera.

7.12. Dr Langlois refuted the suggestion put to him by counsel for HomeCare+ that postural asphyxia is relevant only if the person was intoxicated at the time. He explained that a recent paper of his colleague Professor Roger Byard deals specifically with people who are intoxicated because they end up in unusual positions sometimes due to a lack of coordination or impairment of judgement and are unable to get themselves out of that position, resulting in asphyxia. In the opinion of Dr Langlois, a man with right

[242] Transcript, pages 300-301; Exhibit 2e
[243] Transcript, pages 308-309

sided hemiplegia could also get himself into the same position and not be able to get out of it.[244]

7.13. Dr Langlois was also unable to exclude the possibility that Mr Norman was intoxicated when he got himself into the position described, leading to a partially obstructed airway. He may then have lain on the floor, metabolising alcohol and exhausting. If the position resulted in a completely obstructed airway, causing an inability to breathe for more than a few minutes, death would result. If the airway were only partially obstructed, death may have taken an hour or more while Mr Norman became exhausted and eventually stopped breathing.

7.14. Dr Langlois was unable to exclude the possibility that Mr Norman's death preceded the fall. He hypothesised that Mr Norman could have been in his wheelchair and had a seizure or a fit due to alcohol withdrawal, and then slid out of the chair. He considered it equally likely that he could have died in the process of moving from the bed to the chair or trying to get up into his chair. Due to the lack of specific findings at autopsy, he could not draw any definite conclusions about how Mr Norman ended up on the floor, when he ended up on the floor and how the timing of that was related to his death.[245]

7.15. Dr Langlois did not find any pressure areas or ulcerations. He stated he would expect to see some damage to the skin if Mr Norman had been trapped for a number of hours struggling to breathe but the absence of such damage does not exclude that he was there for hours.[246]

7.16. The results of biochemical analysis of the vitreous humor from the eyes and the cerebrospinal fluid were within the normal range and did not assist in determining the time of death.

7.17. <u>Date of death</u>

7.18. In his report Dr Langlois gave a date of death as '*on or about 6 January 2018*' which, he cautioned in evidence, was an approximation. He explained that he arrives at an approximate time of death by considering when the person was last seen alive, when they were found deceased, any onset of decomposition, and the ambient temperature

[244] Transcript, page 331
[245] Transcript, page 333
[246] Transcript, page 323

of the room where the body had been. Dr Langlois also stated that the presence or absence of rigor mortis may provide information about the time of death. He stated that the rule of thumb is that if a body is perceived to be cool and stiff, death has occurred 8 to 36 hours prior to being found, depending on the ambient conditions.

7.19. Probationary Constable McElroy perceived Mr Norman's body to be cool and stiff on Sunday afternoon, as did Mr Sutton, and the ambulance officers confirmed the presence of rigor mortis. Taking these matters into account, Dr Langlois agreed that the probable window for the time of Mr Norman's death was from 8am Saturday to 9am on Sunday.

7.20. Discussion as to the cause and circumstances of death

7.21. Upon the evidence, alcohol withdrawal and postural asphyxia arise as differential causes of death with no other cause or potential causes evident.

7.22. The evidence clearly establishes that Mr Norman was a chronic alcoholic who consumed alcohol each day and was heavily intoxicated every night.

7.23. Dr Langlois gave evidence that a person who habitually consumes relatively large amounts of alcohol can require a moderate level of blood alcohol, around a level of 0.1%, to function and get through the day.

7.24. It is clear that by the time Mr Norman died, he had metabolised all the alcohol remaining in his body since his last drink. Dr Langlois was unable to assist the Court with a likely timeframe for this to occur. I simply cannot say whether Mr Norman's blood alcohol level was zero by the time Mr Shevsov left after attending on Saturday morning, or whether this occurred later.

7.25. The evidence strongly suggests that if on any day Mr Norman was not assisted in the morning with transfer from his bed to his wheelchair, he would have attempted to get up in order to obtain alcohol, if for nothing else.

7.26. In Mr Sutton's opinion, it did not appear that Mr Norman had left his room since Friday evening.[247] He said that if Mr Norman got up on Saturday, he would have had something to drink and he would have spilled it (in the living room). Mr Sutton said that after finding Mr Norman deceased, while looking around the house he observed

[247] Exhibit C12, page 40

that the floors were clean and there was no alcohol spilled on the floor. I note that Probationary Constable McElroy said that there was a half-consumed packet of corn chips and two half empty Coke containers in the living room. From Mr Sutton there is no specific evidence as to whether these were present when he left on Friday night, although he said he mopped the floor and '*cleaned up generally, including picking up cups*'.[248]

7.27. It is conceivable that Mr Norman got himself up during the night to go to the toilet and, while he was up, ate corn chips and Coke. However, in the absence of evidence, this is just speculation.

7.28. Mr Norman's bed was soiled with faeces which might suggest, although not conclusively, that he did not get up to go to the toilet.

7.29. Having regard to the lack of evidence of alcohol being consumed in the living room it seems more likely than not that Mr Norman did not make it into the living room after Mr Shevsov left on Saturday morning.

7.30. However, the possibility that Mr Norman transferred into his wheelchair, went out to the living room, consumed corn chips and Coke but not alcohol, and then went back to the bedroom with a view to getting back into bed cannot be confidently dismissed.

7.31. It is clear though that once Mr Shevsov was turned away on Saturday morning, at some stage Mr Norman either attempted to transfer out of his bed and into his wheelchair, or successfully transferred, left his bedroom, then returned and attempted to transfer back into bed.

7.32. The position of Mr Norman's wheelchair at the time he was found deceased is relevant. When Mr Sutton made his statement, he said the wheelchair was where he would have left it on Friday night.[249] However, in evidence he said it was a little further away from the bedside cabinet, in a position which would allow Mr Norman to get into it. Usually when being assisted to get out of bed, Mr Norman's carer would place his bathroom chair in that position and take him straight to the bathroom. It might be thought from the position of the wheelchair that Mr Norman had got up at some stage and come back to bed. However, Mr Sutton said it was possible for

[248] Exhibit C12
[249] Exhibit C12

Mr Norman to get into a sitting position on the bed and then to reach the controller of the electric wheelchair, which might explain how it could have been moved by Mr Norman into a position ready for transfer from his bed, without getting off the bed.[250]

7.33. Whether Mr Norman died of chronic alcoholism or of postural asphyxia, it is evident from the position in which he was found that he had suffered a fall, whether from the bed whilst attempting to transfer to the wheelchair, or from the wheelchair whilst attempting to transfer back to the bed.

7.34. There is a plausible argument on the evidence that Mr Norman died relatively instantaneously, most likely as a result of a terminal seizure or fit associated with chronic alcoholism, rather than more slowly as a result of postural asphyxia, which according to Dr Langlois would have taken minutes, or longer with a partially obstructed airway.

7.35. A sudden death would explain why Mr Norman did not activate his call alert pendant or make a telephone call.

7.36. On the other hand, there was no reliable evidence by way of photographs or video from which to exclude postural asphyxia; nor can it be excluded that Mr Norman was somehow rendered incapable, in the aftermath of a fall, from calling for help. Postural asphyxia is a cause of death which remains a real possibility. Dr Langlois explained that Mr Norman's right sided hemiplegia may have prevented him from extracting himself from a position which obstructed his airway and led to his death.

7.37. A fall could have been caused by Mr Norman's right sided hemiplegia and an inability for that reason to physically manage an attempted transfer. If this occurred it was not the fall itself, or injuries from it, which caused his death. He may have suffered a terminal seizure or fit due to alcohol withdrawal post fall or have then found himself in a position from which he could not extricate himself and died from postural asphyxia.

7.38. In the end, every scenario involves such a degree of speculation as not to permit a finding as to whether alcohol withdrawal or postural asphyxia is the more probable cause of Mr Norman's death.

[250] Transcript, pages 50-51

7.39. Accordingly, as I am unable to determine the precise mechanism which led to Mr Norman's death, or the cause of his death, with any certainty, I shall enter a finding that the cause of death is unascertained.

8. Conclusion and findings

8.1. To the extent that conclusions can be drawn as to the circumstances leading up to the death of Mr Norman, and of his death, they have been detailed throughout this Finding.

8.2. In relation to the systems failures which contributed or may have contributed to his death, in addition to specific conclusions previously detailed, I find:

8.2.1. There was tension in the relationship between Mr Shevsov and Mr Norman which may have contributed to the refusal of care by Mr Norman on 6 January 2018 and Mr Shevsov's response to that refusal of care. Mr Shevsov no longer wished to provide care to Mr Norman, and he ought to have been replaced by another support worker prior to 6 January 2018. That he was not, was due to a combination of factors including the difficulty finding support workers for Mr Norman's support team and the Enterprise Agreement, which inappropriately placed the onus upon Mr Shevsov to find coverage for his shifts with Mr Norman.

8.2.2. At the time of Mr Norman's death HomeCare+ did not have an adequate procedure in place to ensure that appropriate steps were taken when a client refused the provision of essential care services. HomeCare+ did not, at the time the evidence in the inquest was heard, have such a procedure.

8.2.3. There was a failure by HomeCare+ to take appropriate action in response to Mr Shevsov advising the office that Mr Norman had refused care. Mr Shevsov should have been instructed to make further efforts to persuade Mr Norman to accept care. This would not have amounted to an inappropriate attempt to interfere with Mr Norman's personal choices.

8.2.4. If, on Saturday 6 January 2018, Mr Shevsov had been instructed to make and persist with efforts to persuade Mr Norman to accept his care, there would have been an increased likelihood that Mr Norman would have done so. It

must be acknowledged that even then there is no certainty that Mr Norman would have accepted Mr Shevsov's care and, if Mr Norman had accepted his care, there would have been no need for him to attempt to self transfer.

8.2.5. It cannot be concluded that Mr Norman's acceptance of Mr Shevsov's care would have prevented his death. However, depending on the time, the cause and the immediate circumstances of his death, it may have.

8.2.6. The non-attendance of a support worker to provide care to Mr Norman on the evening of Saturday 6 January 2018 resulted from Mr Davidson's failure to comply with the shift coverage procedure and the failure of the administrative staff to follow Mr Davidson's instructions in his handover note. A contributing factor was that Mr Karpeh did not return calls from HomeCare+, but it remains the case that his allocation to that shift was not confirmed. HomeCare+ was responsible for that. It was the responsibility of HomeCare+ to ensure that a support worker attended for each and every one of Mr Norman's required shifts.

8.2.7. The evidence does not permit me to find, however, whether or not Mr Norman was already deceased by the time a support worker was due to attend on the Saturday afternoon. For that reason, it cannot be said that Mr Norman's death would have been prevented if a support worker had attended. Again, depending on the time, the cause and the immediate circumstances of his death, it may have.

8.2.8. At the time of Mr Norman's death, HomeCare+ had inadequate systems in place to ensure that support workers knew when they were due to attend shifts, and to ensure that they in fact attended those shifts.

8.2.9. There is very little likelihood that Mr Norman was still alive by the time Mr Edwards was due to attend for his shift on Sunday 7 January 2018. For this reason, his attendance for that shift as scheduled is not likely to have prevented Mr Norman's death.

8.3. In conclusion, the death of Mr Norman was potentially preventable had HomeCare+ provided care in the manner in which I have concluded that it ought to have done.

9. Recommendations

9.1. Through counsel for HomeCare+ and its senior executives, recommendations here made have been accepted in advance by HomeCare+ and, by the time of delivery of this Finding, some may have been implemented:

1) That HomeCare+ renegotiate the Enterprise Agreement to amend clause 15.4 such that the responsibility for shift coverage rests with the administrative staff.

2) That HomeCare+ amend its Shift Coverage Procedure and Position Descriptions in accordance with the renegotiated Enterprise Agreement.

3) That HomeCare+ develop a Client Refusal of Care Procedure and ensure that all staff receive appropriate training in relation to that procedure.

4) That HomeCare+ continues to explore the implementation of a system to enable the attendance of support workers to be monitored, such that HomeCare+ is notified in real time of any non-attendance, enabling appropriate action to be taken in response.

Key Words: Chronic alcoholism; Support Workers; HomeCare+

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 20th day of September, 2023.

State Coroner