MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of GJ

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

a) The identity of the deceased is GJ, date of birth 28 December 1927.

b) GJ was aged 94 years at the time of his death and was married.[1] He was born in Wellington in New South Wales and subsequently moved to Hobart.[2] Prior to his retirement, GJ worked as a tradesman, mainly as an electrician.[3] He was also described in the evidence as being artistic and creative. Since 4 November 2021, GJ was a resident of Glenview Community Centre (Glenview) in its Korongee secure dementia village.[4] GJ suffered from dementia and peripheral neuropathy.[5] Due to his dementia, he experienced unsettled nights, confusion, and disorientation.[6]

The evidence in the investigation establishes that GJ died of injuries sustained as a result of being pushed by another resident at Glenview, AK.

AK has been a resident at Glenview since 1 July 2021. He suffers from Alzheimer's dementia and has a significant history of being physically aggressive towards staff and other residents at Glenview.[7] Both GJ and AK were accommodated in Korongee at Glenview prior to the death of GJ.[8]

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[1] Report of Death.
[2] Glenview records.
[3] Ibid.
[4] See Aged Care Records (admission date on Syringe Driver Observation Chart).
[5] NH GJ: Patient Records.
[6] Nurse Review 2.
[7] Nurse Review 3-4.
[8] Nurse Review 1.

At 4.50pm on 25 June 2022, a registered nurse at Glenview, Natalie Wilson, was called to attend AK because he was exhibiting agitated behaviours.[9] Ms Wilson observed GJ and AK standing outside Room 5 and Room 3 respectively.[10] AK appeared unsettled, leading Ms Wilson to use diversion therapy to divert his attention away from GJ. Unfortunately, this did not have any effect.[11] AK then pushed GJ causing him to lose balance and fall backwards.[12] GJ's head struck the wall as he fell.[13] AK then returned to his room.

GJ was brought to his bed where Ms Wilson conducted a head-to-toe assessment of his injuries. She considered that there may have been fractures from the fall because he was frail. GJ was monitored overnight in his room for signs of deterioration.[14]

At 11.00am on 27 June 2022, GJ was assessed by a nurse who noticed there was a large bruise on GJ's right hip and leg.[15] The nurse consulted a doctor who made the decision to transfer GJ to hospital.[16] At 2.00pm an ambulance was summoned and it arrived at 7.30pm. GJ was transferred to the Hobart Private Hospital for x-rays, which revealed a fracture of his neck of right femur.[17]

On 28 June 2022, GJ underwent a hemiarthroplasty to fix his fracture.[18] The surgery itself was uneventful, but after the surgery GJ appeared delirious with facial drooping on the right side. He was also assessed as having mild left arm weakness.[19] A CT scan of the brain was conducted, which revealed that GJ had experienced a right-sided stroke as a result of the surgery.[20] There were also indications of aspiration pneumonia.[21] The treating medical practitioners who reviewed the CT scan initially gave GJ a guarded prognosis.[22]

Subsequently, on 1 July 2022, a decision was made to move GJ to palliative care.[23]

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[9] Wilson Affidavit 1.
[10] Wilson Affidavit 1.
[11] Wilson Affidavit 1.
[12] Wilson Affidavit 1.
[13] Wilson Affidavit 1.
[14] Glenview Records GJ 38 (25 June 23:09 Entry).
[15] Glenview Records GJ 33 (27 June 14:36 Entry).
[16] Glenview Records GJ 33 (27 June 14:36 Entry).
[17] Medical Records: Nursing Discharge Summary.
[18] Medical Records: Nursing Discharge Summary.
[19] Medical Records: Progress Notes 29/6/22 11.30; Nurse Kevin Review 3.
[20] Medical Records: Nursing Discharge Summary.
[21] Medical Records: Nursing Discharge Summary.
[22] Medical Records: Progress Notes 30/6/2022-1/7/2022.
[23] See Medical Records: Nursing Discharge Summary; Progress Notes 1/7/2022.

On 6 July 2022, GJ was transferred back to Glenview. Between this time and his death, GJ continued his palliative care regime, being provided with pain medication through a syringe driver. As expected, GJ's condition gradually deteriorated and he passed away two weeks later on 20 July 2022.[24]

c) I am satisfied that GJ died as a result of aspiration pneumonia due to suffering a stroke following surgery to repair a fracture of neck of right femur. GJ's existing conditions of dementia and peripheral neuropathy contributed to his cause of death. I find that the operative cause of death was the fact of GJ being pushed ground by AK.[25] If this had not occurred, GJ would not have suffered a hip fracture or had a stroke due to the hip surgery.

d) GJ died on 20 July 2022 at Glenorchy, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity and life extinct;
- Affidavit of Natalie Wilson, registered nurse at Korongee Dementia Village;
- An opinion of the forensic pathologist regarding cause of death;
- Medical records and reports for GJ and AK;
- A review by Coronial Nurse, Kevin Egan;
- Records from the Aged Care Quality and Safety Commission;
- Records from Glenview Community Services for GJ and AK; and
- Records from Tasmanian Civil and Administrative Tribunal (TASCAT) relating to AK.

Comments and Recommendations

The main issue raised in this investigation is whether GJ's death could have been reasonably prevented by managing AK's known aggressive behaviour in a different manner. Therefore, I have been required to examine in some detail AK's condition and history so far as it is connected to the death of GJ.

AK's condition and management

[24] Nurse Review 3. Declaration of Life Extinction (Natalie Wilson).
[25] State Forensic Pathologist Report.

AK is currently 81 years of age and suffers from Alzheimer's dementia and progressive aphasia.[26] As a result of his dementia, AK's cognition, insight and judgement are highly impaired. However, he is mobile and physically fit. From the time of his admission to Glenview in July 2021, he regularly instigated aggressive behaviours towards other residents and staff members. In a "Serious Incident Report Scheme" notification dated 2 July 2022, Glenview reported that there were six previous occasions in the prior six months of "*unreasonable use of force"* inflicted on others by AK.[27]

The first report of AK's aggressive behaviour was on 31 August 2021.[28] Dr Elizabeth Monks, his treating general practitioner at the time, considered that AK's behaviour tended to relate to possessiveness (of his surrounding territory) and the fact he would become easily irritable.[29]

The Coronial Nurse, Kevin Egan, reviewed AK's records and commented that AK's aggression against staff members often occurred when they had their backs to him retrieving his medication from a locked cupboard.[30] AK appeared to believe that the staff members were "*going through his cupboards and stealing from him*". The evidence as a whole indicates that since AK's admission, his ongoing aggression to staff and other residents has mostly involved acts of grabbing, holding and pushing.

AK's unpredictable and aggressive behaviour caused by his dementia presented considerable risk to others around him. Not surprisingly, it also engendered fear in those coming into contact with him. As noted by Mr Egan, the difficulties in managing such symptoms of dementia arise because of the spontaneity of action, variance of triggers and inability of the person suffering to adequately communicate.[31]

AK was initially managed by Glenview using non-medical behavioural management strategies, with additional staff members allocated to monitor and diffuse his behaviour.[32] It is noted that Dr Monks charted oxazepam for occasions when non-medical behavioural management was not effective.[33] AK was otherwise monitored through allied health and medical reviews, which increased in frequency with his aggressive behaviour.[34]

[26] TASCAT Documents 3, pg 62. Progressive asphasia entails loss of ability to speak and understand language.
[27] Age Care Commission Disclosure Notification 4.
[28] AK GP records 11, consult on 31 August 2021.
[29] AK GP records 11, 14 September 2024.
[30] Nurse Review 2.
[31] Nurse Review page2.
[32] AK GP notes 11; Correspondence with Glenview 31/3/23.
[33] AK GP notes 11.
[34] Nurse Review 2.

Attempts made by Glenview before GJ 's death to refer AK for specialist care for his aggressive behaviour were not successful.[35] On 5 May 2022, a referral was made to Tasmanian Health Services Older Person Mental Health Service (OPMHS).[36] Other referrals to acute services were also made.[37] Unfortunately, due to the unavailability and demand of these services, AK did not receive higher services until after GJ's death.

Mr Egan reviewed the management plan in place for AK at the time of GJ's death in his report for the investigation. He considered that, in light of AK's extremely difficult behaviour, Glenview had in place a management plan which appropriately specified matters relating to medication, redirection, toileting and engagement in activities.

Mr Egan considered that Glenview and Dr Monk made appropriate referrals to Dementia Support Australia and OPMHS, but it was unfortunate that specialist assistance was delayed until after the incident occurred. I accept Mr Egan's assessment.

Given AK's continuing behaviours arising from his dementia and the ongoing risk he posed to others, I cannot find that any different care or action at that time would have prevented his episode of spontaneous aggression towards GJ. Further, it was premature at that time for AK to have been accommodated in a higher care facility. The necessary assessments had not then taken place. Subsequently, this issue has been considered but has caused disagreements between Glenview and AK's family.

From his admission to Glenview in July 2021 until August 2024, Glenview reported that AK was involved in 105 physical incidents with 56 of those involving residents and 49 involving staff members. An incident on 16 May 2024 recorded on CCTV footage showed AK pushing another resident causing them to hit a wall and fall to the ground.[38]

Following this incident, Glenview took the unusual step of establishing a full-time male carer for AK for 16 hours per day, subsequently reduced to 8 hours per day. The evidence indicates that this measure has decreased the incidents involving residents. However, it is reported that staff members are still regularly subjected to physical and verbal assaults whilst caring for AK.[39]

It was only after GH's death that AK received some high-level care and advice regarding his behavioural issues.[40]

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[35] Correspondence with Glenview 31/3/23.
[36] Nurse Review 4.
[37] Correspondence Glenview 31/3/2023.
[38] TASCAT Documents 3, pg 48-49, incident report.
[39] Standard Wise Australia report by Linden Brazier, page 2.
[40] Correspondence with Glenview 31/3/23.

AK was reviewed by consultants from THS and from Dementia Support Australia. A letter from Dr Duncan McKellar of Dementia Support Australia (DSA), dated 6 July 2022, outlined possible causes for AK's behaviour. These included that AK may have been suffering from untreated pain and discomfort from constipation. Dr McKellar also noted that the oxazepam charted for AK was underutilised, having regard to his severe behaviour. Dr McKellar commented that it would be reasonable for the medication to be used more frequently and pre-emptively to deal with AK's behaviour.

The Aged Care Quality and Safety Commission received an incident notification on 28 June 2022 (before GH's death) regarding the use of force by AK towards GH on 25 June 2022. That notification was closed by the Commission, which concluded that Glenview took appropriate action to mitigate future risk by re-referring AK to a dementia consultant and to DSA.[41]

The Commission acknowledged that AK's behaviour could be very unpredictable and there were usually no apparent triggers. It was also acknowledged that Glenview had instigated discussion with the general practitioner concerning behaviour management and strategies for staff to monitor AK's behaviour and keep him engaged in activities.

Support plans for AK were also developed by Glenview after 25 June 2022. For example, a dementia consultant assisted in identifying triggers and interventions that could be used to reduce his aggressive behaviour.[42] The suggestions included reassuring AK, inviting him to engage in another activity, and medical intervention as a last resort. Risk management and behaviour development plans were made to assist AK while reassuring him that his independence would not be reduced.[43]

Glenview also applied for and received a grant from the Specialist Dementia Care Program to establish a dedicated care unit to support persons such as AK who do not fit within the traditional residential care model of service delivery due to severity of behaviours and psychological symptoms of dementia.[44]

In recent correspondence to the Coroner, Glenview confirmed that a Specialist Dementia Care Program, called Waratah House[45], was opened in December 2023.[46] However, AK is

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[41] Aged Care Quality and Safety Commission notification 4.
[42] Personal Behaviour Support Plan (see electronic file (under s 59 authorities and returns)).
[43] Personal Risk assessment and Behaviour development plan (Becky Sherring) (see Glenview Correspondence).
[44] Glenview Correspondence 31/3/23 page 2.
[45] Waratah House is a separate residential facility with nine bedrooms.
[46] Glenview Correspondence 1/10/24.

not accommodated in this program and remains a resident of Korongee with the high level of one-on-one care and support previously referred to.

It is apparent from the evidence that strong and entrenched disagreement has arisen, and still exists, between Glenview and OL ("O"). As AK's son, OL has been the family member responsible for medical, residential and care decisions relating to his father who is not capable of making such decisions[47].

It seems that the issues arose at a time after the death of GJ and relate particularly to how AK's rights may be upheld, his care needs met and how Glenview residents and staff can be safe from his behaviours. For example, the evidence indicates that significant issues have arisen regarding the proposal to transfer AK to Glenview's new Waratah House or the Roy Fagan Centre, lack of family consent for assessments and reviews of AK, and the nature and quality of his care and treatment at Glenview.

These issues and disputes have likely prevented clear and decisive strategies for AK's care and mitigation of risk to other's interacting with him. Until May 2024, no application was made by Glenview or a family member to have a formal guardian appointed for AK to make these decisions on his behalf.

Guardianship proceedings

On 16 May 2024, Glenview filed an application for an emergency guardianship order for AK under section 65 of the *Guardianship and Administration Act* 1995 with TASCAT[48]. The basis of the application was that AK had become more aggressive towards other residents at the facility and posed a risk to staff.[49] The catalyst for the application was that OL had not provided consent in a timely manner to allow Glenview to refer AK for another DSA assessment.[50]

On 17 May 2024, in written reasons, Tribunal Member Jones dismissed the application, not being satisfied that there were urgent circumstances sufficient to make an emergency order.[51]

On 13 August 2024, a substantive application for guardianship was filed with TASCAT by OL. In these proceedings, the Tribunal received documentary evidence [52] and conducted the hearing on 30 September 2024.

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[47] The evidence indicates that OL is Power of Attorney for AK.
[48] Tasmanian Civil and Administrative Tribunal.
[49] TASCAT Documents 2, pg 71, [11].
[50] TASCAT Documents 2, pg 72-73, [17].
[51] TASCAT Documents 2, pg 67-74 at [24]-[28].
[52] Including receiving an investigation report by the Office of the Public Guardian.

On 18 November 2024, the Tribunal made a guardianship order appointing OL as AK's guardian for a period of 6 months with a review hearing of the guardianship order to be held approximately one month prior to the expiry date of the order.[53] With an order now made and further review of the order pending, it is likely that the issues pertaining to AK's care and management may be appropriately resolved.

AK's behaviours are caused by his severe dementia, and I do not suggest that his aggression is the product of rational thought processes. However, he continues to pose a risk to staff and other residents. It is concerning that incidents similar to that which led to GJ's death have continued to occur and that the decision-making surrounding his care and treatment has been problematic for a lengthy period of time.

It is not useful in this investigation to undertake the exercise of determining whether Glenview and/or the family of AK have acted unreasonably since the death of GJ.

I have found that Glenview was diligent in applying regular measures to manage and mitigate AK's behaviours in the 11 months between his admission to Glenview and the incident involving GJ. With the benefit of hindsight, however, the ongoing risk posed by AK towards others likely demanded more pressing action to have him assessed and additional measures taken. I recognise that there were also delays inherent in this process not within the control of Glenview.

I cannot find that Glenview should necessarily have taken steps to apply for the appointment of a guardian in respect of AK *before* the death of GJ. However, I comment that Glenview was subsequently slow to act in seeking to resolve the decision-making impasse.

I **recommend** that residential aged care facilities ensure that timely consideration is given to the need for a guardianship order to enable effective decision-making in respect of the care of a resident in circumstances where that person poses a risk to their own health and/or the health and safety of others; and, in appropriate cases, ensure any application is made to TASCAT in a timely manner.

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

Dated: 26 May 2025 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner

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[53] [2024] TASCAT 207.