MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, have investigated the death of Barbara Westcott

With an inquest held in Hobart on 14, 15, 16, 17, 18 December 2015 and 1, 2, 3, 4, 5 February 2016 and 30 May 2016.

Appearances

Counsel assisting	R Munnings
Baldwin Care Group	K Mooney
Bupa Care Services Pty Ltd	B Clarke
Sharon Moss	R Phillips

Introduction

Issues at Inquest

Mrs Barbara Westcott died on 31 March 2012, aged 84 years at Vaucluse Gardens aged care facility in South Hobart, where she was a resident.

By section 28(1) of the *Coroners Act* 1995 ("the Act") I am required to make findings, where possible, as to various matters, including:

a) The identity of the deceased;
b) How death occurred;
c) The cause of death;
d) When death occurred; and
e) Where death occurred.

Pursuant to Section 28(2) of the Act I am required, where appropriate, to make recommendations with respect to the following:

(i) Ways of preventing further deaths; and
(ii) Any other matter considered appropriate.

By section 28(3) of the Act I am permitted to comment on any matter connected with Mrs Westcott's death, including matters pertaining to public health or safety.

The evidence established that Mrs Westcott died in her room at Vaucluse Gardens as a result of positional asphyxia due to her head and neck being trapped between her mattress and a removable bed pole. The bed pole that was fitted to her bed at the time of death was a KA524 model, comprising a steel horizontal rod, which lay unfixed under the mattress, with two upright steel poles attached to the horizontal. These upright poles protruded on either side of the bed. As a mobility device, a resident with such a bed pole could hold the uprights of the pole to assist her/him to roll over in bed, to sit up in bed or to get out of bed. A resident could also hold the poles whilst care staff were mobilising him/her.

Before the commencement of the inquest, the existing evidence indicated that Mrs Westcott died between about 9.00pm and 11.30pm on 31 March 2012. The evidence was that she was discovered apparently deceased on the floor of her room next to her bed in a kneeling type position, with her head facing the floor and trapped between the edge of the bed and the upright pole of the bed pole. The evidence contained uncertainty and some conflict as to when Mrs Westcott was last checked before her death, the extent of her mobility and circumstances surrounding the installation of the bed pole.

The forensic pathologist, Dr Donald Ritchey, determined after autopsy that the cause of death was asphyxia from entrapment in the bed pole. However, the subsequent investigation did not uncover evidence to enable me to determine exactly when Mrs Westcott became entrapped, the time of death and how she came to be trapped in the bed pole. Before inquest there was evidence that Mrs Westcott was extremely limited in her mobility, to the point that she was unable to roll over. Therefore, there was a significant focus upon this issue at inquest, particularly given that she had apparently been lying in a supine position on her bed and had died whilst on the floor. In particular, the scenarios considered at inquest were as follows:

(i) Whether Mrs Westcott deliberately or accidentally rolled herself off the bed;
(i) Whether a member of staff accidentally rolled Mrs Westcott off the bed; or
(ii) Whether another person deliberately rolled Mrs Westcott off the bed.

In addition to the above relating to the immediate circumstances leading to Mrs Westcott's death, there were also other matters which, upon the evidence, were relevant to the wider question of causation.

Firstly, the investigation revealed that in 2011 there was a promise by Vaucluse Gardens to Mrs Westcott's family to ensure that she was checked on a half-hourly basis. It appeared from affidavits of various care staff that staffing levels were inadequate to provide such checks, and that Mrs Westcott had not been the subject of half-hourly checks in the approximately 3 hours before her death. Therefore, evidence at inquest focused upon the ability of Vaucluse Gardens to provide half-hourly checks, whether such checks were clinically necessary for Mrs Westcott, and whether, if those checks had been provided in the time before her death, her death could have been prevented.

Secondly, the investigation also revealed that on 9 June 2010, over 9 months before Mrs Westcott's death, a South Australian coronial finding warning of the dangers of entrapment and asphyxiation in bed poles had come to the attention of Vaucluse Gardens by an email

from the Department of Health and Ageing to management ("the alert"). In that finding the Coroner made certain recommendations about the circumstances in which bed poles should not be used.

The evidence available before the commencement of the inquest did not satisfactorily answer the question as to when or why Mrs Westcott's bed pole was installed, the reason it remained installed or the response by Vaucluse Gardens to the alert.

In light of the above, the following matters were examined at inquest:

a) The circumstances of death;

b) Mrs Westcott's state of health and mobility;

c) Circumstances surrounding failure to remove Mrs Westcott's bed pole;

d) Response by Vaucluse Gardens to the alert;

e) Opportunities to have reviewed Mrs Westcott's bed pole;

f) Actions that should reasonably have been taken with respect to Mrs Westcott's bed pole;

g) Whether inadequate staffing levels contributed to Mrs Westcott's death, and in particular the failure to provide half-hourly checks before her death; and

h) Actions of Vaucluse Gardens immediately after Mrs Westcott's death.

At the inquest, 20 witnesses gave oral evidence over the course of 10 hearing days. The witnesses comprised attending police and ambulance officers, medical practitioners, the forensic pathologist, nursing/care staff, management and agents of Vaucluse Gardens, and Mrs Westcott's daughter. The documentary evidence comprised all relevant witness affidavits, medical reports, photographs, police and ambulance records, correspondence, documentation and records of Vaucluse Gardens, and Commonwealth Department of Health and Ageing (DoHA) records.

Much of the evidence was not actively the subject of contention. However, there were significant areas of uncertainty in the evidence. Where the evidence was the subject of contention or uncertainty, it is discussed in detail in the finding.

In the weeks leading to the inquest a large amount of further documentation from Vaucluse Gardens was produced upon request. This documentation had not previously been provided. This process of document production was prolonged due to difficulties in accessing the server used for the records at the relevant time and difficulty in locating hard copy records. Whilst it appears that some documents may not have been retrieved, the documents that were ultimately produced provided a measure of clarification of some issues in the inquest. I will deal further in this finding with the apparent lack of documentation in some key areas.

Mrs Westcott

Mrs Westcott was born on 20 October 1927. For over 60 years she was married to William Robert Westcott and together they had five children. Mr and Mrs Westcott lived at 71 Central Avenue, Moonah for the duration of their married lives. Mrs Westcott remained at that property following her husband's death in 2007. Mrs Westcott kept private the state of her health. It was not until after her husband's death that the family learned that she had been diagnosed with Parkinson's disease. Initially Mrs Westcott was cared for in her home by her family and community health workers. However, it became evident to her family that she required a high level of care, including during the night. Mrs Westcott therefore made the difficult decision to move into an aged care facility.

In August 2009, at the age of 81 years, she became a resident of Vaucluse Gardens. Her family described her as a private and proud person. Mrs Westcott's family were particularly close. One of Mrs Westcott's daughters, Judith James, who was a trained nurse, took on particular responsibility for her mother's care. Mrs Westcott's son, Mark Westcott, was also particularly involved in his mother's care. Sadly, he passed away on 21 July 2014, before the hearing of the inquest. Both Mrs James and Mr Westcott continued to be involved in the care of their mother while she was at Vaucluse Gardens, and visited her regularly.

Initially when Mrs Westcott became a resident of Vaucluse Gardens she was able to walk and perform tasks independently. However her health deteriorated, particularly throughout the last year or two of her life. As discussed further, at the time of Mrs Westcott's death she was virtually immobile.

Vaucluse Gardens

At the time of Mrs Westcott's death, Vaucluse Gardens was owned and operated by Baldwin Care Group ("Baldwin"). On 11 June 2012, the facility was sold to Bupa Care Services Pty Ltd ("Bupa").

The facility consists of three separate buildings: the Manor, the Court and the Lodge. Mrs Westcott moved into the Manor which accommodated people who required, variously, low, medium and high levels of care.

The Manor spans four storeys and comprises 30 separate residential rooms, kitchen and laundry facilities, a number of store rooms and a communal dining/lounge room. A nurse's station is situated on Level 3 (ground entry level) and there is a small office on Level 4. The four storeys are accessible by lift and stairs. However, for security and safety reasons, access to the stairs is generally restricted to staff. Mrs Westcott occupied room 25 on the fourth floor for the whole of her time at the Manor.

The residents at the Manor were cared for by Registered Nurses (RNs), Enrolled Nurses (ENs) and Extended Care Assistants (ECAs). In general terms, a RN working at Vaucluse Gardens has the highest level of qualification, the ability to administer medication, perform administrative duties and has a high level of responsibility. An EN has a lower level of qualification, less responsibility and provides nursing care under the direction and

supervision of a RN. An EN may be qualified to administer medications. The role of an ECA is limited to the care needs of the residents. An ECA does not require nursing qualifications and is not able to administer medication to residents. An ECA is supervised by an EN and RN.

In general terms, the Manor was staffed by an EN with several ECAs during day shift. During night shift and at the time of Mrs Westcott's death the Manor was staffed by one ECA. Other staff, including RNs that were based at the Lodge, would be available to assist in the Manor if required.

The Circumstances of Death

I now examine, under various headings, the evidence of how Mrs Westcott came to be entrapped in the bed pole leading to her death.

In this finding, I use the terminology of "bed pole" and "bed stick" in particular contexts but the meaning is the same. The evidence at inquest, and the medical records, did not differentiate between the two terms for referring to the same item, even though there are different types of these devices. I have used the term "bed stick" to replicate the terms used by various witnesses.

The inquest heard from the nurses and care staff who were caring for Mrs Westcott at relevant times, as well as police and ambulance officers who were called immediately upon discovering her. The inquest also heard evidence from senior management staff and an independent consultant who spoke to the care staff the day after Mrs Westcott's death.

The time and circumstances of discovery of Mrs Westcott

Ms Michelle Sorrentino, an ECA, worked on the night shift in the Manor on 31 March 2012. Her rostered shift hours were 11.00pm until 7.00am the following morning. Ms Sorrentino was undertaking her first round for this shift when she entered Room 25, being Mrs Westcott's room. She found Mrs Westcott in a kneeling-type position, motionless on the ground beside her bed with her neck trapped between the upright of the bed pole and the side of the bed.

In oral evidence to the inquest, Ms Sorrentino stated that she did not attempt to move Mrs Westcott from that position and offered two explanations for why that was so. Firstly, as an ECA she was not permitted to move Mrs Westcott. She stated that when residents had falls, the ECAs were only allowed to make them "*comfortable*" pending the arrival of a RN. Secondly, she told the inquest that upon sighting Mrs Westcott, she immediately formed the belief that Mrs Westcott was deceased. As she regarded it as a "*crime scene*" she thought that she was not allowed to touch Mrs Westcott.

In her affidavit sworn in May 2012, Ms Sorrentino stated that she located Mrs Westcott at 11.30pm. However in oral evidence she said that it was 11.33pm. She told the Court that the time of 11.33pm had specifically, "*stuck in [her] head*". Constable Raymond Guy and Detective Constable Mark Brazendale were two members of the Tasmania Police Service

who attended Vaucluse Gardens in response to Mrs Westcott's death. In evidence to the inquest, both officers stated that they had been told by Ms Sorrentino at the scene that she had found Mrs Westcott at 11.37pm. Constable Guy recorded that information in his police note book and the document was tendered during the proceedings.

Ms Sorrentino gave evidence that 10 seconds after entering Mrs Westcott's room she contacted the RN on duty in the Lodge using a portable phone. She said that Ms Mary Kamau, RN, arrived within 30 seconds. In oral evidence Ms Kamau stated that she received the call from Ms Sorrentino at approximately 11.30pm and immediately went to room 25.

Ms Kamau gave detailed evidence about her observations of Mrs Westcott. She said that Mrs Westcott's body was completely off the bed, with her neck caught in the 90 degree part of the bed pole that was protruding from the side of the mattress. She stated that Mrs Westcott was facing towards the floor and her hands were hanging down. Her knees were on the ground and her legs were laying on the metal base component of a portable tray table that was adjacent to, and partly beneath, Mrs Westcott's bed. Ms Kamau explained that the tray table was stuck under Mrs Westcott's weight, which she estimated to have been 100kg.

At the inquest Ms Kamau and Ms Sorrentino gave inconsistent accounts about the checks which were undertaken of Mrs Westcott and whether attempts were made to extract her from the "hanging" position. Ms Sorrentino stated that neither she nor Ms Kamau attempted to move Mrs Westcott. She had a memory that Ms Kamau checked for a pulse, but stated that Ms Kamau did not go very close to Mrs Westcott's body and did not get down on the floor to examine her. Her evidence was that Ms Kamau checked Mrs Westcott "*very, very quickly*" and then left the room to make some phone calls. In contrast, the evidence of Ms Kamau was that she attempted to move Mrs Westcott a number of times. She stated that the position of the tray table prevented Ms Kamau from accessing Mrs Westcott's head/face as well as from extracting her from that position. Ms Kamau explained that she tried to move Mrs Westcott by herself but was unsuccessful because Mrs Westcott was too heavy. She said, "*The table could not even move an inch*". Her evidence was that two people were needed to simultaneously move the tray table and release Mrs Westcott's neck from the bed pole. Because she did not know the extent to which Mrs Westcott was caught in the pole, Ms Kamau told the Court that she was fearful that by moving the tray table alone it would cause Mrs Westcott to be strangled. Ms Kamau gave evidence that at one point she asked Ms Sorrentino to assist her but Ms Sorrentino was too hysterical to be of any use. Ms Kamau stated that she checked the pedal and radial pulses and could not feel anything. She was unable to see Mrs Westcott's face and so placed her hands on Mrs Westcott's body to feel for signs of breathing. There were no such signs.

The Court received into evidence a recording of the 000 call made by Ms Kamau after she had checked Mrs Westcott's pulse. The content of the recording largely corroborates the evidence which Ms Kamau gave at the inquest regarding her inability to move Mrs Westcott. It also clearly conveys her panic and distress at the situation.

Ms Kamau told the inquest that she rang for an ambulance at 11.31pm or thereabouts and it took 10 minutes for it to arrive. Ambulance Tasmania's electronic "Guardian" system records indicate that Ms Kamau's call was actually received at 11.41pm, and that paramedics Brett

Norris and Adam Marmion arrived at Vaucluse Gardens at 11.53pm. Although the Ambulance Tasmania Electronic Patient Care Report states that the initial call was received at 11.51pm, I note the evidence that this report was completed manually using time estimations only. I therefore prefer the electronic record, which accords with the other evidence regarding the approximate time of discovery of Mrs Westcott and of the evidence of police officers regarding their arrival time.

The description of the scene included in the Ambulance Patient Care Report is consistent with the evidence given by Ms Kamau and Ms Sorrentino. In oral evidence, Mr Marmion stated that the space between the mattress and the bed pole was roughly the width of Mrs Westcott's neck. Constables Teal Stanley and Raymond Guy arrived at the scene shortly after 11.55pm. By the time police officers arrived at the scene, the ambulance officers had just arrived and had extricated Mrs Westcott from her entrapped position, and she was positioned on her back on the floor. Constable Stanley gave evidence that whilst she was at the scene, she was told that Mrs Westcott's neck had been caught in the bed pole and that her knees were "trapping" a meal trolley. Constable Stanley identified the meal trolley in the relevant photograph of the room tendered in evidence.

Ms Sorrentino described the scene as a "*panic situation"* which was also "*creepy"* and "*quite scary*". She told the inquest that she had never before encountered a resident in such a situation. Ms Sorrentino admitted that she did not remember much about what Ms Kamau did when she entered Mrs Westcott's room. Ms Kamau was clearly distressed by the situation. I accepted Ms Sorrentino's evidence that the situation was one of panic and fear. I note that Ms Sorrentino was ill-equipped to assist by virtue of lack of current knowledge of first aid procedures and knowledge of testing for signs of life. Ms Kamau's evidence was coherent, sufficiently detailed and credible. There was ample reason for the details of her confronting experience to be imprinted upon her memory. She was the RN and therefore in charge of the situation as between her and Ms Sorrentino. I accept Ms Kamau's evidence and prefer it where there is conflict between her evidence and that of Ms Sorrentino as to the actions in the room.

Before the inquest took place, the evidence indicated that the 000 call was received at 11:51pm. It appeared that there was a long period of time, potentially 20 minutes, between the time Ms Sorrentino discovered Ms Westcott trapped in the bed pole and the time of the ambulance call. Concerningly, this appeared to be unaccounted for, with Mrs Westcott remaining trapped. Given the unknown circumstances of Mrs Westcott's entrapment and the fact that she was still in this position upon the arrival of the ambulance officers, it was important to examine the time frame and the actions of those discovering Mrs Westcott.

After the evidence at inquest emerged, I find that it was likely to be closer to 11:37pm when Ms Sorrentino discovered Mrs Westcott, in which case only four minutes elapsed until the ambulance was called by Ms Kamau. Whether it was four minutes or slightly longer, this period was reasonably accounted for by Ms Sorrentino calling Ms Kamau to come from the Lodge and then both of them assessing and trying to extricate Mrs Westcott. I am satisfied that both Ms Sorrentino and Miss Kamau did try to extricate Mrs Westcott. I am further satisfied that they were in a significant state of panic and fear and were not able to think as

clearly as was desirable for effective action at that stage. I found the evidence of the positioning of Mrs Westcott's body difficult to understand in terms of how it was said to be difficult to move Mrs Westcott. I do accept however that somehow her body became lodged in the mobile tray table with her neck wedged on the horizontal part of the bed pole.

Thus, the attempts that were made by Ms Sorrentino and Ms Kamau were not effective because of their state of shock and panic, the position of Mrs Westcott's body, and concern that they might further suffocate her. Ms Sorrentino in particular, in her state of high emotion, was not able to provide great physical assistance or moral support to Ms Kamau. The ambulance officers gave evidence that they were able to extricate Mrs Westcott from her position without significant difficulty, although they indicated that it was a two-person task. Mrs Westcott's weight was 78.2 kilograms and her height was 1.58 metres. In her wedged position, I accept that two persons thinking calmly and clearly were required to dislodge her.

Ultimately, I conclude that both Ms Kamau and Ms Sorrentino tried to act in the best interests of Mrs Westcott in a distressing situation and there was no untoward delay in calling the ambulance. It also follows that I am satisfied that neither staff member witnessed her becoming entrapped or were involved in her death.

Was Mrs Westcott deceased when she was discovered by Ms Sorrentino?

Ms Sorrentino told the Court that she touched the back of Mrs Westcott's leg when she first entered her room and it was cold. Ms Sorrentino described the skin as being a "*motley colour*". Ms Kamau gave evidence that she did not know whether Mrs Westcott was deceased or not at the time she made the 000 call. This was because Ms Kamau had been unable to check all of Mrs Westcott's vital signs, including her pupils and airways. However, Ms Kamau stated that Mrs Westcott was non-responsive, cold to touch and that her legs were blue in colour. Nothing indicated to Ms Kamau that Mrs Westcott was breathing and she was unable to find a pulse.

Mr Marmion's affidavit discloses that Mrs Westcott's pupils were dilated, she was not breathing and did not have a pulse. Mr Marmion gave evidence that Mrs Westcott was "*very obviously deceased*". He was well-qualified to make that assessment, and I accept his evidence that, when he examined her at about 11.54pm, Mrs Westcott was deceased. He described that her skin was cold, she was clammy and there was evidence of post-mortem lividity. Both Mr Marmion and Mr Norris gave evidence that they were not qualified to say for how long Mrs Westcott may have been deceased. However, I accept the evidence of Mr Marmion that the onset of lividity is at least 10 minutes after death. Mrs Westcott was formally pronounced deceased at 11.57pm.

Dr Ritchey performed an autopsy upon Mrs Westcott on 2 April 2012. In the course of giving evidence to the inquest, Dr Ritchey stated that he could not comment upon how long Mrs Westcott had been deceased from examining her body or from looking at the photographs of her at the scene. He also could not comment upon how long it would have taken Mrs Westcott to die after having become entrapped. He stated, however, that in the context of her apparent immobility, unconsciousness would have occurred very quickly - in less than one minute.

Dr Ritchey stated that to determine whether someone is deceased, one is required to be certain of the following matters: (a) that there is no heartbeat; (b) that there are no reflexes; and (c) there is no respiration. Ms Kamau was not able to properly check Mrs Westcott's breathing due to her position, nor her airways. She could not feel a pulse but did not give evidence that she checked her chest. There is no evidence that Miss Kamau checked for reflexes or pupils. In these circumstances, neither Ms Kamau nor Ms Sorrentino could have properly known whether Mrs Westcott was alive or deceased.

However, having regard to all of the evidence, including the length of time for which Mrs Westcott was alone in her room and her state of lifelessness upon discovery, it is highly unlikely that Mrs Westcott was alive at the time of Ms Sorrentino entering her room. I find that Mrs Westcott was deceased by the time she was discovered at or just before 11.37pm on 31 March 2012.

When was Mrs Westcott last seen alive and by whom?

Before the inquest hearing, the evidence suggested that Mrs Westcott was last seen alive by ECA Kerime Abay who briefly checked upon her in her room at a time between 8.00pm and 9.00pm. However, this check was not recorded on the records for the Manor.

The scheduled half-hourly checks of Mrs Westcott were required to be recorded on a document called a "Wandering Residents Checklist" (WRC). This document listed the times of day, at half-hour intervals starting from 0:00hours, and the staff members ticked/signed against the particular time at which a check was undertaken. The WRC was a document created for those residents who were prone to leaving their rooms and/or falling. As set out further, Mrs Westcott had not actually been mobile for about six months prior to her death. She required full assistance with two staff and a lifting device to go to and from her bed and her chair. There was evidence that the WRC was originally used for Mrs Westcott as she was prone to falls and wandering. However, even when she later became immobile Vaucluse Gardens promised her family that she would be checked on a half-hourly basis. The evidence indicates that the WRC was the document conveniently used to record the promised checks.

The WRC entry for 31 March 2012 states that Mrs Westcott was last checked at 2.30pm, but this was not the last time Mrs Westcott was seen or checked. As discussed further, the lack of half-hourly entries after 2:30pm reflects an inability of the staff to maintain the documentation required due to the pressure of work. This was apparent from the evidence given by numerous staff members. It is most unfortunate that the inability of staff to adequately maintain the records resulted in such uncertainty regarding when Mrs Westcott was checked.

Each resident had an individual medication chart which set out the list of his/her medications, the dosages for each and the times at which the medications were to be, and were in fact, administered. Mrs Westcott's medication chart for 31 March 2012 states that she was given medication at 9.10am, 12.20pm, 2.00pm, 5.30pm and 8.35pm. I am satisfied that Mrs Westcott's medication chart for this day represents accurately the times when her medication was administered, the last being 8:35pm by EN Emmily Booth. Whilst I do not

have confidence that the WRCs generally represented accurate and contemporaneous records of half-hourly checks, I do have confidence that the medication charts were accurate. Given the crucial importance of recording medication administered, it is most unlikely that medication records are incomplete.

Of note under this heading is that Ms Dixie Emmerton of the Centre for Tasmanian Industry (CTI) was retained by Vaucluse Gardens to assist with conducting an internal investigation into the circumstances surrounding Mrs Westcott's death. Ms Emmerton attended Vaucluse Gardens on 1 April 2012, the day after Mrs Westcott's death, and conducted three separate interviews with staff members who had seen Mrs Westcott before she was discovered trapped in the bed pole. Those staff members were ECA Natalie Dare, ECA Kerime Abay and EN Emmily Booth.

I now set out below a summary of the evidence of the staff members who worked at the Manor on the day of Mrs Westcott's death, in order to determine who may have last checked Mrs Westcott before she was discovered and whether any of the relevant staff members had knowledge as to the circumstances of her death.

Sharon Moss

Sharon Moss, an EN, worked at Vaucluse Gardens from 2007 until 2013. She gave evidence to the inquest that she worked in the Manor between 7.00am and 6.00pm on 31 March 2012. She stated that her rostered hours were actually from 7.00am to 3.00pm, but the Manor was short staffed during the afternoon shift on that day. Therefore, her hours were extended to 6.00pm. Ms Moss told the Court that her signature appears on the medication chart as having administered medication to Mrs Westcott at 9.10am, 12.20pm, 2.00pm and 5.30pm. She explained that the dashes recorded against the creams and eye drops at 6.00pm on the medication chart indicate that they were not applied at that time.

I accept the evidence of Ms Moss as to her hours. It accords with the shift records. Ms Moss left the Manor well before the last staff member checked on Mrs Westcott. I am satisfied that there was nothing untoward in the actions of Ms Moss towards Mrs Westcott on 31 March 2012.

Questions arose in this inquest regarding Ms Moss's level of responsibility in the Manor and the extent of her responsibility for the failure to remove Mrs Westcott's bed pole. I address those issues further in the finding.

Emmily Booth

Emmily Booth, an EN, was employed by Vaucluse Gardens from late 2011 until 2014. She was ordinarily based in the Lodge, but stated that "*once or twice*" had been rostered to work in the Manor.

She gave evidence to the inquest that on 31 March 2012 she commenced her shift in the Lodge at 3.00pm and was tasked to undertake the 8.00pm "medication run" in the Manor. Ms Booth stated that this was the first occasion on which she had been asked to undertake a

medication round in the Manor as a "single task" whilst working her shift at the Lodge, and it was only the second or third time that she had been into the Manor.

Ms Booth did not swear an affidavit until 31 December 2015, five days into the inquest, due to difficulties in locating her. In that affidavit Ms Booth stated: *"I do not remember the residents in the Manor as it was not my normal work area and I was just filling in to do the medication round. I cannot remember Barbara Westcott or any other residents. After doing the medication rounds I went back to the Lodge and updated some patient notes before knocking off and going home for the night."*

However, Ms Booth was interviewed by Ms Emmerton on 1 April 2012, the day after Mrs Westcott's death. Ms Emmerton's contemporaneously recorded notes of Ms Booth's statements are as follows:

> *"1. I did not think Barbara had the capacity to get out of bed as I have never seen her do this*
>
> *2. I assisted in turning her over when needed*
>
> *3. The bed has a pressure mattress but the alarms don't work with those*
>
> *4. Barbara's General Practitioner is aware of the bed pole*
>
> *5 Barbara's family is also aware that the bed pole is there*
>
> *6. Barbara's family requested half-hourly checks however normally the checks are hourly*
>
> *7. I checked Mrs Westcott at 8:30 pm."*

Ms Booth told the Court that whilst paragraph 7 was accurate, the document could not have been her statement because she "*could not think how she could have known any of those things*". Ms Booth stated that simply completing one or two shifts in the Manor prior to Mrs Westcott's death would not have been sufficient for her to have absorbed all the information which is detailed in the statement. Her claimed lack of memory of the evening extended to all details of being requested to do the medication run in the Manor, being in the Manor, giving medication to Mrs Westcott or any other resident, the number of residents that she visited, and the identities of the carers on duty in the Manor.

Ms Booth was shown Mrs Westcott's medication chart for 31 March 2012. She stated that her signature appeared on the document and it indicated that she had administered two Coloxyl/Senna tablets and two Febridol tablets to Mrs Westcott at 8.35pm.

Ms Mooney, counsel for Baldwin, submitted that I should not accept that Ms Booth had no memory of Mrs Westcott. Ms Munnings, counsel assisting, submitted the same. Mrs Westcott's progress notes from 18 February 2012 show that in the month prior to Mrs Westcott's death, Ms Booth twice tried to administer medication to Mrs Westcott during the course of the shift, and the medications were twice refused. This record also accords with the corresponding medication chart indicating refusal. I accept counsels' submission. Ms

Emmerton's notes of Ms Booth's statements were recorded in her note book whilst speaking to Ms Booth. Ms Emmerton gave evidence from her original note book. She was specifically retained for the purpose of interviewing relevant staff members, and therefore had good reason to record them accurately.

Ms Emmerton was a very good witness and struck me as a most efficient and reliable person, who was careful to record statements accurately. I could not ascertain any reason at all for a lack of impartiality on Ms Emmerton's part. I find that Ms Booth did make the statements attributed to her.

In light of such finding, it is remarkable that despite Ms Booth displaying an extreme concern regarding her potential involvement in Mrs Westcott's death, she could have no memory of the medication round at all.

Ms Booth gave evidence to the inquest that she received a telephone call in the early hours of 1 April 2012 in relation to the death of a resident, but could not say with confidence who telephoned her, whether she was told the name of the resident who had died, or details of the conversation. Again, it seems somewhat incredible, given the significance of the telephone call that woke her, she retained virtually no memory of its contents.

Ms Booth agreed that the only thing that she could recall about the whole matter was feeling upset, particularly when she was in the smoking area at Vaucluse Gardens on 1 April 2012 and overheard how Mrs Westcott had died. Ms Booth described herself as an "*emotional person*" who gave evidence that she felt "*vulnerable*" and "*worried where she stood legally*". She stated that she met with management on 1 April 2012 and found it "*traumatic*". Ms Booth gave evidence that the trauma had contributed to her memory loss, that she experienced sleepless nights and felt concerned about losing her job.

I would have thought that, upon receiving the telephone call advising of Mrs Westcott's death, there would be a natural tendency to replay the medication round back in her mind and thus retain the ability to at least recount some aspects of it. The assessment of Ms Booth's evidence of lack of memory should be considered in conjunction with whether she was withholding evidence about her involvement in any act that may have contributed to Mrs Westcott's death.

In giving evidence, Ms Booth's demeanour was unusual and disconnected. She came across as fearful. This was reinforced by the contents of her affidavit. On any reasonable view, simply administering regular medication to a resident without incident was not a matter that could have contributed to that resident's subsequent death by strangulation in a bed pole. It may be speculated that Ms Booth might have repositioned Mrs Westcott closer to the side of the bed whilst administering medication or repositioned her pillows in a way that caused her to roll. But it is highly unlikely that Ms Booth, an experienced nurse in aged care, would have witnessed Mrs Westcott becoming trapped and taken no action.

Ultimately, I cannot know whether Ms Booth was the last to see Mrs Westcott. It is possible that she perceived some fault or lack of care on her part, or attempted to move Mrs Westcott in a way that created a sense of responsibility for her death. This may be why she has

claimed no memory, or attempted to erase it from her memory. However, this can never be determined on the evidence. Similarly, I cannot determine to the requisite standard whether Ms Booth was deliberately obstructing the court by falsely stating that she had no memory of matters when she actually did.

Whilst Ms Booth apparently had no recollection of her interaction with Mrs Westcott on or before 31 March 2012, she gave detailed evidence in relation to her usual practices when administering medications and completing associated paperwork. She told the Court that if she was unfamiliar with a resident, she would administer the medication and, immediately afterwards, complete the medication chart. Furthermore, if a resident had refused or had difficulties taking the medications, Ms Booth said that this information would be entered in the resident's progress notes. None of the progress notes produced to the Court during the inquest refer to Mrs Westcott having experienced difficulties taking her medication on 31 March 2012, or having been difficult in her behaviour.

I am satisfied that Mrs Westcott was alive at the time she was administered her medication by Ms Booth.

The question now arises whether Natalie Dare or Kerime Abay, the rostered ECAs on duty, checked upon Mrs Westcott before or after Ms Booth administered her medication.

Natalie Dare

Natalie Dare, an ECA, had worked at Vaucluse Gardens for about 10 years before Mrs Westcott's death and still worked there at the time of giving evidence at the inquest. On 31 March 2012 she worked in the Manor between 3.00pm and 10.30pm. She told the inquest that she and Ms Abay put Mrs Westcott into bed after dinner at "*roughly at 8.30pm*". Her evidence was that she performed "*a couple of checks"* of Mrs Westcott on 31 March 2012, but could not say exactly how many. Ms Dare's oral evidence was at odds with the statements that she made on 1 April 2012 to Ms Emmerton. At that time she stated that Mrs Westcott was in bed at 6.15pm and asleep at 7.30pm. Ms Dare told the inquest that she had a "*clear recollection*" that the last time she checked Mrs Westcott was at "*around 8.30pm*" and that Mrs Westcott had her eyes closed. That evidence is consistent with her affidavit sworn on 5 December 2015.

The only contemporaneous record of Ms Dare's interactions with Mrs Westcott on 31 March 2012 is the notes of Ms Emmerton. A typed statement was drafted in accordance with Ms Emmerton's original handwritten notes (although, curiously, the notes state that the call bell was around her neck but the typed version states that it was "near" her neck). For the reasons given previously in relation to Ms Booth, Ms Emmerton's evidence of Ms Dare's account is inherently reliable and should be preferred over the oral evidence which Ms Dare gave at the inquest over three years later, notwithstanding her assertion that she had a "*clear recollection*" that it was "*roughly 8.30pm*".

Ms Dare presented as a hardworking, dedicated ECA who did her best to give accurate evidence. She stated that, due to inadequate staff numbers, she struggled to complete her work within her shift hours. She stated that either she or Ms Abay would have signed the

WRC but the records indicate this is not the case. It may well be that, consciously or unconsciously, Ms Dare sought to portray that she had checked Mrs Westcott at a time later than she actually did, given that a half-hourly checks were required in respect of Mrs Westcott.

Accepting that the statement made by Ms Dare to Ms Emmerton immediately after Mrs Westcott's death is correct, I find that Ms Dare's last check of Mrs Westcott occurred at 7.30pm and at that time Mrs Westcott was asleep.

Kerime Abay

Kerime Abay, an ECA, had worked at Vaucluse Gardens for about three years before Mrs Westcott's death. On 31 March 2012 she worked in the Manor between 3.00pm and 11.00pm. Ms Abay recalled that Mrs Westcott was taken to dinner, bathed, medicated and put to bed by 7.30pm. This is consistent with Ms Dare's evidence of Mrs Westcott being asleep at 7.30pm. However, Ms Abay later told the Court that she was not actually present when Mrs Westcott was medicated; that she did not know who administered the medication or at what time that occurred.

In her affidavit sworn on 1 August 2013, Ms Abay stated, "*At approximately 8.30pm [she] popped [her] head into Barbara's room…She appeared to be alive and well…*" In evidence to the inquest Ms Abay stated that her last check of Mrs Westcott was at "*approximately 8.00pm to 8.30pm*" and only involved "*a glance*" into Mrs Westcott's room. Ms Abay told the Court that, in her mind, "*approximately 8.30pm*" was the same thing as "*8.00 to 8.30pm*". When pressed in relation to this issue Ms Abay gave evidence that "*her memory told her nothing about the time*".

Constable Guy gave evidence that he spoke on the telephone with Ms Abay during his attendance at Vaucluse Gardens and she told him that the check was at "*approximately 8.30pm to 9.00pm*". He stated that he was told by Ms Sorrentino that Ms Abay was the last person to have seen Mrs Westcott alive. I note that Ms Abay told Ms Emmerton that it was between 8.00pm and 8.30pm that she checked Mrs Westcott.

At inquest, Ms Abay gave evidence that the glance into Mrs Westcott's room did not extend to turning on the light or checking Mrs Westcott's face. She did not observe how Mrs Westcott was positioned in bed. She saw Mrs Westcott's feet, and that, in Ms Abay's mind, was sufficient for the purposes of the check. I am satisfied that Ms Abay did see Mrs Westcott in bed at the time of this check. From Ms Abay's evidence I can only find that she checked Mrs Westcott between 8.00pm and 9.00pm.

Conclusion

Based upon the foregoing, I cannot make a positive finding as to whether Ms Abay or Ms Booth was the last to see Mrs Westcott alive. Ms Dare's check was earlier, at about 7.30pm, and is consistent with Mrs Westcott's usual bedtime, as she was asleep. There is also no evidence to suggest that any other person entered room 25 after Ms Booth or Ms Abay. Therefore, the latest possible time at which Mrs Westcott was checked on 31 March 2012

was 9.00pm. Thus, she was not checked for a period of at least 2 1/2 hours before she was found by Ms Sorrentino.

Mrs Westcott's state of health and mobility

One of the issues for determination in the assessment of how Mrs Westcott came to her fate is her ability to move. There was a significant amount of evidence regarding her mobility that I now discuss.

Mrs Westcott was assessed by physiotherapist, Diane Langdale, before she became a resident of Vaucluse Gardens. Ms Langdale was employed within the "Aged Care Assessment Team" of the Department of Health and Human Services. Ms Langdale determined that Mrs Westcott required a high level of care for funding purposes. Mrs Westcott was classified as a "high care" resident for the entire period in which she lived at Vaucluse Gardens.

Mrs Westcott suffered from a number of medical conditions including Parkinson's disease, Addison's disease, hypertension, bowel and urinary incontinence and a frozen shoulder. In the months before her death she did not socialise and preferred to be in her room. She suffered hearing impairment. She suffered impairment to her cognitive functions, including hallucinations, which may have been caused by the medication prescribed for her Parkinson's disease.

Initially, when Mrs Westcott became a resident of Vaucluse Gardens, she was able to walk and perform tasks independently. However her health deteriorated, particularly throughout the last year of her life. At the time of her death, she was effectively immobile and required assistance for every aspect of her living. Two members of staff were required to move, bathe, clothe and toilet her. Mrs Westcott had to be moved with a lifting device.

Vaucluse Gardens had agreed that Mrs Westcott would be checked by staff every 30 minutes. The extract from the progress notes of 24 May 2011 reflects the contents of a discussion between Mrs Westcott's four children, Ms Moss and EN Jolene Green. The notes include the following:

"The family have concerns that Barbara;

- Is not being checked often enough, they have concerns that 4th floor is offered without the presence of a staff member but our understanding of the logistics for staff with 4 floors in the building. It was agreed that Barbara is placed on a Safety check routine.

-Is not being offered fluids regularly enough and is often without a jug and glass in her room. It was agreed that kitchen staff will be spoken to to ensure a jug and glass is always in the room and its staff when completing the safety checks are ensuring they offer Barbara a drink each time and make sure she has a full glass left with her….".

It appears likely that more regular checks of Mrs Westcott commenced at this date. In any event, they had definitely commenced by 8 August 2011, when she was found on the floor of her bathroom. It is noted by Ms Moss in the progress notes of that date that half-hourly

checks were in place. The requirement for half-hourly checks was also noted in Mrs Westcott's care plans.

Mrs James said that Mrs Westcott's movements fluctuated from day to day. Whilst Mrs Westcott could not move without assistance, Mrs James explained that on 24 March 2012, her mother had taken the weight of a baby which had been placed in her arms. In the first of two affidavits sworn by Mrs Westcott's son, Mark, he stated that he visited his mother on 28 March 2012. He stated that she was in high spirits and looked the best he had observed for a long time. Mr Westcott stated that his mother had no mobility and relied upon the nurses and carers to assist her in walking, sitting up, rolling over and movement of the body. He said that she could barely feed herself and that he would have to hold the drinks for her. Mr Westcott explained that his mother was not a paraplegic, but had trouble using her limbs for their usual purpose.

Ms Sorrentino told the inquest that Mrs Westcott had no capacity to move on her own and was virtually paralysed. She stated that Mrs Westcott could not roll over in bed, roll on her side or move her legs. As far as Ms Sorrentino was aware, Mrs Westcott was unable to pick up a cup of water by herself.

Ms Abay gave evidence to the inquest that Mrs Westcott required prompting to eat and drink. Ms Abay described that she would need to hand Mrs Westcott a glass, place her fingers around the glass, guide it towards her mouth and Mrs Westcott would then finish the movement. Ms Abay gave evidence that Mrs Westcott experienced "*moments of clarity*" when she was able to perform tasks herself. However in the month before Mrs Westcott's death, Ms Abay considered that there were not enough moments of clarity for Mrs Westcott to have rolled herself over. She stated that Mrs Westcott was unable to move herself.

Ms Dare gave evidence that just prior to 31 March 2012 Mrs Westcott had the ability to reach out for a drink however that was the limit of what she could do. Ms Dare said that she never observed Mrs Westcott use her body parts on her own.

Ms Moss gave oral evidence that Mrs Westcott required assistance to eat and drink, but was still able to use her arms to an extent. I fully accept the evidence of these carers.

Rosalie Yeo was an ECA who regularly cared for Mrs Westcott at the Manor. She gave evidence at the inquest, as discussed further, that she had repeatedly removed Mrs Westcott's bed pole from her bed due to the dangers of it remaining there. She also gave evidence that she made a large number of incident reports and notifications to Ms Moss about the dangers of the bed pole. For the reasons further given, I do not accept her evidence in this regard. However, Ms Yeo did give general evidence concerning Mrs Westcott's mobility that accorded with the other evidence. This evidence was factual and credible. She told the inquest that she did not think that Mrs Westcott could re-position herself in bed.

Ms Yeo, Ms Moss, Ms Dare or Ms Abay never saw Mrs Westcott roll herself over. Their evidence, with some minor variations regarding the extent of Mrs Westcott's limitations, was

unanimous. They were in a position to know well the limitations of Mrs Westcott's ability to move in the period before her death.

Dr Margaret Williams, Dr Ritchey and Dr Robert Nightingale were questioned during the inquest on Mrs Westcott's capacity to roll herself over from a supine position and onto the floor. Dr Nightingale is a retired consultant physician who treated Mrs Westcott for her Parkinson's disease. Dr Nightingale first saw Mrs Westcott in 2006, when he diagnosed her with Parkinson's disease. At that stage she presented with a tremor of her hand and he presumed that her Parkinson's disease had started a couple of years earlier.

Dr Nightingale gave evidence that the disease is caused by a lack of dopamine in the brain with the primary symptoms being stiffness or rigidity, a problem with initiation of movement and a tremor. He noted that there can be many other symptoms, including problems with cognition in the latter part of the disease. He stated that Parkinson's disease is progressive and incurable. He noted that the medication prescribed acts as a dopamine replacement and may contain a blocking agent to prevent the breakdown of dopamine in the body. He noted that the first five years of treatment with Parkinson's disease is much easier than the following five years, when the effect of the medication tends to wear off. He noted that Parkinson's disease usually progresses over about 20 years.

Dr Nightingale last reviewed Mrs Westcott in September 2011 in his consulting rooms. He noted that for approximately one year before this date and including this date, Mrs Westcott was brought to his consulting rooms in a wheelchair. Ms Munnings, when questioning Dr Nightingale, advised him of the evidence given by the above carers to the effect that Mrs Westcott was virtually immobile. Dr Nightingale told the inquest that he considered it "*unusual*" that the Parkinson's disease had progressed such that Mrs Westcott's mobility had declined so severely in the six months following that review. However, he did offer two reasons why that may have occurred. Firstly, if Mrs Westcott had stopped taking medication prescribed for the Parkinson's disease; and secondly, if she had suffered a series of strokes. In regards to the latter possibility, Dr Nightingale appeared to suggest that the occurrence of strokes were a possibility due to her past history of retinal artery occlusion and the history of hypertension, being risk factors for strokes.

Dr Nightingale was unable to offer a firm opinion as to whether Mrs Westcott would have been able to roll herself over in bed and onto the floor. He said that she would have been able to do so when he last saw her in September 2011. He gave evidence about an "on/off phenomenon" which he said relates to the timing of the ingestion of medication for Parkinson's disease. Dr Nightingale explained that when the dopamine levels fall a patient can be virtually immobile; then, as the dopamine levels rise, the patient can start moving again. Dr Nightingale indicated that ordinarily he would expect to see evidence of the "on/off phenomenon" in the patient notes. He was unable to say whether the "moments of clarity" which were referred to in the evidence of Ms Abay were indicative of the "on/off phenomenon" or not. I observe that Mrs Westcott had been given her Stalevo medication at 5.30pm on 31 March 2012. I did not however have medical evidence about the time taken for her medication to take effect such as to possibly cause a bout of bodily movement.

Dr Williams was Mrs Westcott's general practitioner. She gave evidence that she last observed Mrs Westcott on 22 February 2012 and Mrs Westcott was "*not completely immobile*". Dr Williams explained that Mrs Westcott was in a seated position in her room, moving her arms freely and could take a drink. Dr Williams told the Court that she could not comment upon whether Mrs Westcott was able to roll over by herself in bed, as she had never observed Mrs Westcott in bed.

Dr Ritchey told the Court that there was no way for him to have known Mrs Westcott's functional state at autopsy. He stated that it would be "*decidedly unusual*" for Parkinson's disease to be so disabling that someone is unable to move at all. He did however observe that "*each patient is going to be different*".

Therefore, despite the adamant evidence of the staff, the medical evidence indicates that Mrs Westcott may have been able to initiate sufficient movement to roll off her bed.

Circumstances surrounding entrapment

The question arises as to Mrs Westcott's position in bed or the gradient of the bed immediately before she became positioned on the floor. Ms Booth could not recall anything about what she observed in room 25 during the medication run. She gave some evidence about her general practices and stated that normally she would wake a resident up to give him/her any medications. She would elevate the bed head, sit the resident up, administer the tablets and return the bed to its original position. If a resident asked for the bed to remain in an elevated position, Ms Booth said that she may accommodate the request, depending upon the resident. She told the Court in absolute terms that if Mrs Westcott had asked to be placed on her side she would have obliged and either (i) sought the assistance of another staff member with turning her or (ii) delegated the task of turning Mrs Westcott to the carers.

Ms Rosalie Yeo gave evidence that Mrs Westcott would ordinarily be positioned in bed with three pillows – two at the head and one at the back. Mr Norman Blackburn, an EN, told the inquest that Mrs Westcott would be re-positioned for her sleep and would be *"put on her side, propped up with pillows"*. The notes taken by Ms Dixie Emmerton of her meeting with Ms Abay on 1 April 2012, suggest that Mrs Westcott's bed would have been lowered and a pillow placed at a low angle. The notes in respect of Ms Emmerton's meeting with Ms Dare indicate that on 31 March 2012, Mrs Westcott's bed had been lowered and the back rest was on a slight angle. The photos taken by Senior Constable Tony Fox on 12.35am on 1 April 2012 show that there were at least two pillows on Mrs Westcott's bed. One of those was a "U" shape. Importantly, the back rest does not appear to be on an angle. The bed is flat. There is no evidence that anyone at the scene lowered the bed, and it is unlikely that this would have occurred. I find that the bed was flat and not elevated.

It is possible that Mrs Westcott was not in a fully supine position before she fell from the bed. If one or more pillows had been placed behind Mrs Westcott's back and she was lying on her side, then less physical movement would have been required for her to have rolled over.

As discussed, Mrs Westcott was not checked by staff or carers for 2 ½ to 3 hours before she was discovered by Ms Sorrentino. If Ms Abay was the last to sight Mrs Westcott, this only involved a glance into her room from a distance and not any physical interaction with her.

I am able therefore to find that any repositioning of Mrs Westcott in her bed, including the use of pillows, was done by Ms Booth at the time of administering her medication, in accordance with her usual practice as described above. She claimed lack of recall as to her positioning of Mrs Westcott. However, I find that Mrs Westcott was likely asleep and Ms Booth, in general terms, proceeded through her steps as above. I cannot, however, determine the position in which she left Mrs Westcott in her bed.

There was no neck trauma present at autopsy or damage to the muscle layers of the neck seen upon Mrs Westcott. Dr Ritchey stated that this was a *"significant negative finding"* when considering the question of homicidal strangulation. I accept Dr Ritchey's observation. There is no evidence that any staff member or other resident bore malice towards Mrs Westcott. There is no evidence that any other resident in a compromised mental state had any physical contact with Mrs Westcott to cause her death, either by strangling or deliberately pushing her from the bed. There is no evidence in the records of any residents possessing such propensity, nor any evidence of unusual movements of residents during the evening.

I also reject as fanciful, any scenario that a staff member, including Ms Booth, may have deliberately rolled Mrs Westcott off the bed, whether with homicidal intentions or otherwise. There is no evidence of the entry of any other staff into Mrs Westcott's room after Ms Booth or Ms Abay.

There is no evidence to support a finding that Mrs Westcott deliberately rolled herself off the bed with the intention of ending her life. Whilst Ms Yeo told the inquest that Mrs Westcott's general mood was "*not happy*", Mrs James made the following statement: "*My mother never expressed any suicidal thoughts and she was not the type of person to take her own life*". I fully accept her evidence. An assessment for depression was carried out on 3 March 2012, by Ms Sharon Moss. Whilst there were indications of confusion, poor cognitive functioning, pessimism and sadness, Mrs Westcott showed no signs of anxiety, irritability, agitation, poor self-esteem or suicidal ideation. Additionally, with her mobility issues, there would be no guarantee that such a method would end her life. This scenario can be rejected.

A scenario for consideration is whether Mrs Westcott fell whilst Ms Booth was assisting Mrs Westcott with repositioning. Again, this can be rejected. I reject the proposition that Ms Booth, while repositioning Mrs Westcott, would have allowed her to remain on the floor without calling for assistance immediately, and further, to complete the remainder of her shift in the Lodge without incident in the knowledge that Mrs Westcott was on the floor next to her bed. For safety reasons two people were required to move Mrs Westcott. Ms Booth was very clear that she would not, and had never, turned a resident alone. She told the Court that it was her "strict rule". Whilst I am extremely sceptical of Ms Booth's claimed lack of recollection of the events of 31 March 2012, there is nothing to indicate that she was being untruthful in this aspect of her evidence. I accept that she would not have rolled Mrs Westcott alone. I reject the hypothesis that Mrs Westcott accidently fell in the course of being manoeuvred by Ms Booth.

It is possible, given the strange demeanour and evidence of Ms Booth that some sort of disagreement or argument may have occurred as between Mrs Westcott and herself whilst she was giving Mrs Westcott her medication, which may possibly have aroused Mrs Westcott to movement. Ms Booth may have left Mrs Westcott in an uncomfortable position or while she was agitated or distressed. This is speculative only, but may possibly explain Ms Booth's defensiveness and denial of memory.

In light of the matters raised above, the only conclusion that can reasonably be drawn from the evidence is that Mrs Westcott had enough strength to roll herself further to her left side of the bed and that she accidentally fell from the bed, causing her to become entrapped between the bed pole and the mattress. This scenario is contrary to the observations of staff regarding her physical capabilities but possible on the medical evidence. Her fall was unwitnessed. Most regrettably, the reason for her fall and position on the bed before her fall, remain unknown.

Installation of and history of the bed pole/s on Mrs Westcott's bed

Mrs Westcott would not have died if the bed pole had not been on her bed. Its presence was directly causative of her death. Mrs Westcott died of asphyxiation because she became wedged between the upright of the bed pole and the side of the mattress. The pressure was upon the front of her neck and she was unable by reason of her immobility to extract herself from that hanging position.

One of the central issues in this inquest was the question of whether Mrs Westcott's bed pole should have been removed from the bed before her death. I find that it should have been removed, as the known risks of injury and death associated with its presence outweighed the benefits of the device as a mobility aid in her case. Both Baldwin and Bupa and all relevant staff members accepted this proposition.

In reasoning to this finding, it is necessary firstly to deal in detail with the facts surrounding the installation of the bed pole/s, the purpose it served for Mrs Westcott, and the processes in place for assessment and removal before 31 March 2012.

Mrs James gave evidence that Mrs Westcott first started utilising a "bed stick', as she called it, as a mobility aid in 2008 when she was still residing in her matrimonial home. The bed stick, together with a shower stool and commode had been loaned to her by an occupational therapist on the recommendation of physiotherapist Diane Langdale. Ms Langdale sighted the bed stick and other aids whilst at Mrs Westcott's home for her assessment in July 2009. In oral evidence at the inquest, Mrs James stated that these items were returned from loan before her mother became a resident of Vaucluse Gardens. I accept that evidence.

There are two documents that indicate that Mrs Westcott had a bed pole from the time she became a resident of Vaucluse Gardens in August 2009. The first is a handwritten progress note dated 17 August 2009 which states: *"Arrived today Barbara Westcott…bed stick in situ for assisting herself out of bed…"*

The second is a “Maintenance Request” form dated 13 August 2009 which contains two entries. The first is: *“Bed pole please.”* The second is: *“Already there”.*

Mrs James had no specific recollection of the bed pole having been in place in 2009. She gave evidence that she believed that the bed pole was installed sometime during 2011, after she spoke with Sharon Moss about her mother’s fear of falling out of bed. Mrs James told the inquest that in 2011 she requested “*something*” to assist her mother with rolling in bed. She said that after this conversation with Ms Moss the bed pole “*just appeared*” and there were no discussions with staff about the bed pole or its use by her mother.

Ms Sorrentino was aware of the presence of the bed pole, but could not remember the month or year in which it was installed. She told the inquest that it had been there for a “significant amount of time”.

Ms Dare had a recollection that the bed pole had been present for “possibly six months” before Mrs Westcott’s death but told the Court that she could be wrong about that.

Ms Kamau gave evidence that the bed pole was already on Mrs Westcott’s bed when she started working for Vaucluse Gardens in May 2011.

Norman Blackburn commenced work at Vaucluse Gardens in April 2010. He gave evidence that Mrs Westcott always had a bed pole on her bed.

Ms Yeo said that she commenced employment with Vaucluse Gardens in March 2010 and Mrs Westcott had a bed pole at that time.

I find that the two contemporaneous records of Vaucluse Gardens from August 2009 are reliable evidence. The handwritten progress note of 17 August 2009 was shown to Mrs James during the inquest and she stated: “*If that’s what it says, that’s fine*”, acknowledging that her memory may not be reliable in that regard. I find that Mrs Westcott did have a bed pole on her bed in August 2009. However, there are no records to indicate the model or shape of the bed pole.

In Mrs James’ first affidavit sworn 1 May 2012 she stated (my emphasis): *“Due to my mother’s lack of mobility, she was given an assistance pole … The pole was located at the head of the bed about a pillows length from the top of the mattress. It had* ***handles either side of the mattress*** *and would always be butted very close to the mattress, there was hardly a gap* ***either side of the handles*** *and mattress… I don’t know if the pole was bolted down to the bed or just slid under the mattress”.* This description of the bed pole is consistent with the model on Mrs Westcott’s bed on 31 March 2012. Her first affidavit described very clearly the bed pole and the position of the uprights close to the mattress. In that affidavit it is implicit that the double-sided bed pole came about as a request from herself in the latter half of 2011 and that her mother had no bed pole of any type before that time.

However, in Mrs James’ second affidavit sworn 2 May 2014 and during oral evidence, she described her mother’s bed pole as having a base plate that was stabilised by the mattress. It was a *single* upright pole positioned to Mrs Westcott’s left hand side, one third of the way

from the bed head. Mrs James was shown the double handled bed pole that was photographed in Mrs Westcott's room on 31 March 2012. She told the Court that it was not the same bed pole that had been placed on her mother's bed in 2011. Mrs James is clearly mistaken about her evidence that her mother was using a single-sided bed pole at the time of her death, but as discussed further, other staff also provide evidence that Mrs Westcott had a single-sided pole on her bed at all times.

Both Ms Moss and Ms Yeo recalled that Mrs Westcott had a single-sided bed pole and not a double-sided bed pole. Ms Moss gave evidence that Mrs Westcott only ever had one type of pole, with one pole to Mrs Westcott's left hand. Ms Moss was firm that Mrs Westcott's bed pole was not the same model as the one depicted in the photographs tendered in the inquest. Ms Moss did eventually concede that she could not be *"100% sure"* as the part that she saw was the left hand side. It is interesting that both maintained that evidence, in the face of the photograph of the double-sided bed pole that was clearly on Mrs Westcott's bed at the time of her death. Both were in a position of caring for Mrs Westcott and potentially in a good position to know the type of bed pole in existence.

Variations in evidence and lack of memory of witnesses about the type of bed pole, time of installation, whether there was a period without a bed pole are to be expected. The presence of a bed pole may not be a matter that the witnesses might see as significant at the time. Ms Moss made her first affidavit on 21 November 2014, which did not describe the appearance of the bed pole. Ms Yeo swore her affidavit during the inquest. It is not difficult to imagine that given such lapse of time, both of them may have an incorrect memory of the bed pole as being single-sided, based upon others of that type.

Ms Munnings submits, contrary to this proposition, that bed poles were not a common item in Vaucluse Gardens and that those regularly caring for Mrs Westcott and changing her bed might well be in a position to retain such details. Ms Munnings also submits that I should accept the evidence of Mrs James (that there was a bed pole placed on Mrs Westcott's bed in 2011) as reliable. She therefore submits that I am able to find that between August 2009 and 31 March 2012, Mrs Westcott was provided with, and used, two bed poles.

A finding that there were two bed poles installed on Mrs Westcott's bed during her residency requires examination in the light of all other available evidence, particularly that given by Ms Moss. The implications of such finding are most concerning; including that the second bed pole was installed with no regard to the recently established bed pole installation guidelines, and that untrue evidence has been given regarding knowledge of its installation.

None of the documents that were produced by Vaucluse Gardens during the proceedings shed light on the questions of when the first bed pole may have been removed and a second, double-handled bed pole, installed on Mrs Westcott's bed, or who from Vaucluse Gardens authorised its installation. The only order document pertaining to the bed pole is that of 13 August 2009.

Whilst those records indicate that Mrs Westcott had "a bed pole" in 2009, I agree that Mrs James' evidence that she requested of Ms Moss "*something*" to assist her mother with rolling in 2011 has some credibility. Her affidavit was made early in 2012 and therefore she would

have had a good recall of the issues pertaining to her mother's care during the months of the previous year. If Mrs James' evidence is accepted, this must mean that at some point between 2009 and 2011 Mrs Westcott's original bed pole had been removed.

Mark Westcott, in his second affidavit, queries why the bed pole (that is, the double-sided bed pole) was on his mother's bed. He stated that it must have been to do with a reason other than its normal use as a mobility device because his mother was immobile. Mr Westcott's affidavits were logical and coherent. His statement in this regard may suggest that the double-sided bed pole was installed at the time when Mrs Westcott was immobile; this being approximately in the last six months before her death, and not in 2009. However, this is not a definitive interpretation of his affidavit, as submitted by Ms Mooney, and it is open to find that he was aware of the bed pole for the whole time he was visiting his mother. I accept the evidence of Mrs James and the affidavit of Mr Westcott that there was a note book in Mrs Westcott's room for the family to record any requests or concerns. Unfortunately, this was not able to be produced at inquest by Baldwin or Bupa. It may well have assisted with this difficult issue.

None of the witnesses who gave evidence, with the exception of Ms Yeo whose evidence I later discuss, could elucidate the circumstances of any removal of the original, possibly single-sided bed pole, installed at the time Mrs Westcott entered Vaucluse Gardens. None of the witnesses stated that Mrs Westcott used two different bed poles during her residency.

Mrs Westcott's three monthly care plans were detailed documents setting out the requirements of all aspects of her care at Vaucluse Gardens. The care plans for Mrs Westcott for January 2010, May 2011, January 2011 and September 2011 simply noted the presence of a "bed stick" on the bed. The penultimate care plan, which was reviewed in January 2012 (and approved by the RN), had certain details relating to her mobility and risk assessment removed. In particular, the reference to the bed pole had been deleted. There is no evidence as to why this was so. I will assume that the deletions were made by a RN who believed that the reference was obsolete because, along with other mobility aids, Mrs Westcott was not mobile, did not require them and they were not present. If so, this deletion was made without checking her room to confirm the absence of a bed stick. I do not seriously entertain the proposition that alterations to records were improperly made after Mrs Westcott's death.

Dr Williams, Dr Nightingale, Ms Sorrentino, Ms Abay, Ms Dare and Ms Booth all gave evidence to the inquest that they were not involved in any discussions or decision-making in relation to Mrs Westcott's bed pole.

Ms Kamau told the Court that she was not involved in any decision-making concerning Mrs Westcott's bed pole.

Ms Janine Fyfe, an EN who was responsible for recording and auditing mobility devices used by residents, was unaware that Mrs Westcott had a bed pole.

In determining the history of Mrs Westcott's bed pole/s the evidence of Ms Moss requires careful attention. She stated to the inquest that she did not recall a conversation with Mrs

James in 2011 about the bed pole, but remembered one in 2009 shortly after Mrs Westcott became a resident of Vaucluse Gardens. Ms Moss said that if a resident requested a bed pole, she would refer the matter directly to the Nurse Manager, Ms Amanda Newham, and would not record the request in the resident's progress notes. Ms Moss explained that it was not within her scope of practice as an EN to decide if a resident should have a bed pole or not. She said this was a matter for a RN. Ms Newham, the Nurse Manager for Vaucluse Gardens, told the inquest that she was not aware that a bed pole had been issued to Mrs Westcott.

As will be discussed further, Ms Moss' evidence was not, in many respects, reliable. Her first affidavit did not mention speaking to Mrs James after the alert, even though her second affidavit, sworn a month later on 14 December 2015, sought to "clarify" that statement to say that she did speak to Mrs James after the Coroner's findings in 2010. At that time, Mrs James said she wanted the bed pole to remain in her mother's room because it was the only thing her mother could use to get herself around in the bed. This conversation was not documented in any care plan or record of Vaucluse Gardens. In her second affidavit, she acknowledged that there was in fact a policy in existence requiring a risk assessment, signed by the resident, their family and the general practitioner. In her first affidavit she stated that there was no policy in place at the time Mrs Westcott died and that she was never made aware of any guidelines restricting the use of a bed pole. She stated, *"I was never made aware of any guidelines restricting the use of the bed pole, the decision was solely based on the request of family and the residents needs and their ability to actually use the bed pole".* Her clarification of this statement in her subsequent affidavit of 14 December 2015 sought to restrict the statement to a reference to the process that was in place at the time her bed pole was installed after she entered the facility, as opposed to guidelines in place after the 2010 bed pole alert. The clarification is not credible. Ms Moss' first affidavit, in context, intends to deny knowledge of the need for risk assessments for the whole period of Mrs Westcott's residency.

Ms Moss' final position, articulated in oral evidence, was that she did know that guidelines were in place and that she was notified that a risk assessment was required for a bed pole to remain on a resident's bed. It is fanciful to suggest that the bed pole procedures post the alert could have escaped her attention. This version of her evidence is more likely to be correct as she was involved in a risk assessment process after the alert for another resident of the Manor, Marjorie Roberts, who wished to retain her bed. As stated below, however, the risk assessment process undertaken for Mrs Roberts was inadequate and lacking in documentation.

Ms Moss' comment in evidence about why the bed pole remained without a risk assessment was that *"it was just one of those things that was missed by everybody*" and that it never occurred to her that a risk assessment had not been done. Her evidence was contradictory, defensive and difficult to understand. I found Ms Moss to be unhelpful in crucial aspects of her evidence. The whole of her evidence had the flavour of seeking to minimise her own responsibility.

On this issue one important matter requires discussion, being the conflict of evidence between Ms Moss and Rosalie Yeo. As discussed further, if Ms Yeo's evidence is accepted, it would mean that Ms Moss insisted that a bed pole remain on Ms Westcott's bed, having been advised that Mrs Westcott had been previously injured and entangled in her bed pole on numerous occasions.

Conflict of evidence between Rosalie Yeo and Sharon Moss

Ms Yeo, an ECA, gave evidence at the inquest that from December 2010 onwards she was concerned about the danger to Mrs Westcott presented by the bed pole on her bed. Specifically, she was worried that Mrs Westcott would roll herself into it. Ms Yeo told the Court that "*usually every morning*" she encountered Mrs Westcott entangled between the bed pole and the mattress. She described that ordinarily it was Mrs Westcott's left forearm or leg that would become caught and that "*sometimes*" it resulted in skin tears of the arm and bruising on the leg.

Ms Yeo asserted that she verbally reported the skin tears to the EN, who was usually Ms Moss. Ms Yeo gave evidence that it was the responsibility of the EN to then complete any necessary paperwork, such as incident reports, as the person who would have treated the injuries.

Ms Yeo gave evidence that she documented the injuries in Mrs Westcott's progress notes and personally completed incident reports when injuries had not been sustained. Ms Yeo asserted that about 50 incident reports were generated after finding Mrs Westcott entangled in the bed pole.

There are a number of incident reports pertaining to Mrs Westcott within the resident notes produced to the inquest by Vaucluse Gardens. However, only one is authored by Ms Yeo and it does not relate to a bed pole. Examination of Mrs Westcott's handwritten and electronic progress notes reveals nothing to support Ms Yeo's claims that she became entangled in the bed pole on an almost daily basis and, on occasions, sustained injuries as a consequence.

Ms Yeo told the inquest that she discussed her concerns regarding the bed pole with others, including Ms Moss and other ECAs. Ms Yeo did not name these ECAs. She stated that she became so concerned by the bed pole, that on 10 occasions between December 2010 and February 2012, she physically removed the bed pole from Mrs Westcott's bed and put it into storage. Ms Yeo claimed that Ms Moss replaced the bed pole on each occasion.

All of Ms Yeo's assertions were denied by Ms Moss during oral evidence. She told the inquest that Ms Yeo never came to her with concerns regarding the bed pole. Ms Moss stated that she never placed a bed pole on Mrs Westcott's bed. Mr Blackburn, an EN who also had been involved in caring for Mrs Westcott, told the inquiry that he had never heard reports that Mrs Westcott had previously become entangled in the bed pole.

Ms Yeo told the inquest that she "*definitely*" documented her removal of the bed pole in Mrs Westcott's progress notes. Again, there is no evidence of such entries in the notes which have been produced by Vaucluse Gardens.

Ms Yeo gave evidence that she also brought her concerns regarding the bed pole to the attention of Mrs Westcott's family, including Mrs James, and they were advised about the injuries which Mrs Westcott had sustained. Ms Yeo's claims are not supported by the evidence. Further, there is no suggestion in either of Mr Westcott's affidavits that he conversed with Ms Yeo in relation to the bed pole, or sighted injuries to his mother's arm and/or leg. Given the level of detail in his affidavits, such evidence would be expected to be present.

Mrs James gave very clear evidence that had she been alerted to any dangers associated with the bed pole, she would have instructed Vaucluse Gardens to remove it. I fully accept her evidence, particularly given her expertise in nursing. She was intimately involved in her mother's care and attuned to her state of health. It is extremely unlikely that she would have failed to notice skin tears and/or bruising to her mother's arm and/or leg. Ms Yeo explained that Mrs Westcott wore long sleeved tops which may not have revealed the injuries. I agree with counsel assisting that this evidence was unconvincing and an attempt by Ms Yeo to bolster the credibility of her evidence.

Ms Yeo told the inquest that it was a *"battle of the wills"* between herself and Ms Moss. She said that they would disagree over matters such as staff duties. This was denied by Ms Moss, who asserted in evidence that her relationship with Ms Yeo was satisfactory from a working perspective. She denied a clash of personalities or having had differences in opinion regarding Mrs Westcott's care. Whilst there are unsatisfactory aspects of her evidence, she did not appear defensive or evasive in respect of Ms Yeo and I found her credible on this point. Ms Moss told the Court that if Ms Yeo had asserted to her that Ms Westcott's limbs had been trapped between the mattress and the bed, she would have accepted such assertions and they would have been investigated. However, Ms Moss gave evidence that the conversations simply did not occur. I do not doubt that she would have fulfilled her professional obligations to record and investigate such incidents and injuries if they had occurred.

Ms Yeo's assertions are extremely serious. They suggest that for at least 12 months before her employment was terminated, the day shift EN in the Manor, primarily Ms Moss, was aware that Mrs Westcott was continuously suffering injuries as a consequence of being trapped in the bed pole. Ms Yeo's evidence suggests that Ms Moss refused to take action after these injuries were brought to her attention and, in fact, took positive steps to ensure that the bed pole remained on Mrs Westcott's bed. None of Ms Yeo's assertions are corroborated by witnesses or documentary evidence.

Ms Yeo's employment at Vaucluse Gardens was terminated in early 2012. At the inquest she denied that a grievance associated with her termination was the catalyst for her approach to the Coroners' Office during the inquest in December 2015.

There is nothing to suggest that Ms Moss had a particular dislike of Mrs Westcott. The evidence does not disclose any motivation for (a) why Ms Moss would attempt to conceal injuries that Mrs Westcott had allegedly sustained; (b) why Ms Moss would insist on Mrs Westcott having a bed pole if she knew that it was dangerous; and (c) why Ms Moss would not simply use the correct process to obtain the bed pole rather than continue to be in conflict with Ms Yeo.

Ms Yeo asserted that she made a large number of electronic entries on the Vaucluse Gardens "LeeCare" records system pertaining to Mrs Westcott and the removal of the bed pole. However, no such entries are contained within the documents produced by Vaucluse Gardens to the inquest.

Ms Kate Buckland, RN and facility manager, gave evidence that it is not possible to delete progress notes and/or incident reports from the LeeCare system. Ms Buckland told the court that it was *"nonsense"* to suggest that records had been deleted and to do so would constitute professional misconduct. Whilst I do not have confidence Baldwin and Bupa located every relevant record, I reject the proposition that either staff and/or management of Baldwin and Bupa have engaged in a conspiracy to either selectively produce records to the Coroner or to delete records that might reflect adversely upon them. I accept that those organisations undertook conscientious efforts to locate all available documentation.

A further matter which casts doubt on the reliability of Ms Yeo's evidence relates to the bed pole itself. Ms Yeo gave a clear account that Mrs Westcott only ever had a single-sided bed pole. Yet, when shown the photograph of the double-sided model present on Mrs Westcott's bed at her death, Ms Yeo told the Court that that model was the same as that she had previously observed on Mrs Westcott's bed.

I therefore reject the evidence of Ms Yeo that she made a multiplicity of reports to Ms Moss, and that there were injuries to, and entrapment of, Mrs Westcott. Her account is inherently incredible. There is a lack of corroboration by any other witness, objective record or other known fact. I accept the submissions of Mr Phillips, counsel for Ms Moss, in this regard. It is very difficult to understand the motivation for Ms Yeo giving such evidence. She presented as an articulate, intelligent person who had suffered some personal difficulties, particularly surrounding the time of her termination from Vaucluse Gardens. One might postulate that she harboured bitterness towards Ms Moss, as the primary nurse to whom she reported or to Vaucluse Gardens generally. She stated in evidence that this was not the case. She presented as a worker who was interested and involved in safety issues. She stated that she was aware of the alert and coronial finding that was circulated and she generally made it her business to be aware of such issues. I am not able to fathom her mindset in giving such evidence.

Ms Moss denied Ms Yeo's account. However, in her evidence she stated that she "did not recall" Ms Yeo raising concerns about Mrs Westcott's bed pole with her. She then stated that "it probably didn't happen". Ms Moss's evidence in this regard, as with many other aspects of her evidence, was equivocal and given abruptly. I cannot rule out the possibility that Ms Yeo may have raised a matter associated with a bed pole with Ms Moss, but there is no way to ascertain the contents of any such discussion or even whether it was Mrs Westcott's bed

pole. In any event, Ms Moss was of the view that Mrs Westcott's bed pole was compliant. Having heard her in evidence I doubt that she would have entertained any view expressed by Ms Yeo.

Conclusion regarding history and installation of the bed pole

After hearing the evidence of Ms Moss, I find that she did not raise with Mrs James, after the alert in June 2010, the dangers associated with bed poles. Because she did not, Mrs James was content that the bed pole remained on her mother's bed. On the evidence, as discussed above, there are three scenarios reasonably open relating to the presence and installation of Mrs Westcott's bed pole/s. They are:

(a) That, in August 2009, a single-sided bed pole was installed, removed at a later time, and subsequently a double-sided bed pole was installed;
(b) That, in August 2009, a double-sided bed pole was installed, removed at a later time, and subsequently reinstalled at the request of the family; or
(c) That a double-sided bed pole installed in August 2009 remained on Mrs Westcott's bed and was never removed.

There is some evidence to support each of these scenarios. I comment as follows in respect of each of the three scenarios.

(a) I have carefully considered whether Ms Moss may have been involved in a second installation of a bed pole in 2011 on the basis of a request to her by Mrs James, after which a bed pole appeared. If Mrs James is correct, then Ms Moss did play a role in arranging the installation of the bed pole and took no steps to notify a RN or initiate any required risk assessment. Ms Mooney submitted that Mrs James' recollection of the events leading to the installation of the bed pole may be unreliable, and that Mrs James may, for example, have been confusing this conversation in 2011 with a discussion regarding an assessment for a lifting device that occurred on 15 November 2011. Ms Mooney also pointed out that Mrs James did not actually see her mother in bed whilst she was at Vaucluse Gardens, as she was always in a chair. Therefore her memory relating to the use and existence of any bed pole may not be accurate. She also submits that the evidence of Mr Blackburn, who cared regularly for Mrs Westcott, was of high quality and credible, when he stated that Mrs Westcott always had a bed pole on her bed. I agree that he gave very good, credible evidence with an excellent memory for detail.

Further, there are no records at all of the re-ordering of any second bed pole. Entries in records would be expected given that, by June 2010, Vaucluse Gardens management and senior staff were well aware of the dangers of bed poles and the need for a risk assessment.

If Ms Moss decided to simply accede to Mrs James' request and order a new bed pole outside the established process she would remember when she fitted it that it was double-sided. Therefore, entailed in this finding, is also a finding that Ms Moss was not telling the truth about her knowledge of only the existence of a single-sided bed pole. If she was involved in installing the pole she would also know that she was installing a dangerous device upon Mrs Westcott's bed outside all risk assessment guidelines and consultation.

This scenario and associated false evidence is inherently unlikely. Whilst Ms Moss was not always a convincing witness, she portrayed that she understood her duties and that she was bound to act within established guidelines.

I therefore conclude that Mrs James was mistaken about either the timing or nature of the conversation with Ms Moss. I am satisfied that there was not a second bed pole installed on Mrs Westcott's bed.

(b) The same difficulties as discussed in (a) above arise on the scenario that the double-sided bed pole was installed initially, removed for a period of time and then re-installed. It could only have been realistically re-installed at a time after the alert when Ms Moss, or other ENs, were aware of, and required to, act in accordance with the strict risk assessment guidelines involving family consultation. I do accept that the absence of documentation is explicable in this scenario, as a new bed pole did not need to be ordered. However, I am satisfied that there was no removal and re-installation of Mrs Westcott's original bed pole.

(c) The final scenario is the only plausible one; being that the bed pole was double-sided and remained continuously upon Mrs Westcott's bed from August 2009. This entails a positive finding that Mrs James was mistaken about a conversation with Ms Moss in 2011. As submitted by Ms Mooney, her mother's care was complex and the subject of many discussions and notes to staff. She may well have assumed, given the role of the bed pole in her mother's death, that a particular conversation with Ms Moss in 2011 concerned a request for this item when it did not. I find that Mrs Westcott had a double-sided bed pole on her bed from August 2009 until her death. Having considered the evidence of Ms Moss and Mrs James, I do accept that at a point after the alert (but unlikely as late as 2011) Ms Moss did speak to Mrs James to ask her whether she wished the bed pole to remain on her mother's bed. Mrs James agreed that such a conversation may have taken place. This evidence was given in Ms Moss' first affidavit in which she was more forthcoming. This accords generally with Mrs James' evidence that there was a conversation with Ms Moss about a bed pole, albeit in a different context. It would appear that Ms Moss considered that such a conversation with Mrs James discharged her duties in respect of the risk assessment process.

Dangers associated with bed poles

On 9 June 2010 Vaucluse Gardens was notified that there were dangers associated with bed poles. On that date Ms Newham received the email originating from the Commonwealth Department of Health and Ageing.

The email advised of the finding which had been delivered by the South Australian Deputy State Coroner, Anthony Schapel, following an inquest into the death of a Mr Arthur Hutton. Mr Hutton had been housed in an aged care facility for dementia patients. He fell from his bed during the evening of 15 January 2008 and his neck became entrapped in the space between the mattress and a bed pole. The gap created a hanging point. Mr Hutton, like Mrs Westcott, asphyxiated due to neck entrapment.

The Deputy State Coroner in *Hutton* concluded that bed poles should **not** be used in circumstances where:

a) *there is a gap between the bed pole vertical component and the mattress, or*
b) *potential gap if the device or the mattress moves, and/or*
c) *where the intended user has a history of recurrent falls from bed, has a cognitive impairment, with or without limited mobility, or where the intended user's faculties are compromised by medication.*

He also stated that any person or organisation that utilises bed poles must ensure the use of a bed pole is risk assessed in each application.

In the same finding, the Deputy State Coroner made formal recommendations as follows:

1. *that DoHA draw the findings and recommendations to the attention of all Australian aged care services and approved providers*
2. *that SafeWork SA distribute a hazard alert regarding the use and dangers of bed poles*
3. *that the Office of Consumer and Business Affairs distribute a hazard alert regarding the use and dangers of bed poles.*

He also made recommendations primarily relating to KA 524 bed poles (being the same as that fitted to Mrs Westcott's bed) directed to manufacturers, suppliers and distributors to ensure that consumers are provided with written instructions as to the **correct installation** of the product that dealt with, *inter alia*, the desirability of ensuring that sufficient weight is placed upon the bed pole to ensure minimal movement whilst the user is in bed; any gap between the bed pole vertical component and the mattress be eliminated and; the desirability of frequent checking of the position and stability of the apparatus installed on the bed.

He also made recommendations directed to manufacturers, suppliers and distributors to ensure that consumers are provided with written instructions as to the **dangers** posed by the bed poles, with specific reference to the need for a risk assessment in each application, that they should not be utilised in respect of persons who have a history of falling from bed; that the device should not be used by persons who have a cognitive impairment; that the device should not be used by persons who have no access to immediate assistance; and the fact that a gap created between the vertical bed pole and the side of the bed has resulted in a fatality by way of head and neck entrapment.

Response by Vaucluse Gardens to the alert

I set out, in sections, the main evidence of the response by Vaucluse Gardens to the alert.

1. Ms Newham forwarded the email of 9 June 2010 to various senior staff within Vaucluse Gardens, including Ms Buckland (formerly Ms Rodway), Ms Fyfe, Ms Patmore (RN) and Ms Moss.

   Then, the following emails were exchanged between Ms Buckland and Ms Newham:

- Ms Newham to Ms Buckland (11 June 2010 at 6.22pm)

  "Bugger, just got time to read the Dept's release re the inquest findings re use of bed poles. If you do a search for KA524 bed pole you'll find the report. Let me know, but maybe we need to get them off until we think more?! …. Am I getting over cautious???!"

- Ms Buckland to Ms Newham (14 June 2010 at 5.04pm)

  "Sorry haven't checked emails till now…As it says it is not recommended for someone who has cognitive impairment, impaired mobility or may be effected (sic) by medications, so that pretty much rules out everyone. Plus who is to say that this sort of thing could not happen to a resident who does not have a diagnosis of dementia as they may have a confused disoriented episode related to illness and find themselves falling…"

- Ms Newham to Ms Buckland (14 June 2010 at 7.59pm)

  "I worried about the poles so called Janine on Sat to look into it and we'll follow up tomorrow. I think we have about 3 of that kind".

- Ms Buckland to Ms Newham (14 June 2010 at a time unknown)

  "Yes I think we may need to remove them due to the potential risk. Chat some more tomorrow"

2. Following the alert it was decided that all bed poles would be removed from Vaucluse Gardens. This evidence was given by Ms Buckland and that decision is reflected in the following documents:

   i. The minutes of an "OH&S" meeting conducted on 23 June 2010, which stated that Level 2 Registered Nurses were tasked to remove all bed poles and review residents for "safer alternatives";
   ii. The minutes of a "Quality Improvement" meeting conducted on 1 July 2010, which stated that the ENs in all areas were tasked to provide copies of the Coroner's report to all residents and/or families who wished to continue using the bed pole and to obtain signed "activity at risk forms";
   iii. An email dated 8 July 2010 from Ms Newham to various members of staff which read: *"All residents that have any type of bed pole MUST have them either removed or the resident/NOK MUST sign a Risk Taking Activity Consent Form after reading the coroners report re same. I have copies of both if required. Mandie".*

   There were 20 recipients of the email of 8 July 2010; apparently senior nurses and staff. The recipients of the email included Ms Buckland, Ms Moss, Ms Fyfe, Mr Blackburn and Ms Patmore.

Ms Newham gave evidence that she authored a memorandum in 2010 to notify staff of the finding in *Hutton*. She said that the memorandum, together with a copy of the Coroner's decision, was posted on the noticeboard in the Manor. Ms Buckland gave evidence that she sent an electronic message to staff to notify them of the finding in *Hutton*. Ms Buckland stated in her affidavit that this notified staff (a) to search all residents' rooms and to remove all bed poles from residents' rooms; (b) to inform the nurse manager of a resident or resident's family insisting on the use of a bed pole; and (c) the process to follow to allow continued use of a bed pole by a resident.

Ms Buckland told the inquest that Ms Fyfe (RN) was responsible for ensuring that all bed poles were removed from the facility, but that Ms Fyfe had the ability to delegate the task to "*nurses below her*" within each of the buildings.

The documents produced by Vaucluse Gardens do not reveal clearly that Ms Fyfe was formally delegated the responsibility for physically removing the bed poles, or that she in turn delegated it to any particular nursing staff or nurses on any particular shifts. Meeting notes of 23 June 2010 indicate that the RN Level 2 nurses were responsible for removal. The written directive from Ms Newham on 8 July 2010 was not addressed to any staff in particular. Mr Norman Blackburn stated that he understood that the nurses on all shifts were responsible for removing the bed poles. The same lack of specificity in direction applied to the email of 12 March 2012.

3. In July 2010 two alerts were sent by Ms Buckland and Ms Newham to notify staff of the bed pole alert, and the actions Vaucluse Gardens were taking in response to the DoHA's alert. Ms Buckland stated that, in particular, the internal alerts requested staff to search all residents' rooms and remove any bed poles; to inform the nurse manager if a resident or family insisted on continuing to use a bed pole; and of the process that was required to be performed to enable a resident to continue to use a bed pole.

   I accept that there was an internal alert. Staff members gave such evidence. Whether Ms Buckland's memory is accurate enough to state the contents, I am less certain. This alert was in the category of documents that Ms Buckland stated she had provided to the Coroners' Office and could not locate. This document was not provided to the Coroners' Office at any stage.

   Notwithstanding these communications and alerts, a number of witnesses gave evidence to the inquest that they did not know about the dangers posed by bed poles. Ms Sorrentino, Ms Abay and Ms Dare told the Court that they did not see the notice on the board in relation to bed poles. Moreover, they did not receive Ms Buckland's notification. Neither Ms Sorrentino nor Ms Abay had a work email address. Ms Booth and Ms Kamau were not working at Vaucluse Gardens at the time the finding in *Hutton* was notified to staff. In any event, it is clear that the installation, removal and risk assessment processes for bed poles were within the province of the RNs and ENs, and not the ECAs.

4. In June 2010, after the alert, the Restraint Policy and Practice Standard was written, which included bed poles (even though the policy stated they were not classified as a "physical restraint"). The main requirements of this policy were:

    (a) that prior to any restraint implementation a risk assessment must be completed;

    (b) that mobility devices such as bed poles would only be utilised in the following circumstances: following a thorough assessment process following the Restraint Management Flow Chart; and when the general practitioner, registered nurse L2, L3 or Facility Manager are in agreement; and when consultation with the resident and/or representative has taken place and been documented; and, while the restraint is in use, staff must implement "Restraint Risk Assessment Form" to monitor safety at all times.

    (c) the details of the restraint must be documented in the resident's care plan and record of release of restraint.

5. A *"Mobility Devices – Bed Poles"* policy was subsequently prepared by Ms Buckland. This was additional to and to be used in conjunction with the Restraint Policy. When the finding in *Hutton* was brought to the attention of Vaucluse Gardens, the facility did not have a specific policy in relation to bed poles. The Bed Pole policy mirrored the recommendations and findings in *Hutton* but had significant additions. Extracted below are the salient components of the Bed Pole Policy:

    "3.16 MOBILITY DEVICES – BED POLES

    3. PRACTICE STANDARD

    3.1 The need for any person or organisation that utilises bed poles to ensure that the deployment of the bed pole is risk assessed in each application.

    3.2 That the product should not be utilised in respect of persons who have a history of falling from the bed.

    3.3 That the device should not be used by persons who have a cognitive impairment.

    3.4 That the device should not be used by persons who have no access to immediate assistance.

    3.5 The bed pole must be installed to ensure there is no gap between the mattress and the bed pole. This is to be communicated clearly to staff, residents and relatives.

    3.6 All residents are to be assessed by the Physiotherapist prior to implementation of a bed pole.

3.7 All resident's and relatives requesting the use of a bed pole be provided with written documentation as to the dangers of there (sic) utilization (sic).

3.8 The Department of Health and Aging recommends that when mobility aids, such as bed poles, are used, it is important that:

- *They are used appropriately following the assessment by an appropriate health professional.*
- *Placement of the mobility aids and the risks associated with use have been assessed and documented.*
- *The use of mobility aids is frequently monitored.*

3.9 Restraint process is to be followed to ensure equipment is reviewed 4 monthly. See restraint policy."

During the inquest Ms Buckland was asked about when the Bed Pole Policy was written and whether it had been the subject of review. She told the Court that she was not certain whether the policy was written in 2010 (following the alert), 2011 or 2012. She suggested that it may have been reviewed in February 2012, prior to accreditation assessments in April of that year. The document itself indicates that "Version 1" of the policy was written in February 2012 and had not been reviewed. Ms Mooney submits that the Bed Pole Policy was prepared in October 2011 due to its reference on the Clinic Checklist with that same date. I agree that the policy must at least have been contemplated, and given a number, by that date. However, there may well have been a time lag such that the first version was not written until March 2012. As submitted by Ms Munnings, irrespective of exactly when the policy was prepared, it was clear from the evidence of Ms Buckland that it existed before Mrs Westcott's death.

6. On 12 March 2012, 19 days before Mrs Westcott's death, Ms Newham sent an email to 13 RNs and ENs in the following terms:

"To reflect all restraints and alternatives trialled on a residents care plan, staff are to review and update all falls/safety assessments – Restraint usage.

Ensure to document type of restraint, alternatives discussed/trialled, outcomes and resident/family/GP consultation – (for an example see Lorraine Foong's assessment/care plan).

If a resident has a bed pole (or equivalent) and has signed a Risk Taking Activity Consent Form, this will also require adding to falls safety measurement, mobility risks to ensure reflective on care plan – (for an example see Lorraine Foong's assessment/care plan)."

This email was likely prompted as a result of the February 2012 development/review of the Mobility Devices Policy. Ms Fyfe was copied into the email.

7. In responding to the alert, Vaucluse Gardens management relied upon a particular "portfolio" delegated to Ms Fyfe to comply with organisational key performance indicators (KPIs) relating to restraints. Ms Fyfe was responsible for the "restraints portfolio". This involved a three monthly compilation report sent to Ms Newham and Ms Buckland regarding management of restraints. Ms Fyfe was required to circulate a list of residents who had any form of restraint in their rooms, including bed poles, to nursing staff each month. To compile this list accurately she would rely upon information from the nursing staff in each building of Vaucluse Gardens to advise when a new form of restraint was initiated for a resident. This information would then be included in the list that was circulated to each building on a monthly basis. She stated that once the list was issued each month the nurses in each building were responsible for informing her of any changes to the list so that she could update it. All information gathered monthly by Ms Fyfe was entered into a computer database, which included a graph showing increases and decreases of restraint usage and the reasoning for the type of restraint used. The information and data she collected monthly was also used to compile her three monthly KPI report. Ms Fyfe's role did not include carrying out door-to-door inspections of each resident's room but the updating of the lists was from information provided to her as stated.

8. The use of mobility devices was required to be included on a resident's care plan. This plan was comprehensive and provided vital information to ECAs, ENs, RNs and managers on all aspects of the resident's care needs. Although such recording requirement existed before the 2010 alert, it is clear from the evidence that the updating of a care plan was central to the facility's response to the alert.

Why did Mrs Westcott's bed pole remain?

Unfortunately, despite the above action, Mrs Westcott's bed pole remained in place without question, and without further risk assessment. It remained on her bed despite a clear knowledge by management and nurses that there were dangers of death associated with this device, and despite a policy mandating removal unless strict conditions were satisfied. No one in management, and no RN or EN working in the Manor, were aware that the bed pole was present on Mrs Westcott's bed outside the correct risk assessment guidelines. Ms Moss and other ENs working at the Manor did not question its presence, remove it, report it to Ms Fyfe upon the circulation of her monthly restraint figures or proceed to a risk assessment in respect of it. The RNs reviewing the care plans did not question its continued reference in those plans.

Ms Munnings submitted that there was a fundamental systems failure at Vaucluse Gardens given that Mrs Westcott still had a bed pole in March 2012, when it should have been removed 21 months earlier. She submitted that the evidence indicates that the procedures were inadequate in that there were no checks to ensure that the directives of management were followed.

Ms Mooney submits that Vaucluse Gardens management responded appropriately to the 2010 bed pole alert. She submits that appropriate policies and procedures were created by

Baldwin. She submits, however, that the policies and procedures were imperfectly promulgated and implemented.

Even if there is a difference between these two types of deficiency, it is not necessary to accept one categorisation and reject the other. I have, instead, attempted in this finding, to determine when and how, on the 21 month time continuum, action could reasonably have been taken to prevent the risk that tragically eventuated. It must be borne in mind, in approaching the analysis, that (a) there were only four residents (including Mrs Westcott) with bed poles; (b) that they had been responsible for at least one fatality; and (c) that there were known circumstances when risk of entrapment was high.

In the course of giving evidence to the inquest, Ms Buckland agreed that even in 2010 Mrs Westcott was not someone who should have had a bed pole. Ms Buckland was aware of Mrs Westcott's poor mobility and that she suffered from cognitive impairment.

Initially the bed pole was used by Mrs Westcott to get in and out of bed, as well as manoeuvring herself in bed. However, towards the end of her life, when she was immobile, it was only used for support whilst the carers were rolling and/or changing Mrs Westcott. The use of it for support in those circumstances was obviously unnecessary. It was accepted by Vaucluse Gardens that Mrs Westcott should not have had the bed pole at the time she died.

Ms Buckland and Ms Newham gave evidence that they used a variety of methods (as described above) to bring the information to the attention of staff. Memoranda were posted on notice boards, certain staff had access to email, messages were entered onto the LeeCare system and folders of meeting minutes were placed in the nurses' stations. Notwithstanding these methods of communication, the strict risk assessment requirements for bed poles were not widely known by staff.

The facility also accepted that a risk assessment had not been conducted in respect of Mrs Westcott's bed pole. Mrs Westcott had not been given any documentation in relation to the dangers associated with bed poles and neither had Mrs James. A Risk Taking Activity Consent Form was not signed by Mrs Westcott or Mrs James. Mrs Westcott was not assessed by a physiotherapist in relation to the bed pole and there was no consultation with her general practitioner. The dangers associated with bed poles were never discussed with Mrs James or the family.

Ms Buckland could not offer an explanation for why the procedures and policies at Vaucluse Gardens had not been followed in the case of Mrs Westcott. She gave evidence that she relied upon the managers to ensure that the Bed Pole policy was being adhered to. She agreed that the staff may simply have "*assumed*" that a Risk Taking Activity Consent Form had been signed because Mrs Westcott's bed pole had "*always been there*". Ms Buckland accepted that there could have been improvements in the process of checking for bed poles in Vaucluse Gardens.

Ms Newham told the Court that it was the responsibility of the ENs to notify the RNs of the presence of bed poles. Ms Newham gave evidence that because she had received "*some feedback*" from staff in relation to her email of 8 July 2010 she presumed that it had been

actioned. Ms Newham could not offer an explanation for how Mrs Westcott's bed pole was overlooked for nearly two years. Her words were, *"Ultimately I don't know how this happened".*

Ms Moss stated that Mrs Westcott's bed pole had been overlooked and *"missed by everybody"*. As discussed above, I am satisfied that she was aware of Mrs Westcott's bed pole but, apart from a conversation with Mrs James, did not initiate any formal process of risk assessment and removal. She then overlooked any further required steps to review its use.

There was no other evidence offered (apart from Ms Yeo's evidence) regarding why the bed pole remained.

Ms Mooney submitted that the managers relied on staff to implement processes as they were collectively directed and to report matters of concern to them for attention. This did not occur in respect of Mrs Westcott's bed pole. She submitted that there was a collective failure to take the initiative and act, perhaps based on a lack of direct allocation of personal responsibility to one person. The fact that two other bed poles were actioned and reported back to Ms Newham, led her to assume that all bed poles had been actioned. The fact that lists of restraints, including bed poles, were required on a monthly basis also lulled Ms Newham into presupposing that all bed pole use had been captured. Ms Mooney submitted "this led to the unfortunate situation whereby it appears all staff assumed a risk assessment had been undertaken when it had not".

This submission encapsulates the mechanism of the failure of the process as a whole. On all the evidence, as discussed, I find that Mrs Westcott's bed pole was overlooked in the processes developed for its removal. Her death was so easily preventable had these processes been followed.

Responsibility of Sharon Moss

Much of the evidence involved Ms Moss' obligations as she was said to be the primary nurse in charge at the Manor. In her first affidavit she describes herself as "nurse-in-charge". The ECAs also stated that they viewed Ms Moss as the nurse in charge.

Ms Buckland, in her affidavit, stated *"Sharon Moss, who was the nurse-in-charge at the Manor, failed to report to me that Mrs Westcott also had a bed pole"*. In her affidavit, Ms Fyfe *stated "Sharon Moss, the main nurse-in-charge of the Manor building, should have informed me when Mrs Westcott had a bed pole installed. Nursing staff were responsible for being on the ground and providing care directly to care recipients and they were responsible for reporting up to me about anything relevant regarding resident care."*

Ms Mooney submits that the evidence disclosed that there was an unwritten professional culture and expectation that the EN on the day shift in each facility would assume responsibility for operational requirements. I accept this submission and add that a task such as reviewing bed pole installation would appear to be in the range of duties falling within the remit of that particular nurse, particularly when instructed by management. In her evidence at inquest Ms Moss stated that she never carried out duties as unit manager, and was never

appointed as nurse-in-charge. She was questioned at length but her evidence, again, did not assist me in clarifying her role. Initially she stated that she was on holidays before Mrs Westcott died until viewing evidence of her shift hours. In several similar ways, she distanced herself from responsibility, even though she ultimately conceded that she was in charge on day shifts that she worked. Ms Moss' demeanour and content of evidence tends to indicate a feeling of responsibility.

Ms Moss was in the prime position to have ensured that the bed pole was removed from Mrs Westcott's bed pending compliance with the strict requirements of the Restraint Policy. She was the recipient of the email relating to the South Australian Deputy State Coroner's findings on 9 June 2010 as well as the email requiring removal or signed risk assessment on 8 July 2010. She stated that she was also aware of a memorandum issued to staff electronically and placed on the notice board in the Manor, highlighting the recommendations made by the Coroner relating to bed poles. She was also the recipient of the email of 12 March 2012 to ensure the existence of documented risk assessment for all bed poles.

Having received these notifications, and being the nurse-in-charge of the Manor on day shift, she must have at least been aware of the dangers of bed poles and need for a written risk assessment. She took no further steps in this regard after speaking to Mrs James, and it seems that the bed pole escaped her further attention.

I am very cautious in criticising Ms Moss for an inadequate approach to the risk assessment process relating to Mrs Roberts' bed pole. The evidence indicates that Ms Moss was tasked by Ms Newham to speak to Mrs Roberts about whether her bed pole should remain. Ms Newham gave evidence that Ms Moss did have Mrs Roberts complete a consent form for her bed pole to remain. This document was not produced at inquest. The Aged Care Complaints Scheme report subsequent to Mrs Westcott's death details the inadequacies in respect of Mrs Roberts's bed pole process after considering the relevant records. The inadequacies included lack of written consent, lack of risk assessment, lack of physiotherapy assessment and lack of evidence of communication to Mrs Roberts and her next of kin highlighting the dangers associated with the use of bed poles. Immediately after Mrs Westcott's death Vaucluse Gardens took steps to implement the proper, documented process. I am not required to resolve the issue of whether a consent form was actually signed by Mrs Roberts. The process in respect of Mrs Roberts was directed by Ms Newham on behalf of management. Ms Buckland, Ms Moss and Ms Fyfe also had opportunities to ensure the process was correct and fully documented.

It is particularly notable that on 24 January 2012 Mr Matthew Lamb, a personal trainer, completed a fitness specialist assessment which was noted in Mrs Westcott's records as *"Barbara is unable to weight bare (sic) and requires a full sling for all transfers".* He requested in that note that the care plan be updated. Ms Moss wrote underneath the entry *"noted thank you".* In oral evidence, Mr Lamb stated that Ms Moss directed him to make the progress note. Ms Moss does not recall Mr Lamb, or discussions with him, and noted that it will usually be a physiotherapist who will assess a resident for the use of an aid. I accept Mr Lamb's evidence, corroborated by the progress notes, that Ms Moss requested an

assessment from him. However it is also to be noted that Mr Lamb gave evidence that he did not actually see Mrs Westcott for the purpose of the assessment. This process was an utterly inadequate assessment and contrary to proper process and good practice.

Nevertheless, this assessment for a full sling for all transfers should have provided Ms Moss with yet further opportunity to remove the bed pole as it was not a suitable aid to remain on her bed given Mrs Westcott's obvious lack of mobility.

On the evidence, Ms Moss had the pivotal role in ensuring removal of Mrs Westcott's bed pole and, as further discussed, had many opportunities to do so before Mrs Westcott's death. In making such finding I do not intend to diminish the many other opportunities for action involving management and numerous other staff, as I now discuss.

Opportunities to have reviewed Mrs Westcott's bed pole

There were notable occasions after the bed pole alert when consideration could possibly have been given by Vaucluse Gardens to the bed pole in Mrs Westcott's room. I set them out as follows.

1. *Action immediately after the alert* - When the decision was made in June 2010 that all bed poles across the facility would be removed, there existed the major opportunity to remove and, if appropriate, review Mrs Westcott's bed pole. Despite the prompt email correspondence, decision and directions, other steps may have been taken as follows to ensure all devices were captured:

    a) A follow-up check after the initial directions by Ms Buckland or Ms Newham to satisfy themselves that the directive to Ms Fyfe (and the other recipients of the email) had been followed and that all bed poles had been removed from the facility.

    b) A physical walk-through of the Manor to ascertain which residents at that time had bed poles. The evidence indicates that this may have taken in the vicinity of one hour, and could have been tasked to any member of staff.

    c) A full reconciliation of all bed poles by reference to a walk-through of rooms, updating Ms Fyfe's statistics and updating care plans.

    d) Specific notification to the ENs that bed poles fell within the ambit of Ms Fyfe's portfolio of "restraints" and were therefore the subject of monthly reporting obligations.

    e) The directives in the emails of 9 June 2010 and 8 July 2010 to be made to one person, not many, with an allocated action time and subsequent review of that action.

2. *Proper review of care plans* - Mrs Westcott was classified as a high care resident and, pursuant to the Vaucluse Gardens "Resident Reviews Policy", her care plan was required to be reviewed every 4 months. The "mobility and dexterity" component of a care plan specifically covers bed poles. Therefore, if Mrs Westcott's care plan had been reviewed properly, then her bed pole (and the presence or absence of necessary paperwork) would have been considered on at least five occasions between June 2010 and March 2012

   Specifically, Mrs Westcott's care plan was last reviewed and *signed off* by an RN in January 2012. In that care plan the reference to the presence of a bed pole was crossed out by hand. All previous care plans had indicated that a bed pole was *in situ*. Ms Buckland gave evidence that unless a care plan had been signed off by an RN, it was not valid. She said that it was the role of the RN and not the EN to determine the mobility aid that a resident required. Mrs Westcott's care plan was "printed and saved" on 22 March 2012, but nothing indicates on the face of that document that its contents had been reviewed. There was no signature from a RN on that care plan and it does not reflect the fact that the preceding one (from January 2012) had removed the reference to the "bed pole". Ms Fyfe notified management about the results of her "restraints audit" on 22 March 2012. It may therefore be the case that Mrs Westcott's care plan was not actually reviewed on 22 March 2012, but was only printed for the purposes of the audit. Even if this is the case, it still presented an opportunity to review Mrs Westcott's bed pole.

3. Ms Buckland told the inquest that a Clinic Checklist was utilised in connection with each clinical care review that was conducted of a resident. No such completed document has been produced in respect of Mrs Westcott and it appears that it may not have actually been widely used. This may have been of great assistance. The sample Checklist includes the following item: *"Mobility devices – bed poles. Policy 3.16. All staff to familiarize themselves with the above Policy. Any device mentioned in the policy is to be removed and RNIII or RNII to be notified".* Ms Buckland gave evidence that this particular entry was inserted into the Checklist after the alert. None of the documents produced to the inquest indicate when, after the alert, the words were added, or the methods by which the change in form was brought to the attention of staff (if at all). However, a proper completion of this document pertaining to Mrs Westcott's care should have required consideration of the bed pole.

4. In the process of assessing Mrs Westcott for a lifting device commencing in about November 2011 and culminating in the assessment and approval in January 2012.

5. In February 2012, an audit was conducted by Ms Fyfe of the restraints across the entire facility. The results of the "100% audit" were provided to the facility manager on 22 March 2012. The results indicated that there was 53% compliance within the Manor building. Three issues were identified in the audit report: (i) care plans were not reflective of current restraints; (ii) there was no evidence of alternatives trialled or suggested; and (iii) there was no evidence of 4 monthly reviews having been

completed. Notwithstanding the results of the audit, Mrs Westcott's care plan was not updated.

6. The use of bed poles was specifically considered by Ms Buckland in February 2012 when the "Mobility Devices – Bed Poles Policy" was developed and/or reviewed, yet this did not trigger particular consideration of Mrs Westcott's bed pole.

7. On 12 March 2012 Ms Newham wrote an email to 13 members of the nursing staff requiring them to specifically review the use of bed poles and to ensure the correct risk documentation was in place and reflected on care plans. There is no evidence that this directive was actioned by the recipients or followed up by Ms Newham.

8. On four occasions per day nursing staff attended Mrs Westcott's room to administer her medication, yet these attendances did not trigger consideration of her bed pole.

9. On numerous occasions Mrs Westcott's family had discussions with the nursing staff of Vaucluse Gardens regarding her care. These discussions did not trigger consideration of the use of her bed pole.

I have discussed the above as the main opportunities for review of the use of Mrs Westcott's bed pole and to highlight the multiple omissions to act so as to prevent the known risk eventuating.

Ms Mooney submits that proper processes and opportunities appear clearer in hindsight. She submits that anticipating every possible systems failure is not an easy task in a busy facility which requires processes for managing risks of all types in complex and changing environment. I accept her submission.

The authorities have, primarily in civil cases, dealt with the "clarity" provided by hindsight analysis. For example, in *Rosenberg v Percival* [2001] HCA 18; (2001) 75 ALJR 734, Gleeson CJ at para 16 stated:

"There is an aspect of such a question which may form an important part of the context in which a trial judge considers the issue of causation. In the way in which litigation proceeds, the conduct of the parties is seen through the prism of hindsight. A foreseeable risk has eventuated, and harm has resulted. The particular risk becomes the focus of attention. But at the time of the allegedly tortious conduct, there may have been no reason to single it out from a number of adverse contingencies, or to attach to it the significance it later assumed. Recent judgments in this Court have drawn attention to the danger of a failure, after the event, to take account of the context, before or at the time of the event, in which a contingency was to be evaluated."

In respect of the risk of Mrs Westcott's bed pole remaining on her bed, however, there was every reason for it to have been the subject of special and careful attention. It is not difficult to imagine that, within the environment of an aged care facility, adverse incidents may arise from many objects and situations unexpectedly. It is often possible to unrealistically construct a "systems failure" chain of causation in hindsight. However, the continuation of

the bed pole upon Mrs Westcott's bed presented a known and extremely serious risk requiring only simple measures to eliminate.

In my view, with reference to the possibilities discussed above, the following should reasonably have occurred:

1. Adoption of the more rigorous processes immediately after the alert as itemised above;
2. Thorough reviews of Mrs Westcott's care plans by the ENs and RNs including sighting the required risk assessment documentation for the bed pole;
3. Inclusion of the requirement to sight the completed Risk Taking Activity Consent form on the care plans;
4. An immediate follow-up of the restraints audit results in February 2012, when lack of compliance became apparent;
5. A consideration of the removal of the bed pole at the time of the approval processes for a lifting device in or before January 2012; and
6. On 12 March 2012, a specific direction to particular staff members so as to ensure compliance with the bed pole policy, together with a report back to management within an allocated short period of time.

Staffing Levels and Mrs Westcott's Death

Did the failure to provide half-hourly checks contribute to death?

At inquest, I received evidence concerning the ability of Vaucluse Gardens to provide half-hourly checks and whether such checks were clinically necessary. This issue was examined primarily to determine whether Mrs Westcott's death would or may have been prevented if those checks had been provided as promised, particularly in the 2½ hours before her death.

At the outset, I am not able to make a positive finding that the failure to provide half-hourly checks contributed to Mrs Westcott's death. Dr Ritchey could not comment upon how long Mrs Westcott would have actually taken to die, or how long she may have been in the hanging position. Even if Ms Abay and Ms Dare had been able to undertake the 30 minute checks of Mrs Westcott between 8.30pm and 11.30pm they may not have been able to prevent her death because it is unknown when Mrs Westcott fell from the bed. She may have fallen and died a very short time after a scheduled half-hourly check. However, as a matter of logic, if the required checks had taken place between 8.30pm and 11.30pm, there would have been more opportunities for staff to have prevented her death.

It is quite feasible that Mrs Westcott fell as a result of being poorly positioned in the bed after being administered her medications or through her own subsequent movement in the bed. It is equally feasible to contemplate that she may have been trying to reach for an item, such as a drink, and this precipitated her fall. Therefore the half-hourly checks might have averted death as staff may have intervened, for example, to correctly position Mrs Westcott, to provide her with a drink or even to extract her from her trapped position whilst still alive. It will never be possible to know whether her death could have been prevented by the occurrence of the requisite checks. I am able to find, though, that Mrs Westcott was deprived of a chance of survival by their absence.

Adequacy of staffing levels in the Manor to provide care to Mrs Westcott

I now discuss the staffing levels in the Manor at the time of Mrs Westcott's death as this issue pertains to the ability to provide the half-hourly checks and to provide adequately for her care and safety in the period leading to her death.

On 31 March 2012, there were 27 residents in the Manor. Of this total, 13 were classified as "high care", 13 were "low care" and 1 resident had yet to be assessed. I accept the evidence of Ms Abay and Ms Dare that on 31 March 2012 there were more "high care" residents than usual, including many who required two staff for assistance. I also accept that, besides Mrs Westcott, there were a number of residents in the Manor who were required to be checked every half-hour.

As noted previously, the following staff worked in the Manor as rostered during the afternoon and evening shifts on 31 March 2012:

- Ms Moss (EN) 7.00am – 6.00pm
- Ms Abay (ECA) 3.00pm – 11.00pm
- Ms Dare (ECA) 3.00pm - 10.30pm
- Ms Sorrentino (ECA) 11.00pm – 7.00am (1 April 2012)

Ms Booth (EN) was rostered to work in the Lodge but undertook the 8.00pm medication round in the Manor as a "single task". There was one RN on duty between 3.00pm and 11.15pm and that was Bernard Kargbo-Reffell. He was the RN for the entire facility and was not physically based in the Manor. Ms Kamau was the RN for the entire facility between 11.00pm – 7.00am (1 April 2012) and was physically based in the Court.

Vaucluse Gardens is an approved provider of aged care and is provided with Commonwealth funding to operate as such. The *Aged Care Act* 1997 governs the operations of an approved provider. The objects of the *Aged Care Act* include:

> (a) to provide for funding of aged care that takes account of:
>
> (i) the quality of the care; and
> (ii) the type of care and level of care provided; and
> (iii) the need to ensure access to care that is affordable by, and appropriate to the needs of, people who require it; and
> (iv) appropriate outcomes for recipients of the care; and
> (v) accountability of the providers of the care for the funding and for the outcomes for recipients;
>
> (b) to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;
>
> (c) to protect the health and well-being of the recipients of aged care services.

Under the *Aged Care Act* 1997, section 54.1, the responsibilities of an approved provider of aged care includes:

(a) to provide such care and services as are specified in the Quality of Care Principles;

(b) to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;

(c) to provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles;

(d)-to comply with the Accreditation Standards;

(e) Such other responsibilities as are specified in the Quality of Care Principles.

The evidence at inquest, predictably, disclosed the complexity of the system of Commonwealth funding and the ongoing requirements of Vaucluse Gardens to maintain staffing levels, using that allocation of funding, so that the above responsibilities can be satisfied.

As submitted by Ms Munnings, the evidence adduced during the inquest clearly demonstrated that the nurses/carers in the Manor did not share the view of management that the staff numbers were adequate to provide the required care.

Extended Care Assistants

Ms Sorrentino told the Court that the number of staff at Vaucluse Gardens was always too low for the number of residents. In her opinion the residents did not receive the care they paid for and, in some instances, were not given the care that they required. Ms Sorrentino was of the view that the staffing levels on 31 March 2012 were “inadequate” and “unsafe”. She was the only ECA and staff member physically on the floor in the Manor during the night shift. Ms Sorrentino explained that she would have to contact a staff member in another building each time she required assistance to undertake a task requiring two people. She said that occasionally she undertook tasks by herself even though they were supposed to be performed by two people. If Ms Sorrentino was attending to the needs of a resident on one level, she said that the rest of the Manor was effectively unattended. If Ms Sorrentino was in the lift, then all floors were unattended. She gave evidence that if a resident was unable to call for assistance following an accident, the resident would be entirely dependent upon when Ms Sorrentino happened to check that resident. Ms Sorrentino told the Court that she approached Ms Newham and Ms Buckland to express her dissatisfaction about the working conditions. Ms Sorrentino said that she was told in response, “*This is how it is. This is the ratio we are working with”.*

Ms Abay shared the views of Ms Sorrentino regarding the staff levels on 31 March 2012. She gave evidence that there were insufficient staff to fulfil Mrs Westcott’s needs and described the situation as *“unsatisfactory”.* Ms Abay told the Court that at approximately 5.00pm she contacted the Lodge seeking assistance in the Manor; however assistance was not forthcoming.

Ms Dare told the inquest that she also contacted management on 31 March 2012 seeking the assistance of another staff member, but received no such assistance. She told the Court that it was impossible to undertake the half-hourly checks of residents with the number of staff available. Ms Dare stated that had been the state of affairs for "*easily six months*" before Mrs Westcott died.

The evidence of Ms Abay and Ms Dare was that, during their afternoon shift, they sought assistance from staff within another building at Vaucluse Gardens, but assistance was not forthcoming.

Nurses

Ms Moss gave evidence that a full complement of staff on the day shift was four ECAs and one EN. She said that usually once a week the Manor had insufficient ECAs which meant that the EN had to undertake the duties of an ECA. Ms Moss also told the inquest that undertaking the half-hour checks was difficult due to the layout of the Manor. From my own observations upon inspecting the Manor before the inquest, I can easily accept such evidence. The large building, multiple levels and distance separating each room are clearly factors that would increase the difficulty in monitoring the residents in the event of staff shortages.

In evidence to the inquest Mr Blackburn stated that the staffing levels in the Manor were "*far too low*" and that in March 2012 he rarely worked with the full number of staff as rostered. He asserted that people frequently failed to arrive for their shifts and cited one example where he arrived for his shift and there were no ECAs at all. Mr Blackburn also gave evidence that simultaneous multiple falls were common across all three areas at Vaucluse Gardens.

Mr Blackburn gave further evidence that he experienced difficulty having RNs sign off on the care plans. His evidence was that there were not enough RNs between January and March 2012 to enable the care plans to be completed.

Management

The position of Vaucluse Gardens management was that staff levels were adequate to provide proper care to the residents of the Manor.

The Chief Financial Officer for Vaucluse Gardens, Mr Abinesh Ram, provided an affidavit for the inquest. He stated that the staffing levels at the time of Mrs Westcott's death were "*above industry benchmarks*", particularly insofar as the coverage of RNs was concerned. The relevant benchmarks were provided in a 2010 document entitled the *"Stewart Brown Aged Care Financial Performance Survey"*.

Ms Buckland told the inquest that Mr Ram had the "final say" in relation to the number of staff who were rostered, but that she and Ms Newham then determined the skill sets of those rostered. She stated that the rosters were prepared four weeks in advance and were influenced by Commonwealth funding considerations as well as the care needs of residents within each area. Ms Buckland told the inquest that more staff were rostered in the Manor because of its "unique" layout but that additional staff would not be rostered to cater for the

residents who needed to be checked every half-hour. Ms Buckland explained that a "high care" classification attracted greater Commonwealth funding which in turn, influenced the number of staff who were rostered.

Ms Buckland told the inquest that the staff numbers for 31 March 2012 accorded with industry benchmarks. She disputed the evidence of Mr Blackburn in relation to inadequate staffing levels. She was not able to specifically explain how the calculations were made and said that she relied upon Mr Ram and other advice to satisfy herself that staffing levels were appropriate. She stated that for a period of time while Mrs Westcott was a resident, she also had access to a tool into which data (such as Commonwealth funding, acuity levels and resident numbers) could be entered, in order to check staffing levels against benchmarks. Ms Buckland said that she responded to staffing level needs and regularly conducted a review of staff levels to take into account matters such as acuity levels, care needs, staff feedback and resident feedback. Vaucluse Gardens staffing levels were above average industry staffing benchmarks. It appears that the issue of benchmarking is far more complicated than this statement suggests. For example, I observe that the KPMG review document advised in respect of EN and ECA care that *"Vaucluse Gardens non-registered nursing care exceeds benchmark within high care but is well below benchmark within low care… Vaucluse Gardens can increase its enrolled nursing and extended care assistance hours within low care in order to mitigate the effect of a greater reduction (by cost) within low care registered nursing… Vaucluse Gardens should however also reduce its enrolled nursing and extended care assistants hours within high care. This reduction can be slightly mitigated by a small increase in registered nursing…"*

Ms Buckland did not know how many of the residents in the Manor on 31 March 2012 required the assistance of two staff, or how many needed to be checked every half-hour.

Ms Buckland told the Court that an agency could be contacted for personnel if unplanned absences could not be filled internally. Moreover, management could be contacted by telephone for advice. She disagreed with Ms Sorrentino's assertion that there was an inadequate number of staff in the Manor during the night shift. She also disagreed with the assertions of Ms Abay and Ms Dare that the numbers of ECAs on the afternoon shift on 31 March 2012 were inadequate. Ms Buckland did, however, accept the statement that it was impossible for Mrs Westcott to have been checked every half-hour with the number of staff who worked on 31 March 2012.

An affidavit sworn by Ms Helen Pollard was tendered. She was an RN who is currently the Chief Executive Officer of a home care service for the elderly. At the request of Baldwin, Ms Pollard reviewed the numbers of staff in the Manor on 31 March 2012, the number of residents and their acuity classifications. She expressed the opinion that the staff numbers were "*appropriate*". Ms Pollard did not however explain the basis for that opinion. The lack of a process of reasoning to this opinion renders it of little value. It is also clear from the annexures to her affidavit that she did not have regard to the number of residents who required checking every 30 or 60 minutes, the specific needs of each resident, the number of residents who required two members of staff for assistance or the workload of the staff who were providing care to the residents on the day in question. I accept that Ms Pollard's view is

to be accorded weight to the extent that it is consistent with Mr Ram and Ms Buckland's evidence that the staff numbers were in accordance with industry benchmarks. I also accept Ms Mooney's submission noting that the Aged Care Standards and Accreditation Agency had a number of opportunities to make adverse findings about staffing levels at the facility during the accreditation process conducted on 19 May 2009 and again on 17 April 2012 but did not do so.

Conclusion re staffing levels and Mrs Westcott's death

On the evidence of Ms Buckland and staff members in the Manor, it is clear that when the half-hourly checks were promised in about August 2011 they could not be provided.

I find, on the basis of the evidence led by Baldwin, that Vaucluse Gardens staffing levels around the period of Mrs Westcott's death were in accordance with expected levels in the industry. I am reinforced in this conclusion by the generally held view of the staff members who gave evidence that Vaucluse Gardens was a "better place to work" than other facilities. Nevertheless they universally stated that they were not able to provide the optimum care. Whilst these staff members were caring and dedicated, I did not gain the impression that they sought to provide residents with a level of care that was unrealistic. They simply articulated that they were not able to fulfil their duties. Their evidence was given independently of each other and they bore no malice towards Vaucluse Gardens. I accept their evidence.

I can only reconcile the two categories of evidence by concluding that, at least in the Manor, the industry benchmarks for adequate staffing did not provide for a realistic workload of the staff nor the ability to fulfil all of their tasks. On a wider scale, the evidence suggests that staffing levels are often inadequate across the aged care industry. The evidence also indicated that staff absenteeism was a significant factor in reducing staffing levels to below what was adequate to provide proper resident care. Again, the evidence gives me no reason to believe such an issue is confined to Vaucluse Gardens.

Having made these comments, it is not appropriate to further attempt to reconcile the evidence in a wider context or to make recommendations relating to the aged care industry at large. If low staffing levels, with consequent effects upon care, are endemic in the industry, then this is for ventilation in another forum.

Ms Munnings submitted that notwithstanding any comparison against benchmarks, there should have been two ECAs rostered in the Manor on the night shift. ECAs should not, she submits, have to request and rely upon the availability of staff from another building for assistance. The practice effectively took a staff member away from one area, to assist in another. I accept this submission. Taking into account all of the evidence presented in the inquest I find that one ECA rostered on night shift is inadequate, particularly given the size and layout of building, as well as the care needs of the residents.

I received an affidavit from Ms Maureen Berry, Bupa's Clinical Service Improvement Director, deposing to the fact that Bupa constantly monitors and adjusts its staff numbers to ensure that they are sufficient to meet the needs of its residents so that all residents receive the best possible care.

I find that the staffing levels in the Manor during the afternoon and evening shifts on 31 March 2012 were inadequate to fulfil Mrs Westcott's requirements for half-hourly checks.

There was evidence that Mrs Westcott did not require half-hourly checks for her clinical needs. I accept that this is the case. However, she was doubly incontinent and was not able to provide herself with fluids. She was alone in her room on the fourth floor of a large facility with no nearby nurse's station. Although she had a call pendant around her neck to alert staff if she required them to come to her room, there was no clear evidence that she regularly used it or always had the physical ability to use it. Her immobility may well have prevented her from reaching it if it was lodged in her clothing. More importantly, the evidence indicates that Mrs Westcott was most reluctant to ask for help. In these circumstances regular checks were of crucial importance.

On any view, it was reasonable that, for her safety and comfort, she received regular checks. It would have been reasonable to check Mrs Westcott every hour, as Ms Buckland stated, although even this frequency of checks could not be achieved during the evening before her death.

Actions of Vaucluse Gardens Post 31 March 2012

On 2 April 2012, two days after Mrs Westcott's death, DoHA issued an "industry feedback alert" in relation to the danger posed by bed poles. It referred aged care providers to a New South Wales coronial finding handed down on 26 August 2011 by Magistrate R Denes following the death of one Martha McKee. Magistrate Denes recommended that the KA524 bed pole is to no longer be used in aged care facilities due to the "unacceptable risk". It is most unfortunate that Magistrate Denes' finding had not been circulated prior to 2 April 2012. It would seem that Mrs Westcott's death prompted this alert. I did not have evidence regarding the reasons for the delay after the finding was handed down in August 2011. However, on any logical basis, there did not need to be a notification of a further death in similar circumstances to cause a review of procedures that should have already been appropriately in place.

Ms Fyfe and Ms Newham conducted an audit immediately following Mrs Westcott's death. The restraints and bed pole policies were updated and all ENs and RNs were personally given copies of the revised documents, together with a workbook called "Creating a Restraint-Free Facility".

I have already noted that Ms Dixie Emmerton of the Centre for Tasmanian Industry (CTI) was retained by Vaucluse Gardens to assist with conducting an internal investigation into the circumstances surrounding Mrs Westcott's death. Ms Buckland and the CEO of Vaucluse Gardens, Mr Paul Burkett, had agreed that it was necessary for someone "impartial" to conduct the investigation. Ms Emmerton gave evidence that she attended Vaucluse Gardens on 1 April 2012 and conducted three separate interviews with staff members who had been identified by Ms Buckland. They were Ms Dare, Ms Abay and Ms Booth. Ms Emmerton told the inquest that she prepared draft statements on behalf of the three staff members and emailed those documents to Ms Buckland for review and amendment.

Ms Emmerton told the inquest that she provided some general guidance to Ms Buckland regarding the scope of the internal investigation and the matters which, in her view, needed to be considered during the course of the investigation. Ms Emmerton gave evidence that

she had an expectation that her services would be utilised to finalise an investigation report. However, within a couple of days of Mrs Westcott's death, Ms Emmerton was advised by Ms Buckland that Vaucluse Gardens had decided that her services were no longer required. Mr Burkett gave evidence to the inquest that he did not know who decided to terminate the involvement of the CTI, however he said it was not his decision. He gave evidence that he left the decisions about the internal investigation to Ms Buckland. Mr Burkett stated that he was never provided with a final investigation report. By the time the investigation had concluded, the facility had already changed hands to Bupa Care Services Pty Ltd. Mr Clarke, counsel for Bupa, questioned Ms Buckland on the nature of the internal investigation, questioning the appropriateness of Ms Emmerton. I see no force in such criticism. Vaucluse Gardens was under an obligation to understand the circumstances of this tragic event in a timely way. The retention of Ms Emmerton assisted Ms Buckland in this task, which necessarily required discussion with those staff members who could provide important information.

However, it is appropriate to direct specific comment to Baldwin's management. Ms Buckland was unable to offer any explanation for why CTI's involvement in the investigation was terminated. Surprisingly, Ms Buckland was also unable to recall details of the investigation itself, notwithstanding that she told the inquest that the investigation was her responsibility. She could not recall who was interviewed on 1 April 2012 at Vaucluse Gardens or over the subsequent days. Ms Buckland stated that she would have made notes during the interviews, but could not recall what she did with those notes. Ms Buckland asserted that there was a duplicate internal investigation file, yet it was not produced to the inquest by either Baldwin Care Group or Bupa Care Services Pty Ltd. The witness statements drafted by Ms Emmerton were never signed by Ms Abay, Ms Dare or Ms Booth. There is no evidence before the court about what findings Vaucluse Gardens actually made in relation to Mrs Westcott's death. I do not accept Ms Buckland's evidence that a final report was done. I conclude that the investigation which was conducted by Vaucluse Gardens into the circumstances surrounding Mrs Westcott's death was not continued or completed.

Comments and Recommendations

I make the following comments and recommendations pursuant to sections 28(3) and 28(2) respectively. In this section, I refer to Vaucluse Gardens as "the facility".

Comments

First Aid training

As discussed, the only staff member in the Manor on night shift would have been ill-equipped to have responded to Mrs Westcott's entrapment had she shown signs of life. Ms Sorrentino told the inquest that she did not know the principles to assess someone in an arrest or to determine signs of life. She explained that her first aid training had been undertaken ten years earlier and not "*upgraded*" since. I have found that her lack of current knowledge of lifesaving procedures contributed to her inability to assist in the situation generally.

It may well be that ECAs are likely to be the first people to respond to an incident involving a resident. Depending upon the circumstances and nature of the incident, time may be of the essence. The evidence indicates that it is not a requirement for an ECA to be trained in first aid.

Counsel assisting submitted that I ought to recommend that all ECAs working in the aged care industry hold a current first aid qualification. Ms Mooney provided detailed submissions as to why such a recommendation would not be appropriate, particularly without knowledge of how it could be achieved, without knowledge of the arguments for and against the proposition on a wider scale and without hearing from interested bodies. Her submissions have force. Despite the apparent desirability of ECAs possessing first aid training and an ability to check for signs of life, this inquest did not equip me with such broad evidence. I have made a more limited recommendation.

Assessments for equipment

In this finding I have noted that the facility approved a lifting device for Mrs Westcott on the basis of an "assessment" by a fitness trainer who did not actually physically assess Mrs Westcott. The assessment was written on a document entitled "Physiotherapy Assessment Form" and the evidence indicates that a qualified physiotherapist is required to conduct such assessment. My impression of the evidence of Ms Buckland, Ms Moss and Mr Lamb regarding this issue was that they did not have concerns about the process undertaken. It seems that Mr Lamb was contracted to provide assessments of this nature during a period when a physiotherapist was not available. However, it was a process that was incorrect, misleading and resulted in the possible loss of an opportunity for a thorough physiotherapist's assessment of Mrs Westcott's mobility and the possible detection and removal of the bed pole.

Documentation

Despite the concerted efforts of both Bupa and Baldwin to provide all records of the facility relating to this inquest, this did not occur. It appears from the evidence given by Madeleine Walsh, solicitor for Baldwin, that there was no realistic way to retrieve records from the Leecare database that was transferred from Baldwin to Bupa in the sale of the Manor. It is unsatisfactory that records which could potentially have assisted me in my functions are incomplete. Most importantly, it is concerning that documents evidencing care of residents were not kept complete, ordered and accessible. The manner in which the documents were obtained gave me little confidence that there was an ordered process for retaining and accessing records.

Internal Investigation

As discussed above, the investigation conducted by the facility into the circumstances surrounding Mrs Westcott's death was not continued or completed further than the very beginning stages. This situation was unsatisfactory, as was the evidence given in respect of it. There was also no evidence of internal processes requiring the following of a set procedure until its completion. I understand that the facility may have derived some comfort

from the fact that the matter had been brought to the attention of DoHA and the Coroner. I also understand that the sale of the Manor was imminent. These factors should not have dissuaded management from continuing a rigorous internal process to its completion.

Misleading representations

When the facility promised half-hourly checks of Mrs Westcott, that promise could not be satisfied and continued not to be able to be satisfied. It would have been prudent, before making such promise, for the facility to undertake an assessment of the clinical necessity for such checks, the ability of staff to satisfy such promise, the requirement for associated increased staffing and any possible compromise to the care of other residents. I do not suggest that the facility did not intend to do its best to fulfil that promise when it was made. It does appear that there were periods of time when Mrs Westcott was checked with the required frequency. However, for the reasons discussed in this finding, it was misleading to represent to the family that the facility could provide those checks on a consistent and continuing basis.

Systemic failure

I categorise the failure to detect, assess and remove Mrs Westcott's bed pole as a failure of the highest magnitude. I have given reasons for such conclusion in this finding. There was a collective and ongoing failure of individuals and processes to effect proper action to eliminate the risk. The failure occurred notwithstanding official notification to the facility 21 months before Mrs Westcott's death of the risk that tragically eventuated. It occurred notwithstanding that processes had been developed and directions given to address the risk. There were multiple, obvious opportunities to take action that could have prevented Mrs Westcott's death, including those in the month before her death. Mrs Westcott's unnecessary death in such confronting circumstances has been devastating for her family, who placed their trust in the facility for her care and safety in her last years.

Recommendations

Pursuant to section 28(2) of the Act I recommend:

1. That aged care services and approved providers immediately cease the use of bed poles of the model KA524 or similar style in aged care facilities.

2. That the Department of Health and Ageing promptly draws these findings and recommendations to the attention of all Australian aged care services and approved providers.

3. That the facility undertakes a program to provide all ECAs with appropriate and current first aid qualifications.

4. That the facility rosters a minimum of two ECAs in the Manor during the night shift.

5. That the facility reviews its current policy implementation processes to ensure that all staff are notified promptly of alerts, policies and alterations to policies concerning resident care and safety; these processes should also ensure that such notifications are the subject of regular updates and reminders;

6. That the facility reviews its systems and processes for maintaining records, including resident's files, to ensure that they are retained in a complete, ordered and accessible manner and retained for the required period of time as provided by archiving legislation.

7. That the facility develops a consistent and rigorous process for internally investigating and responding to significant incidents.

I am most grateful to Ms Munnings, counsel assisting, and also to Constable Kathryn Luck, Coroner's Associate, for their dedicated efforts in this inquest. I have also relied significantly upon Ms Munnings' final submissions. Those submissions were of outstanding quality. I am also appreciative of the detailed submissions of Ms Mooney on behalf of Baldwin. Finally, I acknowledge the efforts of the solicitors for Baldwin and Bupa respectively in obtaining the available records.

I convey my sincere condolences to Mrs Westcott's family and loved ones.

Dated: 1st September 2016 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner