MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Robert Webster, Coroner, having investigated the death of Kathleen May Earl

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Kathleen May Earl (Ms Earl);

b) Ms Earl died in the circumstances set out below;

c) Ms Earl's cause of death was complications of poorly controlled type 2 diabetes; and

d) Ms Earl died between 21 and 23 June 2022 at Glenorchy, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Earl's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- A report of the forensic pathologist Dr Christopher Lawrence;
- A report of the forensic scientist Mr Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Affidavit of Mr Luke Earl together with a letter from Mr Earl;
- Letter of concern from Ms Earl's daughter Joanne Baxter;
- Letter from Independent Health Care Service (IHCS) together with statutory declarations of Mr John Smith and Ms Natasha Wills and records of IHCS;
- Records obtained from Wintringham Supported Accommodation;
- Ms Earl's medical records obtained from her general practitioner (GP);
- Ms Earl's medical records obtained from the Royal Hobart Hospital (RHH);
- Prescription records of medication dispensed to Ms Earl; and

- A very detailed response to my draft decision in this matter received from lawyers acting on behalf of IHCS (the response) together with supporting documents including IHCS progress notes from 3 April 2014 until 24 June 2022, file note dated 23 June 2022, and statutory declarations of Natasha Wills and Jessica Phillips.

Background

Ms Earl was 58 years old, single, in receipt of a disability support pension from Centrelink, and she lived alone at the date of her death. Ms Earl had an intellectual disability. She had two children; a daughter Joanne and a son Luke. Luke Earl says that he and his sister were in foster care for much of their childhood due to family trauma which he did not wish to go into. Ms Earl resided in supported accommodation provided by Wintringham, which is an organisation which assists otherwise homeless older women and men into accommodation and helps them access aged care services.

Mr Earl says his mother, because of poor health, did not have a job in the traditional sense. That I infer means she never had regular paid employment. He does recall she worked for a disability advocacy agency at some point and did a few odd jobs. He noted she had a number of health issues. One of those was diabetes and he says that he has, since her death, found diaries which contain a record of her blood sugar levels.

Because of her health conditions, he says she received assistance from a health support agency. He says she was a very structured and rigid person, and he provides the example that he could only ever see her on Saturdays. She was in his view a stoic person in that she never complained about her health.

Circumstances Leading to Death

Luke Earl had not seen his mother for approximately three weeks, so on 23 June 2022, he attended her address but could not raise her. He then contacted Tasmania Police who made enquiries, but they were unable to locate her at any hospital. Enquiries made indicate Joanne Baxter last spoke to her mother about 2 weeks prior to 23 June 2022. The police report indicates IHCS could not be contacted. Police attended the address at approximately 8:00pm and forced entry. It was noted the home was well secured prior to the entry by police.

Ms Earl was located deceased in bed. There were no signs of injury or signs of foul play. The house was searched and very little food of any nutritional value was found. The house was cold, untidy, and the bathroom was unclean. There were numerous medications in relation to her diabetes found, however, the opinion of attending police is there was little evidence

the medications were being used. Further enquiries confirmed a neighbour last saw Ms Earl on the evening of 21 June 2022 walking around outside her unit during the later evening.

Ms Earl was identified by her son and taken to the mortuary by the mortuary ambulance.

IHCS says the comment made by the investigating police officer in the Police Report of Death for the Coroner that IHCS could not be contacted requires clarification. IHCS say there was contact between them and Tasmania Police on 3 occasions on 23 June 2022 as follows:

> *"(a) shortly after midday, John Smith, Company Director, received a call from Tasmania Police enquiring about Ms Earl's whereabouts. It is during this call that Mr Smith advises the police of the steps taken by IHCS to attempt to locate Ms Earl, and suggests that a good time to catch Ms Earl at home would be at 7pm during her favourite television show, Home and Away;*
>
> *(b) at 6.56pm, Lisa Percy, on-call Service Coordinator from IHCS received a welfare call from Tasmania Police…; and*
>
> *(c) at 8.05pm, Tasmania Police phoned and spoke to IHCS to advise that Ms Earl has been found deceased in her bed (see enclosed Total Care Progress Notes entry dated 24 June 2022)"*

It is clear from this evidence Tasmania Police did have contact with IHCS on 23 June 2022, but I think what the police officer is alluding to is that at the time they arrived at Ms Earl's home to check on her welfare, at approximately 8:00pm, contact with IHCS was attempted but as that attempt failed, they had to force entry to her home. Nothing turns on this.

Investigation

(i) Post-Mortem Examination and Toxicology

This examination was carried out by the forensic pathologist Dr Christopher Lawrence on 24 June 2022. He conducted an examination and considered information provided by Tasmania Police, the medical records, some photographs, and arranged for blood and vitreous samples to be taken.

Mr Neil McLachlan-Troup says in his affidavit the results of toxicology showed that three of Ms Earl's prescribed medications were detected at greater than therapeutic levels.[1]

[1] Which were prescribed to treat insomnia, pain and depression.

Tramadol[2] was detected at a sub therapeutic level and rosuvastatin[3] was detected at a therapeutic level. Acetone was also detected at a very high level. This substance is normally found in blood and urine as it is naturally produced and disposed of in the human body through normal metabolic processes. Levels of acetone can fluctuate greatly due to normal diurnal variations, a person's age, nutritional status and fasting and degree of physical activity. The presence of diabetes, trauma and alcoholism can also result in increased levels of acetone. Acetone concentrations are markedly elevated during diabetic ketoacidosis, which is where the body has a high blood sugar level and not enough insulin to break it down to use for energy. As a result, the body starts to burn its stores of fat for energy. I accept these opinions.

Dr Lawrence says Ms Earl had poorly controlled type 2 diabetes, he noted her blood sugar levels had been in the 20s, she had hypoglycaemia and a medullary sponge kidney[4] and pyelonephritis[5] of the right kidney. She had not been attending the outpatient's department of the diabetic clinic at the RHH. The vitreous glucose result was 9.4 and toxicology revealed elevated levels of acetone, doxylamine, paracetamol, and dothiepin. In summary, it is Dr Lawrence's opinion Ms Earl died due to complications of poorly controlled type 2 diabetes. I accept his opinion.

(ii) Family Concerns

Joanne Baxter says because of her mother's intellectual disability she needed help which for many years had been provided by IHCS. She believes that organisation should have been able to ensure her mother's diabetes was monitored properly. She is also concerned because she says IHCS had not done any welfare checks despite Ms Earl not answering her telephone. She says her concerns were dismissed by IHCS and on both occasions she telephoned that service, she was told not to contact the police. She did so with the police attending as set out above. In order to assess these concerns, I have considered the nature of diabetes and analysed the records obtained from Ms Earl's general practitioner, housing provider, pharmacy, IHCS and the RHH. That analysis follows.

(iii) The Nature of Diabetes

Diabetes involves the pancreas gland which produces a hormone called insulin. All cells in the body need glucose or sugar from the food we eat for energy. Insulin allows glucose to enter cells and without it the cells in the body cannot use the sugar for energy. Accordingly,

[2] This is an opioid prescribed to treat chronic pain.
[3] This medication is prescribed to lower what is called bad cholesterol.
[4] This is a condition Ms Earl was born with which is characterised by the dilation of the collecting tubules in one or both kidneys by cysts.
[5] A kidney infection.

glucose stays in the bloodstream and builds up and is filtered out into a person's urine. Glucose in urine causes urine output to increase in frequency and amount. This causes a person to become thirsty. When the body cannot use glucose because of a lack of insulin it uses fat for energy. This causes weight loss. When large amounts of fat are broken down too quickly acetone is produced. Acetone builds up in the bloodstream and again is filtered out via a person's urine.

Type 2 diabetes which is what Ms Earl was diagnosed with is a condition in which the body becomes resistant to the normal effects of insulin and gradually loses the capacity to produce enough insulin in the pancreas.

In so far as treatment is concerned, there must be a balance between the provision of insulin, food and exercise. Insulin administered by injection is ordinarily required on a number of occasions every day. Foods that produce energy and keep a person's blood sugar in balance ought to be consumed. Often a person with diabetes needs assistance from a dietician to teach the person about meal planning. Exercise improves general health, keeps a person mentally alert and increases heart muscle tone. It improves the way insulin is absorbed and used by the body, and usually assists in the reduction in the level of blood sugars.

Monitoring of diabetes is required to check if it is under control. Blood testing is one way to check to see if a person's diabetes is under control. Often an exercise book is used to record blood sugar levels. In addition, blood tests initiated by the general practitioner are ordered. The GP's records disclose blood tests were routinely ordered and Ms Earl was advised of results in the 6 months prior to her death on 1 occasion, namely on 10 March 2022.

(iv) The General Practitioner's Records

The records of Ms Earl's GP cover the seven-year period leading up to her last appointment on 6 June 2022. They disclose Ms Earl suffered from a number of long-standing health ailments, including insulin-dependent diabetes myelitis (IDDM), chronic pain, depression and anxiety along with post-traumatic stress disorder (PTSD), insomnia, B12, iron and vitamin D deficiencies, gastro-oesophageal reflux disease, chronic kidney disease, hypertension and hypothyroidism. In that seven-year period, Ms Earl attended on her general practitioner on at least 171 occasions and in addition, there were further attendances on nurses and other staff at the practice. Accordingly, Ms Earl averaged approximately 24 attendances on her general practitioner per year. In the six months prior to her death, she attended on seven occasions as follows:

- 11 January 2022: splinter;
- 8 February 2022: pain and the obtaining of scripts;
- 7 March 2022: chronic pain. There was a discussion about reducing Ms Earl's consumption of tramadol;
- 10 March 2022: she received the results of some blood tests and was advised she had very poor control;
- 28 March 2022: Ms Earl attended to obtain some prescriptions and advised she had no current carer;
- 14 April 2022: Ms Earl attended to obtain some prescriptions; and
- 6 June 2022: she was advised she had poorly controlled diabetes and chronic kidney disease. She was suffering from insomnia.

The records disclose that Ms Earl's PTSD arose out of abuse she was subject to as a child. On a number of occasions, there is mention of the attendance of, or contact with, Ms Earl's individual support worker[6] (ISW) as follows:

- 8 November 2016: ISW in attendance;
- 1 September 2018: Ms Earl's ISW is advised of her poor kidney function and high level of diabetes;
- 8 April 2020: call from ISW – Ms Earl was not having insulin as it froze in the fridge. A script was left for the ISW to collect and take to Ms Earl;
- 12 May 2020: a call was made to the ISW advising of the necessity for Ms Earl to undergo a test before her appointment at the diabetes clinic;
- 30 July 2020: the ISW was contacted to bring Ms Earl in for a medication review; and
- 5 August 2020: the ISW attended with Ms Earl for that medication review.

In relation to these appointments, IHCS notes the following *"[f]or further context"*:

> *"(a) IHCS understands that Ms Dann had a personal relationship with Ms Earl's general practitioner, and that they had spent time together socially;*
>
> *(b) IHCS' records show that with the exception of the attendance on 8 November 2016, each of the attendances recorded by Ms Earl's general practitioner occurred outside the hours that Ms Dann was rostered to assist Ms Earl;*

[6] This is the term used by IHCS to describe the employee that organisation supplied to assist and support Ms Earl.

(c) on each occasion where the attendance is recorded as occurring by phone, they appear to have occurred on Ms Dann's personal mobile phone;

(d) the attendance recorded on 5 August 2020 where Ms Dann is said to have attended an appointment with Ms Earl in person, IHCS' records show that Ms Dann was rostered for a shift with a different client;

(e) other than the attendance on 8 November 2016, none of those attendances have been reported or documented by Ms Dann, nor have they been charged to Ms Earl by IHCS; and

(f) the attendance on 8 November 2016 (being the only recorded attendance) has been documented by way of a time entry, but no comments or feedback has been recorded as to what was discussed (by either Ms Dann or Ms Earl's general practitioner)."

With respect to each of these points made by IHCS I make the following comments (my paragraph (a), (b), (c) etc responds to the points made by IHCS in (a), (b), (c) etc):

(a) I do not see the point which is being made here. It is not suggested, for example, that any relationship, if indeed one did exist, had any bearing on the treatment provided by the GPs and/or care provided by the ISW. In any event, Ms Earl saw three different general practitioners when she attended the practice for those six appointments.

(b) With respect to this point, the ISW is only present at the appointments on 8 November 2016 and 5 August 2020. The second of those appointments was required by the general practitioner given the telephone contact that had occurred on 30 July 2020. At each of the other four appointments, there was either direct phone contact or it was noted that there would be subsequent phone contact. When the general practitioner made or indicated he or she would make contact, I am reasonably confident the general practitioner was unaware when the ISW was rostered to assist Ms Earl.

(c) I do not see the relevance of this point.

(d) As indicated in (b) the appointment on 5 August 2020 was required by the general practitioner. Whether the general practitioner had appointments available when the ISW was rostered to assist Ms Earl is not known. The point made by IHCS assumes of course the rosters are accurate and there were never any changes made due to, for example, a clash of appointments or the unavailability of an ISW due to sickness or some other reason.

(e) Again, I am not sure of the relevance of the point being made here. It simply might be indicative of poor record-keeping and/or the failure of IHCS to ensure its ISWs keep proper records.

(f) I repeat the comments made at (e) in relation to this point.

IHCS then says:

> *"[i]n any event, we reiterate that to the extent that [the ISW] was informed of the outcome of appointments with Ms Earl's general practitioner, it was not her role to participate in the management of Ms Earl's medical conditions. From an ISW's perspective, being informed about a client's medical circumstances may be relevant to other considerations (for example, being aware of requirements for the client to attend further appointments with the general practitioner or relevant specialists) but is not otherwise something that Ms Earl's ISW had any role in managing."*

While I agree the ISW had no role in managing Ms Earl's medical conditions, it is clear from the appointments of 12 May 2020 and 30 July 2020, for example, the ISW was responsible for coordinating the management of Ms Earl's medical conditions by taking her to appointments for tests and by taking her to reviews by her general practitioner.

The records mention the prescription of Ryzodeg which is insulin used to treat IDDM. It appears the prescription was 26 units in the morning and 28 units in the evening. As of December 2020, the records disclose Ms Earl's blood sugars were at a good level. By April of the next year, her diabetes was noted to be poorly controlled and that was confirmed by an attendance on 21 September 2021. However, by 14 December that year her blood sugars are said to be okay. Poor diabetes control is again noted at attendances on 10 March and 6 June 2022.

Finally, the records disclose Ms Earl had difficulties with her neighbours and as a result had to move houses on a number of occasions.

(v) Wintringham Records

This organisation is a not for profit which specialises in housing and care of older people who are homeless or vulnerable to homelessness. Wintringham provided Ms Earl with her housing from in or about October 2021 until her death. The notes of that organisation indicate that in March, April and May 2022, there were complaints made against Ms Earl due to her playing loud music and verbally abusing other residents. Ms Earl initially attended a meeting with this organisation and her ISW in September 2021. A further meeting was held between Ms Earl, her ISW and Wintringham at which the lease was signed in October 2021.

At that meeting, the organisation's COVID-19 vaccination policy was discussed and the ISW was to speak further to Ms Earl about the policy and was to assist her to complete the relevant forms.

(vi) Pharmacy Records

In the 6 months prior to her death, Ms Earl regularly filled prescriptions in relation to three medications which were prescribed to lower her blood sugar level. She also filled scripts for medication to treat her insomnia, pain, hypertension, depression, and to lower her cholesterol. It appears though she only purchased five insulin pens on two occasions namely on 2 March and 26 May 2022.

As for the prescription of pain medication, there were two medications prescribed, one being an opioid namely tramadol. It appears two tablets per day were prescribed. The number of tablets purchased by Ms Earl in the six months prior to her death actually equates to a little less than two tablets per day, however, there are some notes in the records where attempts have been made to reduce Ms Earl's reliance on that pain medication. The consumption of tramadol by Ms Earl did not cause her death.

Ms Earl's daughter is concerned that when she visited her mother's home after her death she could find no prescribed medications. This was no doubt due to the fact medications were seized by Tasmania Police after Ms Earl was found to have passed away. These medications included 32 Ryzodeg insulin pens and a Webster pack containing multiple medications with 14 sealed compartments containing medication for the next 2 weeks.

(vii) RHH Records

Ms Earl was admitted to the RHH on the following occasions:

- 30 April 2007 for an endoscopy and colonoscopy;
- On 19 November 2009, Ms Earl was found semiconscious on the floor by an ISW having suffered a hypoglycaemic attack. The notes record Ms Earl knew she should ring her doctor when her blood sugar levels were abnormal, but she acknowledged she did not do that;
- On 3 October 2010, Ms Earl attended the RHH. Her ISW advised staff she had been unwell for one week and had refused to see her doctor or contact her ISW. It was queried whether she was complying with her medication regime. It was noted there was poor compliance in taking her diabetes medication and she had missed doses for two days prior to her admission. There is a note which

suggests Ms Earl last took her blood sugar levels in August. She was diagnosed with type 2 diabetes, a urinary tract infection and septicaemia;

- Between 9 February and 15 February 2016, Ms Earl was admitted for the excision of a retroperitoneal tumour which had been found on a CT scan. It is clear from the notes IHCS was aware of this admission to hospital and she was discharged into the care of her ISW;
- On 16 October 2015, Ms Earl presented to the Department of Emergency Medicine (DEM) with abdominal pain;
- On 12 May 2016, Ms Earl underwent a gastroscopy and a colonoscopy. The notes indicate her ISW was spoken to and she advised she would facilitate the necessary bowel preparations so that Ms Earl could undergo the colonoscopy. The ISW is noted to have facilitated Ms Earl's discharge home; and
- On 1 April 2019, Ms Earl was sent to hospital by her general practitioner and was assessed in the DEM. She presented with hyperglycaemia and an acute kidney injury in a setting of a gastrointestinal like illness. It was noted Ms Earl had poor glycaemic control. The notes reveal her ISW attended medical appointments. A note of the diabetic educator for 3 April 2019 reveals Ms Earl administered her insulin but had difficulty using the pen. It was noted she had previously misreported her blood glucose levels in a diary when those levels were compared to actual readings on the machine. <u>IHCS was spoken to as that organisation's phone number is on the RHH file. The diabetic educator discussed with IHCS the importance of blood glucose levels and that they need to be reviewed with Ms Earl's general practitioner.</u>

Insofar as the underlined section of the notes of the hospital attendance on 1 April 2019 is concerned, IHCS say in the response:

> *"'IHCS' progress notes for 3 April 2019 have a corresponding entry relating to the discussion between Julie at the RHH and Ms Wills at IHCS which states: "3/4/19 ph call Julie RHH Client can go home on Fri 5/4/19 – They have reduced the insulin & she now has a meter gage (sic) to take to Doctors which does the BLS[7] for her & to now eat 30 mins after having insulin. They might adjust again in 2 wks'.*
>
> *We are instructed that the purpose of this call was for the diabetic educator to notify IHCS of the new measures that the clinic had put in place for Ms Earl's self-management of her diabetes. There was no action required of IHCS."*

[7] Blood sugar level.

If that is so, why was there any discussion with IHCS at all about Ms Earl's diabetes? Surely at a minimum IHCS was to ensure the metre gauge was taken to the appointments with the general practitioner and the BSL readings were properly recorded. That is not managing Ms Earl's diabetes condition. It is simply coordinating the treatment so the condition is properly managed by the general practitioner given Ms Earl was unable to properly do this herself. This is the purpose of involving an organisation such as IHCS because Ms Earl had an intellectual disability and was not, as the records show, able to manage her diabetes herself.

The RHH outpatient notes indicate Ms Earl attended diabetic clinic assessments on 14 December 2018, 5 June 2019 (which represented a new referral), 18 June 2019, 15 November 2019, 15 May 2020, and 19 November 2021. It is clear the long-time allocated ISW to Ms Earl supported her at some of these assessments and she was integral in monitoring and reporting blood sugar level readings in August and September 2019. On each occasion Ms Earl attended, a letter was sent by the diabetic clinic to the GP. There had been appointments with the diabetic clinic and with the podiatry in 2013 and 2016, however, Ms Earl did not attend. She attended fairly regularly in 2006 and 2007 before appointments became irregular, in that she attended in 2009 but there is no regular attendance until 2018. It is clear from these records Ms Earl's ISW assisted her to attend the diabetic clinic on a regular basis from 14 December 2018 until 19 November 2021. As such, IHCS were on notice, given the ISW was their employee, of the seriousness of Ms Earl's diabetes and what treatment was required.

As to the underlined passage in the last paragraph, IHCS says an entry in Ms Earl's IHCS notes for 7 August 2019 is as follows:

> *"'p/call J.Dann insulin for client, client is meant to ring in insulin readings but is not doing it properly dr has asked J.Dann to pls do for about 1 month & phone them in each day – carer starting that today – M – F'*
>
> *"As set out in the above note, Ms Earl was generally responsible for and independent in recording insulin levels. The request for Ms Dann to monitor the levels for approximately 1 month was a short-term intervention designed to support Ms Earl in her own self-management of her diabetes. There was no involvement of IHCS required or requested beyond this."*

The response by IHCS simply reinforces what the underlined passage says; that is the ISW was integral in monitoring and reporting blood sugar level readings for two months in 2019.

(viii) IHCS Records

IHCS acknowledge in correspondence to me that Ms Earl was in need of individual support including an ISW. In fact, that organisation had provided that support since July 2005. Initially, IHCS were funded to provide support to Ms Earl under the individual support program through the Department of Disability, but in 2019 she transitioned to the NDIS. IHCS knew Ms Earl had suffered an abusive and traumatic childhood and knew she did not trust others easily and would not speak to people she did not know, or answer the phone to numbers she was not familiar with. When she had to meet with other agencies, including NDIS or her support coordinator, this was always done at the offices of IHCS. That organisation knew she was unable to read or write and say she would bring her mail into the office for IHCS to help her with it. That organisation was also aware of some anti-social behaviours which she displayed from time to time. Tasks IHCS assisted with included medical appointments, some shopping, meal planning on a budget and some cooking, and staff tried to educate her on healthy meal choices. They assisted her with her mail and was liaising with Medicare and Services Australia. It is said Ms Earl was independent with most other aspects of life including medication, personal care, domestic assistance, transport, meal preparation and she was able to remain living independently. Ms Earl would also contact IHCS if she required assistance with a particular task such as moving house, arranging the storage of furniture, getting the electricity put on, and/or dealing with government agencies or accessing community services.

IHCS advises Ms Earl was a very private and independent person. This is corroborated by Luke Earl, who in his affidavit demonstrates he knew very little about his mother's health and/or the extent of the assistance she received from IHCS. There were only a few employees she would allow into her confidence. I am told Ms Earl looked after her own medications and medical appointments, although she would sometimes have an ISW transport her to those appointments. Similarly, she would do her own shopping, sometimes with an ISW's assistance and she managed her personal care, meal preparation, and accessed public transport and her mailbox in Moonah independently.

I have been provided with two contracts between IHCS and Ms Earl, the first covering the period 25 July 2019 to 26 May 2021 and the second covering the period 29 November 2021 until 29 November 2022. The first contemplates the provision of 6 hours assistance per week for activities of daily living and community access whereas the second contract contemplates the provision of 5 hours per fortnight. A schedule of visits for the period 14 January 2021 until 23 November 2021 indicates on average approximately 4.9 hours per week of assistance was provided during that period. No visits were conducted after 23 November 2021.

In the response, IHCS advised it provided support to Ms Earl which was funded by the NDIS. The support was provided pursuant to Ms Earl's NDIS plan which was referred to in the latest IHCS Service Agreement for the period 29 November 2021 to 29 November 2022 (Services Agreement). IHCS' engagement was to provide supports under Ms Earl's NDIS plan. The plan referred to those supports as *'core supports'* which were described in the following terms: *'core supports are flexible and can be used as required'*. As noted in the Services Agreement, the aim of the NDIS scheme is to:

- support the independence and social and economic participation of people with disability, and
- enable people with a disability to exercise choice and control in the pursuit of their goals and the planning and delivery of supports.

I also note a review of the provision of supports was to be conducted by IHCS with Ms Earl *"at least 6 monthly"*.

The "Statement of Rights and Responsibilities of Service Users and Service Provider" attached to the Services Agreement also notes that clients of IHCS have the right to, among other things:

- refuse a service; and
- refuse services by, or in the presence of, particular workers, health care students or family members.

Therefore, although IHCS was contracted under the Service Agreement to provide a certain number of hours (5 hours per fortnight at the time of Ms Earl's death), the actual hours were arranged flexibly taking into account what services Ms Earl requested from time to time, and her right to refuse services as she wished. The amount of 5 hours per fortnight was an upper limit that represented the amount of NDIS funding that had been allocated.

IHCS was paid by NDIS for those services actually provided and invoiced rather than being paid for a fixed number of hours irrespective of the services actually provided. The last payment to IHCS related to the ISW's final visit to Ms Earl's home on 23 November 2021. From IHCS' initial engagement in 2005, it was not uncommon for Ms Earl to go for periods of up to several months without any support from an ISW.

IHCS say, based on observations of Ms Earl over the 17 years she was provided support by IHCS that, whilst she benefited from assistance from IHCS and other service providers, she was relatively high functioning and was capable of living independently to a large degree. While I generally agree with this statement, it is clear from the medical records she had

significant difficulties from time to time managing her diabetes. It was the role of IHCS to provide support for community access. This included providing the following services as and when required by Ms Earl:

(a) Transport to and from medical and other appointments, and attendance by Ms Earl's ISW at some medical appointments as a support person;

(b) Some assistance with shopping, meal planning and budgeting;

(c) Liaising with other services such as Medicare and Services Australia; and

(d) Other particular tasks arising from time to time such as moving house, arranging storage, or organising the electricity connection.

Ms Earl was largely independent in all other respects. IHCS did not, for example, provide assistance with cleaning or personal care (for example, assistance with hygiene, dressing or similar activities). Ms Earl would regularly catch buses or walk to appointments with doctors, or to the IHCS office in Moonah.

IHCS say its responsibilities did not include monitoring or managing Ms Earl's diabetes. Ms Earl's long term ISW was not qualified to provide any form of medical or clinical care to clients. While IHCS was aware of Ms Earl's diagnosis and had facilitated her attendance at medical appointments, Ms Earl independently managed her treatment with guidance from her general practitioner and other medical services, including the diabetes clinic. The services provided by IHCS did not include the following:

(a) Managing Ms Earl's medical conditions and/or medications. As noted in the Occupational Therapist's report dated 21 June 2021, at page 3: *"Kathleen is responsible for taking her prescription medications using a Webster pack and does not receive any assistance. She was unable to explain her medication regime and purpose independently, but it was reported that she has been compliant with medication adherence."*;

(b) Implementing any recommendations relating to Ms Earl's health, with the exception of some basic assistance provided at the specific request of Ms Earl's treating practitioners (for example, during the brief period in August and September 2019 when the ISW was asked to review Ms Earl's reporting of her blood sugar levels for approximately 1 month as a temporary measure, or in May 2016 when Ms Dann was asked to facilitate the necessary bowel preparations for Ms Earl's colonoscopy);

(c) Monitoring Ms Earl's health and assessing whether and when appointments were required with Ms Earl's general practitioner or other health service providers such as the diabetics clinic at the RHH. Ms Earl's ISW did not have any qualifications or training that would enable them to make assessments as to Ms Earl's health requirements; or

(d) Arranging appointments with health service providers, unless specifically directed to do so by Ms Earl or her general practitioner.

The progress notes I have been provided suggests there were three attendances in May 2021 to access Ms Earl's property at a storage facility and a further attendance in that month in relation to an extra shift to support Ms Earl while she underwent an occupational therapy assessment. Then there is a note in October 2021 where the ISW was going to support Ms Earl when her new lease agreement was signed. Then there were additional attendances in November 2021 when the ISW took Ms Earl to a doctor's appointment and then to an appointment at the diabetic clinic at the RHH. Then there were a number of attendances in March 2022 including phone calls and a number of visits to the office by Ms Earl whereby she was attempting to arrange repairs to her unit. Next there is a note from Wintringham for 12 April 2022 about a complaint from a neighbour. The next note is not until 23 June 2022 which outlines contact IHCS received from Mr Earl and Ms Baxter raising concerns that they had not been able to contact their mother. It was suggested to Ms Baxter she not contact the police because *"we know how horrified she would be if the police showed up."*

As to this comment IHCS says:

> *"The employee that spoke with Ms Baxter on that occasion was Ms Diane Archer. …Ms Archer agrees that she made a comment to the effect that Ms Earl would likely be concerned if police attended her house, but disagrees that she at any time advised Ms Baxter not to call the police.*
>
> *Ms Archer was aware from IHCS' previous experience with Ms Earl that she was a very private person and had reacted negatively to police attending her property in the past, including behaving aggressively toward the attending officers. Ms Archer considered it was relevant to bring this to Ms Baxter's attention."*

Two employees of the service were sent to check on Ms Earl's welfare and some other checks were conducted but she was not located. The report from the employees was that the person who lives in number 24 said he had seen Ms Earl one hour ago walking down into Glenorchy. Affidavits have been sworn by those two employees in which one says she telephoned Ms Earl a couple of times but there was no answer. Following this she and the

other employee went to Ms Earl's home but could not raise her. They then knocked on the door of unit number 25 but there was no answer. Thereafter, they walked around the back of her unit where they could see through a window. They then knocked on the door of unit 24 and asked a man who answered the door whether he had seen the lady from unit 26. He said he thought he had seen her about an hour ago walking towards Glenorchy. He gave a description of the person. They then left the premises and proceeded towards Glenorchy in an effort to locate Ms Earl, but after checking around the Glenorchy Council Chambers, the Glenorchy bus mall and the Glenorchy Central shopping centre they did not find her. They returned to the office. One of the employees was contacted by and spoke to Tasmania Police whereas the other kept trying to contact her on her mobile telephone. Neither employee asked for the name of the person who lived in unit 24 and felt because it was believed he lived in close proximity to Ms Earl plus the description he gave that the report was a credible report.

An occupational therapy functional assessment report dated 21 June 2021 sets out some history which is Ms Earl was born and raised in Coffs Harbour New South Wales. She relocated to Tasmania in 1996 – 97. She grew up in a large family of 16 siblings. Her parents, stepfather and some of her siblings have passed away. She has siblings living interstate. It is noted she receives 4 hours assistance per week. Her home environment, mobility and transfers, personal activities of daily living, domestic activities of daily living, comprehension, expression, social interaction, problem solving, memory and behaviours were assessed. Areas of concern included maintaining physical and mental health, performing domestic activities of daily living, managing and solving problems, making decisions, maintaining a safe in-home environment, and connecting to services. There were others which included moving in the community. A number of recommendations in relation to assistance were made. It does not appear from the material I have been provided with that any of those recommendations were explored and/or implemented.

IHCS says by way of context, the involvement of that organisation with Ms Earl from November 2021 until June 2022 is as follows:

As vaccinations became available for COVID-19, IHCS encouraged and required, to the extent permitted, all staff to be vaccinated as they were often in contact with vulnerable clients. Ms Earl's ISW was opposed to vaccination and refused to be vaccinated. When it became mandatory for home care workers to be COVID-19 vaccinated, with the first dose required by 30 November 2021, IHCS was able to stipulate to the ISW that she not continue working with clients, including Ms Earl, until she was adequately vaccinated. The ISW's response to this requirement was to not be vaccinated and to take extended leave while she considered her options with respect to being vaccinated. Ms Wills of IHCS says

she received a phone call from the ISW on 30 November 2021 who said she would be taking indefinite leave. Ms Wills completed the Leave Notification Form annexed to her statutory declaration based on the discussion with the ISW.

The Leave Notification Form indicates the ISW's next shift for Ms Earl was to be on 1 December 2021. There is a note on that form which says Ms Earl declined a replacement ISW during the ISW's leave. That is not what the form says. It says a replacement was declined on 1 December 2021. The form clearly states *"leave dates from 1/12/21 to 1/12/21."* Ms Wills says that the return date written on the form of 21 February 2022 was added by her at a later date, although she does not recall when that addition was made. Ms Wills however says in her statutory declaration, she spoke to Ms Earl on 30 November 2021 and advised her the ISW was going on leave and asked if she would like a replacement carer, which Ms Earl declined. This direction not to appoint a replacement ISW was consistent with Ms Earl's history of declining replacement ISWs during her ISW's leave periods, which meant she had gone for extended periods without ISW support.

IHCS says although an ISW was not appointed following the leave and departure from IHCS in early 2022 of Ms Earl's ISW, a number of supports were provided to her by IHCS during the period from November 2021 to June 2022. Ms Earl was not charged for any of these attendances, and IHCS was content to continue providing ad hoc assistance to Ms Earl without charge as required. These supports included the following:

(a) Ms Earl called and spoke with Ms Wills on 23 March 2022 and 24 March 2022;

(b) Ms Earl attended the office at IHCS in person on 28 March 2022 to report maintenance issues at her home and request assistance dealing with Wintringham;

(c) Ms Wills contacted Wintringham about the maintenance issues on 29 March 2022, and was told that Ms Earl would need to supply photos. Ms Wills called Ms Earl on the same day to advise that photos were required;

(d) Ms Earl attended the IHCS office in person on 30 March 2022 to provide photos. During the same appointment, Ms Earl asked for assistance finding a bulk billing general practitioner in the Glenorchy area. Ms Wills contacted two clinics but neither were accepting new clients;

(e) On 5 April 2022, Ms Wills sent the photos to Wintringham via email;

(f) Ms Wills attempted to contact Wintringham on 5, 6, 7 and 8 April 2022 with no answer. After the final attempted call on 8 April 2022, she sent an email to Wintringham seeking a response; and

(g) On 12 April 2022, IHCS were contacted by Wintringham regarding concerns of neighbours about Ms Earl's behaviour.

Although the records suggest there was no contact between IHCS and Ms Earl after 30 March 2022, IHCS say there was a further in person meeting between IHCS staff members Ms Wills and Ms Phillips, and Ms Earl, on 12 May 2022. Ms Earl attended the IHCS office in person for that meeting. The statutory declarations of Ms Wills and Ms Phillips indicate the following occurred at that meeting:

(a) Ms Earl queried when a new ISW would be assigned to her. Ms Phillips recalls that Ms Earl indicated that she would be receptive to a new ISW, but would only agree to meet with a new ISW at the IHCS office and only *"if [IHCS] could find the right person"*;

(b) Ms Earl left the appointment telling Ms Wills and Ms Phillips that she was going to go to the supermarket; and

(c) Neither Ms Wills nor Ms Phillips (both of whom had previous dealings with Ms Earl) identified any changes in Ms Earl's health or demeanour. She did not appear to be unwell or suffering from poor health.

Following the meeting, Ms Phillips attempted to call Ms Earl three to five times over the next fortnight to discuss a potential new ISW. Ms Earl did not answer any of the calls. This did not raise concerns as it was not unusual for Ms Earl not to answer her phone. The attempted calls are not recorded anywhere in the records.

The reason why there were no ISW visits on Ms Earl after 23 November 2021 is because her regular and long-standing ISW took leave from 9 December 2021, and then her employment was terminated on 28 February 2022. Ms Earl was advised her ISW would not be returning to work at the beginning of March 2022. There was some discussion later that month, although it is not in the progress notes, that Ms Earl be introduced to a new ISW. This did not occur because the Executive Director of IHCS says they were *"unable to identify an existing ISW, or newly employed ISW that they perceived would be acceptable to Ms Earl, namely an appropriately qualified, Caucasian female of middling years."* Finally, the Executive Director of IHCS says any risk from the delayed introduction of a new ISW to Ms Earl was not perceived, and it was believed she would make contact regarding any pressing matters

and they had no information regarding concerns for her health or well-being from either Ms Earl or any third party.

As to this final comment IHCS sought to clarify it by saying it was made in the context of:

> *"(a) IHCS' role not including any management of Ms Earl's health or any form of medical intervention;*
>
> *(b) Ms Earl's continued contact with IHCS staff throughout the period from November 2021 and June 2022, and IHCS' willingness to continue to assist with any particular matters raised by Ms Earl (without charge to Ms Earl); and*
>
> *(c) the increased support that Ms Earl was receiving during that period through the NDIS in the form of:*
>
> > *(i) a Support Coodinator at Life Without Barriers (appointed in 2020) who [IHCS] understands was responsible for oversight of Ms Earl's NDIS plan, and assisting Ms Earl with capacity building (in the nature of the recommendations in the Occupational Therapist's report);*
> >
> > *(ii) an NDIS Plan Manager at Peak Plan Management (appointed in January 2021) who [IHCS] understands was responsible [for the] oversight of the NDIS funding provided to Ms Earl; and*
> >
> > *(iii) an NDIA Planner who [IHCS] understands is responsible for reviewing and updating Ms Earl's NDIS Plan.*
>
> *It is noted that the funding allocations for these services are outlined in Ms Earl's NDIS plan which covers the period from 14 January 2021 to 14 January 2022 (2021-2022 Funding Period). IHCS has never been provided with the most recent NDIS plan which would presumably cover the 12- month period from 15 January 2022 onwards."*

IHCS also advised:

> *"IHCS' understanding that some degree of tenancy support was provided to Ms Earl through Wintringham, including by Wintringham's Homelessness Support Worker and their Tenancy Management Worker. Further, … the Draft Report records 7 attendances by Ms Earl on her general practitioner during the 6 months leading up to her death. At 2 of those appointments, being 10 March 2022 and 6 June 2022, the GP noted that Ms Earl has poor control over her diabetes. It is also apparent from the records that from at least 28 March 2022 the GP was aware that no current ISW was appointed to Ms Earl. It is noted that IHCS was not contacted in relation to the appointments. IHCS is not aware of any steps taken by*

> *Ms Earl's general practitioner to refer her back to the diabetes clinic. Alternatively, if the general practitioner had been of the opinion that she required clinical care at home (which is not a service capable of being provided by IHCS) [IHCS] notes that Ms Earl could have referred to an agency like the District Nurses who have Commonwealth Home Support Program funding."*

Having said all of that, the Executive Director goes on to say given the services provided by IHCS to Ms Earl *"it is likely that any regularly attending, qualified ISW would have been able to identify any acute failure in Ms Earl's health. It was from a confluence of factors, as stated above, that IHCS was unable to provide her with that support at, and around, the time of her passing."*

In the response, IHCS indicated this comment required clarification which was as follows:

> *"IHCS did not have any indication that Ms Earl's was in poor health in the lead up to her death. As detailed above, they had been in regular contact with Ms Earl and had not identified any change in her condition or usual behaviour.*
>
> *By this statement [the Executive Director] Mr Vickers intended to convey that if an ISW had attended at Ms Earl's house in the final stages of her life whilst she was suffering an acute and observable decline in her health, then the ISW would have been able to take steps to seek medical assistance for Ms Earl. For example, had the ISW attended to find that Ms Earl was lapsing into a hypoglycaemic coma (as on the previous occasion when IHCS attended on 29 November 2009) the ISW would have been able to intervene to assist Ms Earl.*
>
> *Mr Vickers was not intending to suggest that an ISW would have been able to detect and prevent a decline in Ms Earl's health at any earlier stage. As detailed above, the role of Ms Earl's ISW was not to monitor or manage her diabetes. An ISW does not have any particular training or knowledge of diabetes and would not have been able to detect any decline in health before that decline would have become apparent to an ordinary person observing Ms Earl."*

Comments and Recommendations

It appears from the documentation I have been provided that from 29 November 2021, IHCS was contracted to provide 5 hours of assistance fortnightly. That did not occur. Neither is there any evidence of a review of the supports being conducted by IHCS with Ms Earl in almost 7 months prior to her death, which is contrary to the agreement. Ms Earl did not have an ISW after 30 November 2021 and no visits were conducted at her home in the 7 months prior to her death. There was no contact with Ms Earl at all after 12 May 2022, which is almost 6 weeks prior to her death. After the phone contact on 29 November 2021,

there was no contact for about 4 months, after which, there was then 3 phone calls from Ms Earl and 2 office visits. There was a final office visit approximately 6 weeks later on 12 May 2022.

IHCS had been providing assistance for 17 years, and even from the limited documentation I have been supplied, that organisation knew Ms Earl had an intellectual disability, she was mentally unwell, and she had suffered from diabetes for many years. It is clear from the GP's notes and the records of the RHH, the ISW played a key role in assisting Ms Earl in co-ordinating the management of her health. The occupational therapist had highlighted a number of areas of concern, which included maintaining her physical and mental health. I accept Ms Earl may have been a difficult client,[8] but as the Executive Director himself acknowledges if Ms Earl had been regularly attended to by an ISW then any acute failure in her health would have been identified even by an untrained observer. That is, it would have been obvious to Ms Earl's ISW she was unwell. Treatment could have then been organised. No specialist medical training is required for this to occur. Ms Earl was not regularly attended to in the last 7 months of her life and so her failing health was not identified and attended to. It follows, given her cause of death and what is set out above, IHCS provided Ms Earl with sub-standard and inadequate support and assistance after 23 November 2021 until her death between 21 and 23 June 2022.

IHCS has advised it was actively reviewing its internal policies in light of matters raised in my draft decision which was sent to that organisation for comment. IHCS advised as follows:

> *"Among other actions under consideration, IHCS is committed to implementing a formal policy at the earliest opportunity that provides for:*
>
> > *(a) a mandatory requirement for staff to perform administrative checks to identify clients who have not had service without documented reasons for a period of one month, and follow up with the client to enquire whether any services are required; and*
> >
> > *(b) where services continue to be refused on an indefinite basis or are not able to be provided, a prompt for IHCS consider the appropriateness of formally withdrawing as a service provider for the client.*

[8] IHCS has raised concerns that a reader of this report may infer that this is a position put forward by IHCS. IHCS say that it is not their assertion that Ms Earl was a difficult client, but rather that she was an individual with considerable personal agency and, like any other clients supported by IHCS, had individual needs that IHCS tried to accommodate. IHCS is concerned that the term "difficult client" is critical of Ms Earl and is not a description that they would use in relation to their clients. Despite this clarification by IHCS I take the view after objectively assessing all the records in this case Ms Earl would have been a difficult client for IHCS to manage.

IHCS is in the process of formulating the precise terms of a policy of this nature, to ensure that it is capable of properly adapting to the varied needs of its clients.

A further change that has been in progress for approximately the past year and has come to fruition in recent months is putting in place internal processes to ensure that clients have a designated "Individual Service Coordinator" (ISC), and that this designation is clearly communicated to the ISC.

This has now been put in place for all clients and will ensure that there is a clearly assigned employee with responsibility and accountability for oversight of the services provided to each client."

The circumstances of Ms Earl's death are not such as to require me to make any further comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Ms Earl.

Dated: 23 October 2024 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner