FINDINGS **of Coroner McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:**

AUDREY BEVERLEY STREET

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Audrey Beverley Street with an inquest held in Hobart, Tasmania, make the following findings.

Hearing Dates

5 and 6 October 2020, with closing submissions received by 16 November 2020.

Representation

Counsel Assisting the Coroner: J Ansell

Counsel for OneCare Limited: L Mackey

Counsel for Mr Ward: N Munting

Introduction

1. On the morning of 21 September 2017, Mrs Audrey Beverley Street was found by a carer lying in a prone position on the floor of her room at Bishop Davies Court (BDC), a residential aged care facility in Kingston operated by OneCare. At the time, the carer (an extended care assistant or "ECA"), was performing her breakfast rounds. The ECA observed Mrs Street to be conscious, but confused and incoherent. She was attended to by nursing staff and transported by ambulance to the Royal Hobart Hospital where she remained as an inpatient but, unfortunately, passed away on 22 September 2017. The evidence revealed that Mrs Street had suffered a closed traumatic head injury after an unwitnessed fall in her room at BDC during the night of 20/21 September 2017. It was this head injury which caused her death.

2. The evidence gathered in the coronial investigation suggested that Mrs Street may not have been checked by an ECA or other staff member at BDC for a significant amount of time after her fall. Upon being found on the floor, Mrs Street was dressed

in her day clothes from the previous day, her bed was made and undisturbed, her night clothes folded on the end of her bed, and the curtains drawn.

3. The evidence in the investigation indicated that ECAs were required to perform three separate checks upon residents during the night to ensure that they are safe and to administer timely and appropriate care. The BDC facility is staffed overnight by one registered nurse and three ECAs. The ECA responsible for conducting the three overnight checks upon Mrs Street during the night of her fall was Mr Harold Ward. Inconsistencies in Mr Ward's statements in the investigation concerning his alleged checks of Mrs Street meant that I was unable to safely conclude that he had actually performed those checks satisfactorily or at all.

Scope of inquest

4. As coroner, my jurisdiction to investigate Mrs Street's death under the *Coroners Act* 1995 arises because her death was unexpected and/or directly or indirectly the result of an accident or injury.

5. Further, a coroner may hold a public inquest into a death where they have jurisdiction if the coroner considers it desirable to do so.

6. This investigation raised the particular issue of whether Mrs Street was checked or adequately checked by BDC staff, in particular Mr Ward, during the evening of her fall and, in that context, whether her death may have been prevented. Associated with this issue were other issues arising for ventilation – the circumstances and time of Mrs Street's fall, the respective contributions of her injuries and her other illnesses in her death, and whether the staffing levels of BDC were adequate to provide for her care.

7. The question of the checks of Mrs Street by Mr Ward, and the consequences to Mrs Street if one or more of those checks were not performed, was a central issue in the investigation. This was an issue which could not be resolved without a public inquest to hear the oral testimony of Mr Ward and other important witnesses.

Evidence and exhibits at inquest

8. In this investigation, the comprehensive documentary exhibits tendered at inquest included:
    - Tasmania Police and Royal Hobart Hospital Reports of Death;
    - Affidavit of the forensic pathologist, Dr Donald Ritchey, who conducted the autopsy;
    - Report of Dr Anthony Bell, coronial medical consultant;
    - Affidavits confirming identification and life extinct;
    - Affidavits of Margaret Johnson and Debra McAdam, Mrs Street's daughters;
    - Mrs Street's BDC records;
    - Mrs Street's medical records from Kingborough Medical Centre and RHH;
    - Affidavits from numerous BDC staff members;
    - Affidavits of three members of OneCare management, accompanied by relevant policies and procedures;
    - Affidavits of four attending and/or investigating police officers;
    - Incident Investigation Report by OneCare Quality Manager;
    - OneCare personnel file for Harold Ward; and
    - Affidavits, statements, emails and police video interview of Harold Ward.

9. Further, at the inquest itself, I heard oral evidence from the following persons:
    - Dr Donald Ritchey, State Forensic Pathologist;
    - Martina Odwogo (ECA on the afternoon shift on 20 September 2017);
    - Gerald Gangler, enrolled nurse on afternoon shift on 20 September 2017;
    - Fen Pang, ECA on the breakfast round on 21 September 2017;
    - Ma Palmer, ECA with significant knowledge of Mrs Street;
    - Robyn Warne, registered nurse in charge on the night shift of 21 September 2017;
    - Mr Harold Ward, ECA on the evening shift of 21 September 2017 and responsible for checking residents on Mrs Street's floor;
    - Lyndal Cowen, enrolled nurse on the morning shift of 21 September 2017;
    - Jacinta Kennedy, registered nurse in charge on the morning shift of 21 September 2017;

- Lynnmaree Padman, Quality Care Manager employed by OneCare; and
- Mrs Margaret Johnson, Mrs Street's daughter.

Background

10. Mrs Street was born in Smithton, Tasmania on 14 October 1929 and was the eldest of five children to Lionel and Ivy King. She was aged 87 years when she died on 22 September 2017.

11. Mrs Street was raised by her grandmother, Mrs Annie Cook. At the age of 13 years, she was formally adopted by Mrs Cook and moved to Hobart. She completed Year 12 at school.

12. In 1952, she married her late husband, Mr Stanley Kile Street. They were married for over 50 years until his passing in 2007. Mr and Mrs Street were the loving parents of five children: David, Margaret, Debra, Christine, and Peter (deceased).

13. Mrs Street enjoyed an industrious working life as an accounting machinist with several long-term employers until her retirement. Mrs Street's daughter, Mrs Margaret Johnson, told the court at inquest that her mother was committed to her work as well as being a dedicated mother. Mrs Johnson said that her mother always had time for her children and was a kind and caring lady. She said that her mother was also an accomplished seamstress, cake decorator and lawn bowler. Mrs Johnson described Mrs Street as being a devoted and loving grandmother and great-grandmother.

Mrs Street's medical history

14. Mrs Street was in reasonable health for most of her life. Nevertheless, she suffered some notable medical difficulties. Relevantly, in 1987, she was diagnosed with Type II diabetes which required ongoing management for the remainder of her life. In about 1998, she was diagnosed with bilateral femoral artery stenosis which required an operative procedure. She also suffered long-term hypertension and, in 2014, she was diagnosed with congestive cardiac failure. In that year she underwent coronary

angioplasty for the condition. Mrs Street was also diagnosed with early stage dementia in about 2010 when she was 81 years of age.

15. For many years, including during her residency at BDC, Mrs Street was under the regular care of her general practitioners at the Kingborough Medical Centre. She was continuously prescribed various medications to manage her diabetes and cardiovascular issues, among other less significant conditions.

16. In 2014, Mrs Street became a resident of BDC. As will be discussed, she was accommodated in an individual room and was assessed as having low care needs.

17. In August 2017 Mrs Street suffered an apparent respiratory tract infection which affected her breathing. It appears that she may also have suffered a minor cardiac event. She was hospitalised for this condition at the RHH between 6 and 9 August 2017. Upon her return from hospital, she was reviewed by her general practitioner who adjusted her medications. She was also confined to her room for several days for infection control purposes. The BDC care notes reveal a gradual improvement in her symptoms and cough.

18. At the time of her fall and death, her current medical conditions included congestive cardiac failure and ischaemic heart disease, hypertension, dementia and Type II diabetes. It appears that Mrs Street had not completely recovered from her respiratory illness at that time, although she had returned to her normal routine and was participating in many of her usual activities.

The BDC facility

19. The OneCare facility at Bishop Davies Court consists of four units – Huon, Franklin, Wellington and Derwent. The Huon and Franklin Units are staffed as one unit. At the time of Mrs Street's death, the Franklin Unit was the only low care needs unit, but it now accommodates a mixture of lower and higher needs residents. At the time of Mrs Street's death, there were 98 residents in the four units at BDC.

20. Mrs Street was accommodated in the Franklin Unit. The Franklin Unit is situated upon a lower floor of the facility and is the furthest away from the nursing station

which is located upstairs. The higher needs residents in the other units are located closer to the nursing station for improved monitoring and to provide for their needs. There is no issue in this inquest that Mrs Street was accommodated appropriately in the low care section of BDC. Her assessed levels of care did not necessitate her moving away from the Franklin Unit.

21. BDC is staffed by registered nurses, enrolled nurses, physiotherapists, ECAs, and leisure and lifestyle therapists. Notably, nursing and care staff work in three general shift rotations - day shift (7.00am-3.00pm), afternoon shift (3.00pm-11.00pm) and night shift (11.00pm-7.00am). There are more staff rostered during the day time hours than on night shift.
22. During the night shift, the facility is staffed by one registered nurse and three ECAs. One ECA is allocated to the Huon and Franklin Units. If that ECA requires assistance, then he or she will call one of the other ECAs or the registered nurse to assist.

23. The main duty of an ECA is to provide direct care to residents under the supervision of an enrolled nurse or registered nurse. Specifically, the night shift ECA is required to perform three checks of each resident during the shift. The ECA is also required to attend to residents when call bells are initiated or when residents are wandering. I note that some residents explicitly decline nightly checks, but I am satisfied that Mrs Street was not one of those residents.

Mrs Street's typical habits and personality

24. Mrs Street was universally described by the BDC who provided evidence in the investigation staff as an independent person who rarely activated her call bell. She was described as kind and quiet. She was able to use the toilet, dress, and maintain her room by herself. However, she would accept help on occasions to get changed, organise her clothes, shower, apply creams and other personal tasks. Her most recent BDC care plan identified that Mrs Street needed some assistance with dressing and aspects of personal hygiene. Her mobility assessment described her as ambulant and a "low falls risk".

25. Mrs Street had a relatively consistent evening routine. She would attend dinner in the dining room at about 5.00pm. During the evening, she would sit in her chair in her room watching television in either her day clothes or night clothes (depending on the day). She would receive supper in her room between 7.00pm and 8.00pm.

26. The evidence at inquest from Mrs Street's regular nursing and care staff tended to indicate that Mrs Street required a higher level of care after her hospitalisation in early August 2017. However, they said that it was not unusual to see Mrs Street walking to the dining room with a walker or stop half way to (or from) the dining room for a rest.

27. Mrs Street would often stay up late, sometimes even after midnight, sitting in her chair. She would sometimes be reminded by staff that perhaps she should go to bed. Mrs Street would always go to bed in her night clothes, which would be laid out at the foot of her bed.

28. Mrs Street took a great deal of pride in how she dressed and, again, was largely independent in dressing herself.

29. Mrs Street was often visited by her daughters and taken for family outings.

Circumstances surrounding death

30. On the evening of 20 September 2017, Mrs Street attended the dining room before returning to her room in the Franklin Unit. At approximately 5.00pm, Mrs Street was observed by Ms Martina Odwogo, ECA, returning to her room. She appeared to be struggling to walk and was out of breath. She declined Ms Odwogo's offer of assistance.

31. At approximately 9.00pm, Ms Odwogo attended Mrs Street's room and saw her sitting in her chair in her day clothes. Ms Odwogo offered assistance to Mrs Street to change into her night clothes, but Mrs Street stated that she did not need assistance.

32. Ms Odwogo performed a final check upon Mrs Street before the conclusion of her shift at approximately 10.30pm. At that time, she saw that Mrs Street was still sitting in her day clothes awake in her chair with her room light on. Ms Odwogo said in her affidavit that her checks of residents were conducted with a torch to determine whether the resident is asleep or, alternatively, awake and safe. She said that there was nothing unusual about Mrs Street's condition that would have caused her to make a report to the nurse in charge. She is an experienced ECA who provided a detailed affidavit and gave credible, consistent evidence at the inquest concerning her care of Mrs Street that evening. I accept her evidence and find that at 10.30pm Mrs Street was awake, responsive and sitting in her chair in her day clothes.

33. At approximately 8.30am the following morning, Ms Fen Pang, the morning ECA, was performing her breakfast rounds and attended Mrs Street's room. She knocked and received no answer. She proceeded to enter the room. It was dark with the curtains drawn and the room light was off. Ms Pang could not initially see Mrs Street in her bed or in her chair. She then saw Mrs Street lying face down on the floor. Mrs Street was not communicative and appeared to be rubbing her head on the floor.

34. Ms Pang located an enrolled nurse, Ms Lyndal Cowen, and advised Ms Cowen of Mrs Street's condition. The registered nurse in charge, Ms Jacinta Kennedy, arrived quickly to the scene after being notified.

35. Ms Kennedy observed that:
    - Mrs Street was wearing her clothes from the day before;
    - Her bed was made and had the appearance of having not been slept in;
    - That her stuffed bear was still positioned on the bed as it usually was when the bed had been made;
    - That half of Mrs Street's supper had been eaten; and
    - There was a large bowel motion in the toilet with a small amount of blood present on the bowel motion and on the toilet seat.

36. Ms Kennedy examined Mrs Street and noted that she felt cold on top of her body, but was warm underneath. She also checked Mrs Street's blood sugar levels which

were high, but she was not in a hyperglycaemic state. She appeared to have no broken bones.

37. At the time of giving her evidence, Ms Kennedy had retired from a career in nursing spanning 45 years. She was a most impressive witness, recounting her observations carefully, consistently and thoughtfully, with good knowledge of Mrs Street and her room. For example, Ms Kennedy gave evidence at inquest that Mrs Street was a restless sleeper who would move frequently during the evening in bed and toss her covers off. The bed, therefore, would be messy by the morning. She also gave evidence that Mrs Street never made her own bed, that task being completed by staff. She also described Mrs Street as being dressed in quite smart clothes when she encountered her on the floor. She gave Mrs Street's position, consistent with the other witnesses, as her head being closest to the window and her feet closest to the door. She said that Mrs Street had pride in her clothes and that it was not usual for her to wear the same clothes on two consecutive days. She also said that Mrs Street's usual morning habit was to change into her day clothes from her nightwear at about 8.00am, although since her return from hospital she was more likely to remain in her nightwear until a little later in the morning.

38. Ms Kennedy noticed a small amount of blood on Mrs Street's brow. Ms Cowen said that Mrs Street had an *"incredibly swollen left eye"*. Both nurses described Mrs Street as conscious but extremely disorientated.

39. Ms Kennedy gave evidence that her concern upon arriving at the scene was that Mrs Street had been lying in the position in which she was found for a lengthy period during the night. This is a matter which I analyse further, although it is quite understandable that a very experienced and senior nurse held such concerns upon her observations of Mrs Street and the room.

40. In relation to the unflushed bowel motion in the toilet which contained small amounts of blood, Ms Kennedy speculated that she may have suffered a medical event (such as low blood pressure) and had fallen on the way back to her bed. She said that the blood on the toilet seat appeared to have finger marks through it. The

evidence in the investigation was that Mrs Street would routinely flush the toilet, this being in keeping with her normal level of independence.

41. I fully accept Ms Kennedy's helpful evidence regarding her observations of Mrs Street and of her room generally. Her evidence, and that of the other staff members at the scene, was reliable and consistent.

42. After ensuring that Mrs Street was medically stable, Ms Kennedy called an ambulance. Very shortly afterwards, ambulance paramedics arrived and transported Mrs Street directly to the RHH, and she was formally admitted at 12.07pm on 21 September 2017, still in a distressed and confused state.

43. At the RHH, Mrs Street was provided with sedating medication and underwent a CT scan of her head, chest x-ray and blood tests. The CT scan revealed a subarachnoid haemorrhage and intraparenchymal haemorrhage. The chest x-ray revealed pneumonia. Mrs Street was commenced on intravenous antibiotics.

44. Mrs Street's condition deteriorated and, after discussions between her treating doctors and family members, she was provided with palliative care and not actively treated. She passed away at 4.50am on 22 September 2017, the day following her fall and admission to hospital.

Post-mortem examination and medical evidence

45. On 22 September 2017, forensic pathologist, Dr Donald Ritchey, conducted an autopsy upon Mrs Street to determine cause of death.

46. Dr Ritchey opined, and I accept, that Mrs Street's cause of death was traumatic closed head injury from a standing height. He noted in his affidavit that significant contributing factors in her death were pneumonia, atherosclerotic and hypertensive cardiovascular disease, dementia, and Type II diabetes. In relation to the condition of pneumonia, this may have been existing at the time of her fall or, alternatively, had a rapid onset after she sustained the head injury.

47. Dr Ritchey subsequently provided a further report and also oral evidence at inquest concerning the issue of whether it was possible to ascertain the length of time Mrs Street had been lying on the floor of her room. This issue assumed particular importance in determining when or if Mrs Street had been checked by Mr Ward during the night as he was required to do.

48. Dr Ritchey suggested in his supplementary report that, given her normal body temperature when found on the floor, Mrs Street may have been in her lying position for a fairly short time because she had not lost any heat to the environment. However, in his evidence at inquest further questions were asked of him regarding the effect of clothing and a carpeted floor on the loss of body temperature, being matters not known to him at the time of his report. Dr Ritchey indicated that warm clothing and carpet may cause preservation of body temperature. Ultimately, he was unable to be precise about the length of time Mrs Street had been lying on the floor due to the number of variables involved.

49. The evidence indicates that Mrs Street was wearing black long trousers and a top and that her room was carpeted. She may not have lost body heat whilst lying for an extended period of time. Dr Ritchey did make comment that the evidence of Mrs Street being found in her day clothes was, in fact, the best evidence that she fell at an earlier time rather than a later time, and there was nothing from his medical perspective that would negate such a scenario.

50. Dr Ritchey also gave evidence that significant bruising, such as that seen around Mrs Street's eye, can develop rapidly after injury. The amount of time for bruise development can be anywhere from five minutes to an hour. For this reason, bruising is of no assistance in determining the length of time that had passed since the injury.

51. Dr Anthony Bell, who provided a medical report, suggested that the blackness associated with the bruising indicated a development over several hours. However, determination of the age of bruises is notoriously difficult and I am not able to safely form a conclusion about when Mrs Street suffered her injury on the basis of the

appearance of the bruise. I do accept, however, the evidence of Dr Ritchey that the location of the bruising upon Mrs Street was the point of impact of the fall.

52. I accept Dr Ritchey's evidence that the fall resulted in an irreversible brain injury from which Mrs Street could not recover. Dr Bell was of the same opinion. Dr Ritchey and Dr Bell both emphasised that each of Mrs Street's significant pre-existing diseases (dementia, diabetes and congestive cardiac failure) predisposed her to falling by mechanisms of unstable gate imbalance or momentary fluctuations of blood pressure. I note that, upon the evidence, there was nothing in her room that presented a tripping hazard.

Harold Ward's account

53. Mr Ward was 37 years of age at the time of the inquest and 34 years of age at the time of Mrs Street's death. In 2013 he completed a Certificate III in Aged Care and started employment as an ECA at BDC in January 2014. He was provided with orientation and training for his work. Shortly after starting he commenced to work only night shifts (11.00pm-7.00am), normally working eight or nine shifts per fortnight. Mr Ward was the ECA responsible for conducting three checks of the residents in the Franklin Unit, including Mrs Street, during the night shift commencing at 11.00pm on 20 September 2017. Mr Ward did not complete any written record during his shift of having completed the checks upon Mrs Street, although it is unclear upon the evidence whether there was a specific requirement that he do so.

54. I deal below with the accounts given by Mr Ward.

55. On the morning of 21 September 2017, after Mrs Street had been discovered on the floor of her room and after Mr Ward had completed his shift, Mr Ward was contacted by Ms Sally Murdock, Care Manager of BDC. She asked Mr Ward to provide details of his care of Mrs Street on the shift he had just completed. At 10.58am, within four hours of the conclusion of his shift, Mr Ward sent a statement by email to Ms Murdock. In that email, he stated that he performed three checks upon Mrs Street - at midnight, 3.00am and 6.00am. He stated that at the midnight and 3.00am checks, he saw Mrs Street in bed and she appeared to be safe and

comfortably sleeping. On the last check, at 6.00am, he found Mrs Street in the toilet and he gave her a *"quick wave good morning"* and left her to her privacy after ensuring that she was well and comfortable. He said that he assumed that she would return to her bed when she was finished *"as she usually does"*.

56. Following that initial statement, Mr Ward gave two further statements to OneCare over the following days, maintaining that he performed the three checks upon Mrs Street. In the first of these two further statements, Mr Ward asserted that when he saw Mrs Street in the toilet on his last check, she was dressed in "day clothes". This is quite inconsistent with his assertion in the initial statement that he believed she would return to bed. There is no evidence at all that Mrs Street was in the habit of going to bed dressed in day clothes. In fact, the evidence is to the contrary – that she would always change into her night clothes for bed.

57. Shortly after this statement, Mr Ward was asked by BDC to provide more details of his account. He then retracted his statement that he saw Mrs Street in day clothes, stating that he was *"momentarily mistaken"* in recalling this fact as *"part of his own memory"* and attributed the mistaken memory to being told by other staff members that she was in her day clothes. He stated that he saw Mrs Street on the toilet at 6.00am but did not recollect what she was wearing. On any reasonable view, the vacillation in his initial three accounts regarding the alleged 6.00am check is a cause for concern about his veracity. These were made at a time when the events were fresh in his memory and after being informed of Mrs Street's serious injuries (and then death). It would be thought that a person responsible for her care, as he was during that night, would easily be able to provide a consistent and accurate account of his involvement with her.

58. Subsequently, Mr Ward's further accounts of the night were as follows;
    - An affidavit sworn on 19 January 2018;
    - A video record of interview with investigating police officers on 26 June 2019;
    - An affidavit dated 10 September 2020, four weeks before the inquest; and
    - His sworn evidence at inquest on 6 October 2020.

59. In his affidavit of 2018 he did not state that Mrs Street was "comfortably sleeping" in her bed at the time he conducted his first two checks. In fact, he specifically stated in respect of both checks that he remembered seeing Mrs Street but could not remember *where she was and what she was wearing*. Again, this change in his evidence is surprising, particularly in respect of the second check, being scheduled for about 3.00am. If Mr Ward had seen Mrs Street in a location other than bed at that check, presumably he would have needed to take active steps to assist her into bed. For example, if she had been asleep in her chair dressed in her day clothes, he would have or should have encouraged her to change into her nightclothes and retire to her bed. If she was in the toilet, he would have again needed to ensure that she was safe and would return to bed. In either situation, Mr Ward would have recalled such an event and would have been able to recount his interactions with Mrs Street consistently from the time he was first asked to provide an account.

60. His video record of interview with police officers in 2019 did not touch significantly upon the inconsistencies in his accounts up until that date. When an interviewing officer suggested to him that he may not have conducted the checks upon Mrs Street, he replied *"I don't see how but I mean like I don't know…I really don't think so um I mean there are some times it sort of feels like one night just sort of melts into another but..."*. I take his answer to mean that he maintained that it was likely that he conducted the checks upon Mrs Street but had issues with his memory. Again, this vague answer was most surprising, given that the officers had already gone through with Mr Ward earlier in the interview details of his previous accounts. In this interview, he also explained his general duties on a nightshift and the manner in which he checks the residents – opening the door sufficiently to observe with a torch that they are breathing and safe.

61. In his comprehensive affidavit sworn in the month before the inquest, Mr Ward said that in making his previous affidavit in 2018 he had been conscious of it being a sworn document and gave that as the reason for his statement that he did not actually remember seeing Mrs Street in bed on each of the first and second checks. Again, this justification of his inconsistencies impact significantly upon his credibility. One more obvious reason for him stating that he did not recollect the first and second checks may well have been a realisation that his statements made to

OneCare regarding seeing Mrs Street in bed could not sit with the objective evidence of her bed being made and that she was wearing her clothes from the previous day.

62. In his affidavit, Mr Ward stated that he was terminated from employment of OneCare in July 2020. He deposed that, in the month before his termination, he received formal written warning about the inappropriate extent of his internet usage at work. He also said that he was stood down from work very shortly after this warning as a result of a separate allegation that he left a resident in a distressed state without a handover to morning staff. Mr Ward said that he disputed the allegation but his account was not accepted by his employer. I deal with this matter below.

63. Mr Ward said in his affidavit that, after the termination of his employment, he enrolled in a two-year Diploma of Nursing course through Tas TAFE to become an enrolled nurse.

64. Mr Ward's testimony in court was not that of a credible witness. He said that he did not have a specific recollection of checking Mrs Street on the evening in question, indicating that it was after a *"string of night shifts".* Night shifts, according to Mr Ward, can run together and it can be difficult to distinguish each one. He said that he thought he may have remembered the final check when she was in the toilet and later in his testimony became definite that he did see her sitting on the toilet. He said that it was possible that he had mixed up his interactions with Mrs Street that night, confusing it with nights he had performed the relevant checks.

65. Mr Ward could not provide any rational or coherent explanation for the changes and inconsistencies in his previous statements and affidavits, at one stage stating that he "felt pressure to come up with information" shortly after the event and believed he was being honest at the time.

66. There is no documentary record held by OneCare that Mr Ward completed any checks upon Mrs Street during the night in question. In his 2018 affidavit, Mr Ward stated that *"after conducting the bed checks I am required by company policy to log the checks. I don't remember logging the checks and looking back over the logs I did not log the*

checks on that night." In his evidence at inquest, he seemingly moderated this position by stating that he was just required to document any events during these checks that were *"out of the ordinary".* As discussed below, the requirements and procedures for documenting checks of residents was not particularly clear. I do not place significant weight on this fact, compared to the many inconsistencies in Mr Ward's accounts, in determining whether he actually conducted the checks. If he checked Mrs Street, it would have been of assistance to have a contemporaneous record of those checks occurring. However, Mr Ward did not appear to be a person who would diligently attend to documentation, especially if it was not strictly required.

67. There are two additional matters which impact upon Mr Ward's credibility.

68. Mr Ward maintained in his evidence that the night in question was unremarkable and quiet. Ms Robyn Warne was the registered nurse in charge for the night shift during which Mrs Street suffered her fall. Ms Warne gave evidence at inquest that the night of 21 September was, in fact, particularly eventful due to a high needs resident requiring the administration of a Schedule 8 drug for pain management. Ms Warne gave evidence that this particular resident was screaming in pain and was waking other residents. The resident had to be settled and provided with additional care (a heat pack, drink and food). Ms Warne said that it was Mr Ward who assisted her with the administration of the drug and with care generally. She said that it took the resident half an hour to settle, with Mr Ward remaining with her. At handover, Ms Warne fully briefed Ms Kennedy, the incoming registered nurse in charge, about the situation with this particular resident. Ms Kennedy confirmed in her evidence that she had been told of this resident and the event at handover. There were no concerns regarding Mrs Street in handover, and Mr Ward did not hand over any information to the morning ECAs at the conclusion of the shift.

69. I note that Ms Warne was not challenged on her evidence by Mr Ward's counsel, and that she proved to be a reliable witness. I accept her evidence regarding Mr Ward's involvement in this incident. There was no mention of this matter by Mr Ward in any of his accounts. At inquest, he said that he did not recall the incident but suggested that it may have simply been part of his 5.00am medication duties, which was routine. It might be thought that this singularly eventful incident, as well as

Mrs Street's serious fall, might have brought Mr Ward's memory to the fore from the time he was asked to give the first account several hours after the conclusion of the shift.

70. The other matter pertaining to both Mr Ward's character and credibility involves issues surrounding his employment at OneCare occurring in 2020 before his employment was terminated.

71. OneCare wrote to Mr Ward in July 2020 concerning his internet usage at work over the previous 12 months being consistently the highest in the organisation and in breach of the Computer Usage and Social Media Policy. OneCare noted that it had warned Mr Ward of the issue in June 2019 and his breaches had been recently occurring at the same level. Mr Ward was invited to provide an explanation regarding this matter. Mr Ward responded on 8 July 2020 by stating that his internet use did not compromise his job performance but he would cease his usage. Mr Ward was immediately given a formal warning in respect of the matter.

72. Only two days later, on 10 July 2020, OneCare wrote to Mr Ward in response to seven allegations of misconduct involving breaches of OneCare's code of conduct and his duty of care obligation to residents occurring on 8 and 9 July 2020. Five of those allegations were found to be substantiated by OneCare and Mr Ward's employment was terminated on about 30 July 2020. The allegations against Mr Ward included:
    a) That he did not answer the residents' call bells within a reasonable time frame;
    b) That he did not check the operation of residents' sensor beams and/or turned residents' sensor beams off during his shift.

73. OneCare determined that these actions constituted serious neglect of his duties. I note that, in one instance, OneCare determined that there was delayed care to a resident assessed as a high falls risk who suffered an unwitnessed fall. It was determined that the resident had not been checked, the sensor beam in his room was turned off, and he had not been discovered until morning staff commenced work. The time between the fall and discovery was not able to be ascertained.

Another instance involved a resident who activated her call bell for assistance in toileting. She was found distressed by morning staff.

74. The investigation into these instances determined that Mr Ward spent considerable time watching entertainment using the internet, regularly with the volume up high and, on occasions wearing headphones. OneCare, in its written determination, advised Mr Ward that such conduct was unacceptable and that such neglect of his duties had placed the residents at high risk.

75. In responding to the correspondence from OneCare advising that five instances of neglect of duty had been substantiated, Mr Ward wrote to Mr George Wilson, the Facility Manager of BDC in most offensive and irrational terms. As a result of Mr Ward's letter, Mr Ward was notified by the management of OneCare that he was prohibited from attending any of the OneCare premises in the future.

76. Although the instances of neglect were disputed by Mr Ward, it is apparent that the investigation and evidence upon which they were based was robust and that he had a full opportunity to respond. I have no reason to consider that they are not correct. The instances of neglect and his extensive use of the internet are indicative of an unprofessional attitude and low work ethic. Although the instances leading to his termination were subsequent to Mrs Street's death, they have some relevance in demonstrating Mr Ward's general attitude and approach to his care of the residents.

77. I cannot accept any of the accounts provided by Mr Ward concerning his alleged checks of Mrs Street. Further, I am positively satisfied that he did not, in fact, check Mrs Street at all for the first two checks. If he had checked her, he would have clearly seen that Mrs Street was not lying on the bed and that the bed was made and untouched. In that situation, he would not have provided the initial account that he did which was able to be easily contradicted by the state of the bed (observed by many in the morning) and the fact that Mrs Street was wearing the same clothes as the previous day.

78. In relation to the third check, I cannot fully discount that he may have put his head into Mrs Street's room and spoke to her while she was in her bathroom. However, I

am satisfied that he did not actually sight her on or in the toilet at this time. This is particularly clear because of his inability to describe her clothes, the state of her bed or her intended movements. It is also not consistent with the bowel motion found in the toilet, which would suggest that Mrs Street was unwell and not in a position to chat in a friendly manner as recounted by Mr Ward. It is also inconsistent with her usual habit of still being in her nightclothes at that early time. It is more likely that Mrs Street was lying on the floor at this time and that Mr Ward did not check her at all. However I am not able to make this factual finding to the standard of proof required.

Factual findings regarding the circumstances of death

79. During the early evening before her fall, Mrs Street had engaged in her normal evening routine and, as was regularly her habit, sat up late in her chair watching television. I find that at some time between the last check performed by Ms Odwogo at 10.30pm and the morning breakfast round by Ms Pang at 8.30am, Mrs Street fell and sustained a closed traumatic head injury. Sadly, this injury was fatal and, regardless of when she was discovered, she would not have been able to recover.

80. The evidence given by the BDC staff members, both in affidavit and at inquest, was credible and indicated that they provided a high quality of care to Mrs Street. All of the circumstances tend to suggest that Mrs Street may have fallen closer to the time of the last confirmed evening check and may have been lying on the floor in the same position for many hours. The medical evidence cannot provide answers to the question of the timing of her fall.

81. I am satisfied that Mrs Street did not lie in or upon her bed at all that night. It appears quite likely that Mrs Street, at a point after Ms Odwogo's check, alighted from her chair (possibly after falling asleep for a lengthy period) and attended the bathroom. Given the direction of her head in the lying position, it is likely that she fell whilst making her way back from the bathroom. She was not prone to falls and it seems from the state of the toilet that she was unwell at the time.

82. As discussed above, I am satisfied that Mr Ward did not perform the midnight and 3.00am checks. If he had performed those checks, he would have either found Mrs Street on the floor or in her chair. If she was found in the chair, then it is likely that he would have assisted her to retire to bed safely. In such a scenario, the assistance of a carer at that point may have mitigated her risk of falling. Conversely, if Mrs Street had already suffered her fall at that time, then there was an opportunity to prevent her ongoing distress by seeking medical attention. Finally, as noted, I am not able to discount that Mrs Street suffered her fall after 6.00am, being the time for her third check. In this scenario, she would not have been attended to at an earlier time than actually occurred, being 8.30am.

83. These scenarios must necessarily be speculation, given the uncertainty in the evidence. However, as a resident of BDC, Mrs Street required, and was entitled to, the scheduled overnight checks for her safety and comfort. If the three checks had been conducted (or, in the case of the third, properly conducted), this may have changed the course of the night for Mrs Street or resulted in more timely medical attention. Even with all appropriate care, however, Mrs Street may still have fallen and suffered her fatal injury.

Summary of formal findings

I find, pursuant to Section 28(1) of the *Coroners Act* 1995 that:

a) The identity of the deceased is Audrey Beverley Street;
b) Mrs Street died in the circumstances set out in this finding;
c) The cause of Mrs Street's death was closed traumatic head injury resulting from a fall from standing height with significant contributing factors of pneumonia, atherosclerotic and hypertensive cardiovascular disease, dementia and Type II diabetes; and
d) Mrs Street died on 22 September 2017 at the Royal Hobart Hospital in Tasmania.

Comments and Recommendations

84. I have been greatly assisted by OneCare in this inquest by the provision of relevant documentary evidence and oral testimony, as well as the arrangement of views of the BDC facility.

85. This investigation considered the issue of whether any systemic issues existed that may have been connected to Mrs Street's death. There was no suggestion upon the evidence that this is a case where the staffing of the facility, at least on the overnight shift, was insufficient for the appropriate care of Mrs Street. Further, the BDC staff members who gave evidence, with the exception of Mr Ward, impressed me as hard-working, caring professionals who were dedicated to the interests of the residents. The documentary plans and assessments for Mrs Street were current and a variety of medical and allied health services were involved with her. Her general nursing records provided adequate information about her health status and her medications were administered properly and regularly. Her room did not contain tripping hazards and she had no prior falls inside the facility. Apart from issues with Mr Ward, it appears that Mrs Street consistently received her regular checks by the ECAs. I had the opportunity to view the facility on two occasions for the inquest and, to the extent possible, my impression was favourable.

86. I accept Ms Mackey's submissions that OneCare provided good quality care to Mrs Street appropriate to her levels of need and her wishes.

87. In respect of the employment of Mr Ward, there was no evidence that there were poor performance issues concerning him at the time of Mrs Street's death. OneCare cannot be criticised for continuing Mr Ward's employment pending the resolution of the full coronial investigation where factual findings would be made.

88. In summary, I cannot make a finding that any omission, want of care or inadequate staffing on the part of OneCare played any role in Mrs Street's death.

89. OneCare conducted a critical review of the circumstances leading to Mrs Street's death and has implemented various changes. Some of the changes do not involve

matters that are connected with any significant issue in this investigation. It is unnecessary to deal in detail with the review or the changes, except in respect of one matter as follows.

90. At BDC, ECAs are still required to perform three nightly checks upon residents and to record them in the AutumnCare computer system. I comment that the issue of the documenting of checks by ECAs is somewhat vexed. It would seem that if each check is to be recorded by completing a "tick box", the task of documenting becomes not only onerous but can result in a later wholesale ticking of boxes to comply with procedure such as to become meaningless. I was not left with any clear impression that this system was more effective than recording only those checks which were out of the ordinary or where information needed to be passed on. OneCare should consider further how the ECAs should be required to document their checks.

91. The OneCare Quality Control Manager, Ms Lynnmaree Padman, identified in her evidence that prior to Mrs Street's fall, ECAs were not required to report or advise the registered nurse in charge regarding the completion of overnight checks. Ms Padman stated that registered nurses now "check in" with ECAs after each round of checks. Even if such a system had been in place at the time of Mrs Street's fall, it is most unlikely that it would have resulted in the nurse in charge becoming aware that Mrs Street had not been checked.

92. I note that Ms Warne, who was still employed at the time of the implemented changes, stated that she had no knowledge of this change occurring. There must be responsibility upon the ECAs themselves to perform the required checks in accordance with their duty. The registered nurses have a significant workload within their own duties and must rely upon the checks having been conducted. However, where an ECA is not fulfilling his or her duties, thus impacting upon the safety of the residents, there should be a mechanism to identify such an issue in a timely manner and ensure that all supervising nurses and ECAs are aware of it. Again, I would encourage OneCare to continue to consider measures to implement an effective system in this regard.

I extend my appreciation to all counsel appearing in this inquest for their most competent assistance.

I convey my sincere condolences to the family and loved ones of Mrs Street.

Dated: 5 March 2021 at the Coroners Court Hobart, Tasmania.

Olivia McTaggart
Coroner