IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 / 2017

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: CATERINA MONTALTO

Delivered On:	18 December 2013
Delivered At:	Coroners Court of Victoria, Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	10, 11, 12, 15, 23 & 31 July 2013
Findings of:	HEATHER SPOONER, CORONER
Representation:	Dr Brophy on behalf of Arcare Pty Ltd Dr Halley on behalf of Dr Elberg Mr Reid on behalf of Ms Catherine Condon
Police Coronial Support Unit	Senior Sergeant J. Brumby

I, HEATHER SPOONER, Coroner having investigated the death of CATERINA MONTALTO

AND having held an inquest in relation to this death on 10, 11, 12, 15, 23 and 31 July 2013
at Melbourne
find that the identity of the deceased was CATERINA MONTALTO
born on 27 January 1935
and the death occurred on 31 May 2011
at Arcare Hampstead Aged Care Facility, 31 Hampstead Road, Maidstone 3012
from:

1 (a) IMMERSION WITH UNDERLYING CAUSE UNDETERMINED IN CIRCUMSTANCES OF A FALL INTO A COURTYARD WATER FEATURE

in the following circumstances:

1. Mrs Montalto was aged 76 when she died. She was a resident in the dementia unit of Arcare Hampstead, part of Arcare Pty Ltd (and herinafter referred to as Arcare). The dementia unit was situated on the ground floor of the facility, known as Jasmine Unit. It had access through opening doors to an internal courtyard containing a decorative water filled fountain or pond (as variously described throughout the investigation and inquest).

2. Mrs Montalto had a medical history that included hypertension, ischaemic heart disease, angina, atrial fibrillation, severe vascular dementia, recurrent urinary tract infections, osteoarthritis, depression, thyroidectomy and previous pulmonary tuberculosis. As a consequence of her dementia, Mrs Montalto had wandering type behaviour.

3. The death was not initially reported to the coroner as it should have been and it was only as a result of the courageous act of a young carer speaking up to her union that the unusual and reportable circumstances surrounding the demise of Mrs Montalto were uncovered.

4. A police investigation was launched and it was fortuitous for Constable Yin[1] that as he walked away from the facility after an initial enquiry, he noticed a closed circuit camera directed towards the courtyard. Prior to that he had gained the impression from Ms Cathy Condon, the Facility Manager that Mrs Montalto had been found in the vicinity of the fountain and possibly having some part of her in that fountain submerged.[2]

[1] Transcript page 538

[2] Transcript page 537

5. The footage that he subsequently retrieved and accessed proved extremely telling. It revealed not only a lengthy 50 minute time frame of events but valuable evidentiary proof of just how Mrs Montalto stumbled and fell and became immersed in water in the courtyard fountain. Importantly it also revealed the presence and actions of staff once Mrs Montalto was discovered.

6. The death of Mrs Montalto was complicated by breaches of policy and procedure at Arcare. Indeed the actions of some staff amounted to little more than a cover-up with Dr Elberg being called to attend the facility and certify the death of her patient without being fully informed by staff of all that had actually occurred. The family were similarly kept in the dark about the true surrounding circumstances and not surprisingly, they were left somewhat bewildered and concerned by the unfolding investigation. I was not surprised to learn later on during the Inquest that Arcare had apparently engaged a PR company to assist them with responses regarding the death.

7. As for the whistleblower Ms Susan Mutami, she was sacked by Ms Condon on the basis that her probationary period had proven unsuccessful; in effect for an alleged breach of confidentiality in speaking up regarding the truth about the death.

Events Leading to Death

8. After review of CCTV footage by police, it was apparent that at about 3.00pm on 31 May 2011 Mrs Montalto was walking unattended in the internal courtyard of Jasmine Unit. The courtyard included a path, garden beds on both sides and a water fountain adjacent to the path. Mrs Montalto wandered into the garden bed in the vicinity of the fountain, and when returning to the path knocked over a garden light adjacent to the path with her knee. Continuing to walk on the path, Mrs Montalto tripped on the knocked over garden light and fell head first into the pond section of the fountain, possibly striking her head.

9. Mrs Montalto remained motionless, lying face down with her face and torso in the base of the water filled fountain from the time of initial fall. Staff discovered Mrs Montalto at 3.51pm on 31 May 2011, when she was removed from the fountain.

10. Clearly Mrs Montalto had been able to wander unheeded in a hazardous area and she had not been regularly checked during the time she was absent from inside Jasmine Unit.

11. By coincidence, the evidence revealed that there may have been an ambulance on site at the facility at about the very time Mrs Montalto was found, however their assistance was not sought.

12. No resuscitation attempts was performed by the two registered nurses in attendance, as they believed Mrs Montalto was already deceased having observed no pulse or respiration detected and cyanotic lips.

Forensic Examination and Evidence regarding Cause of Death

13. An autopsy was performed by Dr Linda Isles, Forensic Pathologist at the Victorian Institute of Forensic Medicine. The death was not reported to the coroner as it should have been and the family had arranged for the body of their mother to be sent to the funeral parlour where it was embalmed. This proved problematic and hampered the ability of the pathologist in determining a cause of death.

14. Dr Isles found insufficient natural disease to account for the death. Whilst she commented that Mrs Montalto probably died from immersion, Dr Isles could not determine between two possible mechanisms of death; Mrs Montalto may have been rendered unconscious from blunt head trauma and subsequently drowned or the immersion in cold water may have precipitated a reflex cardiac arrest.

15. The report from Dr Isles included an 'undetermied' cause of death and the following comments to which I propose to set out in full:

> *"The deceased, Caterina Montalto, aged 76 years, had a history of angina, atrial fibrillation, hypertension and dementia. As a consequence of the latter she often demonstrated wandering type behaviour. Her death was initially not reported to the Coroner, however subsequent to an allegation made via the Nursing Federation, the case was subsequently reported to the Coroner and investigated by police.*
>
> *As this case had not been previously reported to the Coroner, the deceased's body had been embalmed prior to post mortem examination. As a result, no cause of death is evident at autopsy examination. There is however no post mortem evidence of significant head injury or significant cardiac disease.*
>
> *I have viewed CCTV footage of the deceased in the gardens of her nursing home. In this footage the deceased appears to strike her left knee on a garden light and subsequently trip over the light and fall into a fountain that appears to contain water. The deceased appears to make partial protective-type arm movements to break her fall, thus based on this footage, this appears to be a mechanical fall. After entering the fountain she does not appear to move. Due to the fact that this lady's body has been embalmed, it is not possible to accurately interpret the presence or*

absence of the post mortem changes of drowning, which can be non–specific, even under ideal post mortem conditions.

There is insufficient natural disease identifiable at post mortem examination to account for this lady's death. After viewing the footage made available to me, appearances suggest that this lady has died as a result of immersion. However, it is significant that from this footage (and the footage is unclear at this point), it appears that after entering the fountain, Mrs Montalto does not move. That being the case, there are two possible mechanisms for her death as a result of immersion. Firstly, she has been rendered unconscious from a concussive blow to her head sustained on falling into the fountain. Whilst at post mortem examination there is no evidence of deep bruising to the scalp, there is an intradermal (superficial) bruise on the left side of the forehead, and I cannot exclude the possibility that this lady has been rendered unconscious from blunt head trauma and subsequently drowned, even in the absence of deep scalp bruising. The second mechanism is that of reflex cardiac arrest in the setting of immersion in cold water. In this instance, death occurs very rapidly, and the 'typical' signs of drowning are absent at post mortem examination.

This lady's cause of death after post mortem examination has been given as undetermined, principally because the effects of embalming have hampered the assessment on pathological findings at post mortem examination. Whilst there are natural causes of death for which there may be no anatomical findings at post mortem examination, such as sudden cardiac arrhythmias, despite this lady's reported history on angina and atrial fibrillation, I can find no post mortem evidence of significant heart disease. However, in my opinion, this lady has died as a consequence of a fall into the fountain, mostly likely the result of immersion. This opinion is based on the CCTV footage made available to me and the absence of significant ischaemic heart disease at post mortem examination.

Examination of this lady's brain demonstrates features of Alzheimer's disease. There are no substantial areas of ischaemic injury to go along with a pure vascular dementia. In addition, there is evidence of Hashimoto's thyroiditis.

Toxicological studies performed on vitreous humour demonstrate the presence of diazepam and its metabolite, risperidone and its metabolite, paracetamol and a very

small amount of alcohol. The latter is most likely artefact. Blood has not been analysed as the deceased's body had been embalmed.

This case has been subject to the Institute's technical review process."

16. Dr Isles was unavailable for the inquest to give evidence about her forensic examination, however Associate Professor David Ranson who is an extremely well qualified and experienced Forensic Pathologist and Deputy Director at the Victorian Institute of Forensic Medicine did provide some additional helpful testimony to assist me with an appropriate cause of death.

17. Dr Ranson told the inquest that whilst he did not examine the body of Mrs Montalto he was familiar with the death and the report of Dr Isles. Dr Ranson had also looked at the CCTV footage immediately before, during and after the fall. He agreed with the conclusions of Dr Isles and expanded on the difficulties that were created by the embalming which occurred due to the failure to report the death.[3] In regard to a change to the cause of death he told the inquest:

> *"..as Dr Isles said, appearances suggest this lady has died as a result of immersion".*[4]

Later he indicated that immersion could be constituted even if the mouth was only partially in the water:

> *"..one doesn't require complete occlusion."*[5]

18. Dr Brophy put it to Dr Ranson that it was theoretically possible that Mrs Montalto was having a cardiac event when she tripped on the light bollard. Dr Ranson responded:

> *"....Well, of course that's possible. One couldn't exclude the fact that's something she may be having, an angina episode or maybe she has had some damage to heart muscle. But I think the fact that she makes – seems to make purposive movements in the process of the fall would suggest that she's certainly conscious at that particular time. I would however agree that if she has got some cardiac event happening then the – as I mentioned earlier, the additional insult if you like of water in the airways,*

[3] Transcript page 404

[4] Transcript page 412

[5] Transcript page 416

on the face, in the voice box area may well increase her vulnerability to being suddenly immersed in water."[6]

19. At the conclusion of his evidence I asked Dr Ranson about the position of Mrs Montalto when she fell:

> Question: *You've observed the CCTV footage and you've seen what happened to Mrs Montalto, did you think it looked like she landed on her side or that she – are you able to proffer any opinion as to whether she looks like she lands face down in the water or on her side?*
>
> Answer: *---Look, I would have to look at it again. I wasn't turning my mind specifically to that issue. And thinking back, I certainly recall she goes into the water, she's generally face down in the sense that she's – the front of her body is downwards. I can't recall whether her head might have been turned slightly in one direction or another. Certainly I couldn't see any further movement and that much of her head did appear to be in that water. That's all I can say.*[7]

20. Although Dr Brophy submitted that I should not amend the cause of death, I disagree and having considered all the evidence, I propose to amend and formulate it as follows:

> 1(a) Immersion (with underlying cause undetermined in circumstances of a fall into a courtyard water feature)

Inquest

21. An Inquest was convened. At the outset Dr Brophy offered "*a sincere expression of regret and sympathy to the family.*" on behalf of Arcare.

22. Several Arcare staff were called to give evidence about what they said had occurred that was proximate and relevant to the death of Mrs Montalto. There were some competing, inconsistent and sometimes unedifying accounts and explanations and the factual conflict left me in some doubt about the degree of knowledge and complicity of some staff. I refer to but a few of the long list of witnesses who gave evidence.

23. The Montalto brothers both gave evidence.

---

[6] Transcript page 415

[7] Transcript page 417

24. Mr Guiseppe (Joe) Montalto told the inquest that he had accepted the story that he was told by staff to the effect that his mother had been located deceased from a heart attack in the courtyard. He told the inquest:

> *"..I just took what they said as the truth."*[8]

The first he knew that his mother may have had a fall in a fountain was when he was in contact with the Coroners Court. He was aware that his mother had a history of falls and was a wanderer, but she had access to the courtyard through open doors. Mr Montalto had since noticed whilst visiting to see his father that the doors were now locked. If they were to be open to residents then Mr Montalto considered that the pathway should have handrails installed.

25. Mr Francesco (Frank) Montalto told the inquest that he noticed a different atmosphere at Arcare on the evening his mother died:

> *"...they were all in a huddle and it was all a bit of a hush.....thinking about it now, ...it all made sense that they were all pretty much stunned themselves and not sure what to say...."*[9]

Later he echoed his brother's reaction stating:

> *"...so we took – whatever the staff told us, we took that as gospel because they – they're the one treating her.."*[10]

26. Mr Montalto had signed a *'not for resuscitation order'* earlier during her admission. After the death of his mother had been reported to the Coroner, Mr Montalto had been contacted by management at Arcare and had a meeting with them on 7 June 2011. He had been concerned about the possibility that his mother drowned.

He told the inquest:

> *"....they clearly told me....it was Kay or Colin, I can't remember, but they wanted to make sure that I knew that she was wet but her face was not in the water...."*[11]

Later he conceded that he may have been told by them that:

---

[8] Transcript page 24

[9] Transcript page 26

[10] Transcript page 29

[11] Transcript page 33

"...her face was not face down in the water I guess.."[12]

They had not mentioned any CCTV footage capturing the incident and the first he learnt of it was through the investigating police member.[13] He was also adamant that during the meeting he understood:

"...that she (Cathy Condon) offered her resignation and they refused it and they offered her sick leave.."[14]

The family were in a difficult position as their father was also a resident at Arcare. They preferred he remain there, so they didn't wish to make too much of a fuss or in any way compromise his care which remained a primary concern for them during the course of the investigation involving their mother. It was apparent however that they felt the circumstances reflected a breach of trust they had placed in the Facility.

Mr Montalto was shown photos of the courtyard changes since the death of his mother but he still felt that the fountain itself was a hazard.[15]

27. Dr Liliana Elberg was Mrs Montalto's General Practitioner. Dr Elberg, was contacted by phone regarding the event, and was informed by Ms Mandeep Sandhu that Mrs Montalto was found dead next to the small pond in the courtyard, without further detail. Dr Elberg told the inquest that Ms Mandeep Sandhu had led her to understand that Mrs Montalto was already deceased[16] having been located next to the pond outside. Dr Elberg denied ever being asked to attend[17] the facility at that time and was certain it was merely for the purpose of certifying cause of death.[18]

After completing all of her scheduled appointments at her clinic, Dr Elberg attended Arcare Hampstead at approximately 7 pm on 31 May 2011 to verify the death of Mrs Montalto. When Dr Elberg arrived she was taken to Mrs Montalto's room by a registered nurse, Ms Leah

[12] Transcript page 46

[13] Transcript page 35

[14] Transcript page 45

[15] Transcript page 38

[16] Transcript page 55

[17] Transcript page 71

[18] Transcript page 76

Marie Sanchez who provided no further information and Dr Elberg sought none.[19] When she viewed Mrs Montalto in her room *"she was very tidy, peace –very peaceful."*[20]

Dr Elberg told the inquest that she felt comfortable with not seeking further information from staff. It was not until she was contacted by the police that Dr Elberg became aware of the circumstances surrounding Mrs Montalto's death.[21] She was *"furious"*.[22] Had she been made aware by staff that Mrs Montalto was found in the water of the pond then she *"..would have reported the death initially to the coroner.."*[23] Dr Elberg felt she had been misled by staff.[24]

Dr Elberg was asked a number of questions about her professional approach to attending and writing Death Certficates and the apparent shortcomings that were evident.[25] Dr Elberg had since realised falls-related deaths were reportable to the coroner and she had changed her practice and agreed that when in doubt about whether a death was reportable, she should err on the side of caution and report.[26]

Dr Elberg was clearly under a misapprehension about the circumstances surrounding the death and acknowledged she could have adopted a better approach to her task of completing the Death Certificate.

28. Ms Mandeep Sandhu was a Registered Nurse who no longer worked at Arcare. She had telephoned Dr Elberg on the instructions of Ms Condon after Mrs Montalto was located in the pond. Ms Sandhu strongly disputed the conversations alleged by Ms Mutami and Dr Elberg. I found aspects of her recollection and evidence unsatisfactory. To the extent that there were inconsistencies between her evidence and that of Dr Elberg and Ms Mutami about certain events and conversations that transpired, I preferred the evidence of the latter two witnesses. Her struggle to answer questions directed to whether she thought Mrs Montalto was dead or

---

[19] Transcript page 57

[20] Transcript page 58

[21] Transcript page 63

[22] Transcript page 78

[23] Transcript page 64

[24] Transcript page 66

[25] Transcript page 70

[26] Transcript page 77 and see findings in Memedovski COR 2009 005807

alive when she saw her by the pond and how Mrs Montalto had become wet verged on the absurd at times.[27]

29. Ms Leah Marie Sanchez is a Registered Division One Nurse working at the facility. She referred to and amended statements made to the police and lawyers for Arcare. Ms Sanchez told the inquest that the hierarchy at the facility required all staff to report to her as the nurse in charge of the shift and she would then report up to Ms Condon.[28] She explained differences in her statements by claiming she was *"confused"*[29] and given the police presence she was *"scared, like I was shocked, I was scared"*.[30]

    Ms Sanchez only told the truth about what she alleged really occurred when confronted with the reality of the investigation. Aspects of her evidence were concerning and unsatisfactory including that in regard to falsifying the dispensing of medication and progress note record[31], the reference to the *"jolly voice"*[32] of the nurse reporting the fall, her initial claim (prior to discovery of CCTV) that Mrs Montalto had only been in the courtyard 10 minutes,[33] telling the family that Mrs Montalto was "*circling*" her husband that afternoon and the significance and meaning of that[34], her vague assumptions that the family had been told by Ms Condon of Mrs Montalto's fall[35] and that Ms Mandeep had also informed Dr Elberg.[36]

30. Ms Sanchez gave evidence of the sequence of events upon finding Mrs Montalto in the pond; she "*screamed*" and called for help.[37] Ms Sanchez had some difficulty under questioning by Counsel for Arcare to specify where Mrs Montalto's face and body was in relation to the water level[38] however she told the inquest that only part of Mrs Montalto's mouth and face were in the water.

---

[27] For examples refer to Transcript pages 101 and 113

[28] Transcript page 145

[29] Transcript page 141

[30] Transcript page 142

[31] Transcript page 162

[32] Transcript page 146

[33] Transcript page 187

[34] Transcript page 157

[35] Transcript page 157

[36] Transcript page 159

[37] Transcript page 215

[38] Transcript page 208

Ms Sanchez told the inquest that Ms Condon told Ms Mandeep to call up Dr Elberg and the family,[39] saying "*she's gone*"[40] and that it was "*too late*" for any medical intervention.[41] A tub chair had been utilised to help transfer Mrs Montalto from the fountain/pond back to her room whereupon another carer dried and reclothed her in preparation for the family. Ms Sanchez was aware that some deaths had to be reported to the coroner however, she told the inquest "*it didn't cross my mind.*"[42]

Ms Sanchez had not completed an incident report as otherwise required and she claimed that she was told by Ms Condon to inform staff they would be sacked if they mentioned it.[43] Ms Sanchez claimed that she was stood over by Ms Condon to write false entries and records, however this did not sit well with her subsequent voluntary attendance at an offsite farewell party for her.

Whilst Ms Sanchez may have been initially shocked at finding Mrs Montalto, I was not convinced that she was altogether an unwilling participant in the cover-up given all her evidence around her behaviour and her subsequent attendance at the farewell party. That of itself was surprising, because if her allegation that she was overborne was true, then Ms Condon had placed her nursing registration in considerable jeopardy and presumably a party in her honour would be the last thing Ms Sanchez would have wished or felt obliged to attend. There was no escaping the fact that Ms Sanchez was the responsible nurse in charge and she had apparently failed to ensure that Mrs Montalto was adequately supervised whilst under her watch. At the very least and if only by omission, she had actively misled the family and Dr Elberg of the true circumstances surrounding Mrs Montalto's demise.

31. Ms Susan Vivien Mutami was the whistleblower who had first seen Mrs Montalto in the pond from an upstairs window in the facility when staff were alerted. Attempts to undermine her credibility as a witness largely failed. Although she may have been mistaken about what she perceived to be an attempt at resuscitation upon Mrs Montalto, I preferred her evidence to that of other witnesses and I was satisfied that she was motivated by a genuine desire to do the right thing.

---

[39] Transcript page 152

[40] Transcript page 153

[41] Transcript page 155

[42] Transcript page 161

[43] Transcript page 167

32. Ms Kay Foster, Chief Operations Officer of Arcare Pty Ltd, set out a raft of policy and reference guideline documents (some very recent) that were designed to ensure as far as practicable that an incident such as that surrounding the demise of Mrs Montalto could never recur.

Ms Foster agreed that information from the physiotherapist regarding Mrs Montalto's Falls Risk Management had still not been transferred to her Lifestyle / Care plan as at the time she died. Ms Foster went on to say that her facility did not provide one on one care; it was not achievable and a second physiotherapy assessment / opinion should have been obtained.

As the most senior clinician on site, Ms Foster stated that it was up to Ms Condon to make the call about referring the death to the Coroner. She agreed that were it not for the actions of Ms Mutami, the death would never have come to the attention of the Coroner.

Ms Foster elaborated on the fact that Arcare had taken the death and failure to report to the Coroner seriously and, also introduced reasonable and appropriate protocols It was understandable that the organisation was trying to minimise reputational damage, but I wondered whether the need for real cultural change had been recognised and acknowledged from a governance point of view.

33. Ms Catherine Condon (referred to throughout the inquest as Ms Cathy Condon) gave evidence under the protection of an indemnity certificate that I granted under s.57 of the *Coroners Act 2008*. I concluded that it was in the interests of justice that the inquest should hear her testimony.

Ms Condon was the Facility Manager at the time of Mrs Montalto's death and had been in that position since 2008.[44] She agreed that she did not have a clear understanding of reporting deaths to the Coroner.[45] However, in hindsight she also agreed that given a fall was involved it should have been reported.[46] Ms Condon agreed that were she to rely on the doctor to report deaths to the Coroner then the doctor would need all '*relevant information*'.[47]

---

[44] Transcript page 568

[45] Transcript page 570

[46] Transcript page 625

[47] Transcript page 629

Ms Condon agreed that the CCTV footage portrayed a different version of what occurred to that which was contained in her statement.[48] When asked whether she thought Mrs Montalto may have drowned given the location and the fact that she was wet, Ms Condon stated:

> *"It didn't cross my mind at the time and even – even that night, even the –the- the – next day, it – it just didn't cross my mind.*[49] *I relied on the information I was given at the time and I remember asking staff was there any risk that, you know, her head was in the water and the answer I got back was no."*[50]

When asked about subsequent conversations with Ms Foster she told the inquest that whilst she had not told her that Mrs Montalto was in the water she had told her she was wet.[51] When asked why she had not informed Constable Yin about the CCTV footage of the incident when he had attended the facility, she told the inquest *"I...it didn't – it didn't cross my mind."*[52]

Overall the evidence of Ms Condon reflected someone in denial and whilst I considered her to be the leader in covering up the details of Mrs Montalto's death, her assertions about the role of other staff did have some cogency.

Coroners Prevention Unit (CPU)[53] Review

34. I requested the CPU to review the measures, changes and protocols instituted at Arcare in response to the death of Mrs Montalto:

Existing safety measures prior to 31 May 2011

35. The Aged Care Standards and Accreditation Agency (ACSAA) previously audited Arcare on 25 and 26 November 2008, and 44 of the 44 expected accreditation standards were met, resulting in accreditation of Arcare Hampstead for three years until 20 February 2012.

36. Mrs Montalto's medical records from Arcare reflect that appropriate mobility and falls risk assessments were conducted upon arrival at the facility, and subsequently reviewed on a three monthly basis as part of the Lifestyle/Care plan review undertaken by a registered nurse. Reviews were also conducted whenever there was a significant change in care needs or

---

[48] Transcript page 574

[49] Transcript page 588

[50] Transcript page 589

[51] Transcript page 596

[52] Transcript page 597

[53] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

medical condition. Mrs Montalto was assessed as a high falls risk, and was to be monitored closely. Jasmine Unit is secure, and its residents are able to wander more freely throughout the unit, including the outdoor garden courtyard when weather permits.

37. Mrs Montalto had a history of falls at Arcare Hampstead, with incident reports completed and medical reviews as necessary. Mrs Montalto wore hip protectors to reduce the severity of injury in the event of a fall.

38. The most recent Lifestyle/Care plan review was undertaken on 20 April 2011. Due to a recent increase in the number of falls, Mrs Montalto was referred to Dr Elberg for a medical review, and for a physiotherapy assessment on 21 April 2011.

39. The recommendations from the physiotherapy assessment included that a staff member should always assist Mrs Montalto with walking, that optimal walking distance be 10 metres, use of a wheelchair for long distances, and that staff regularly monitor and direct Mrs Montalto to a sitting position if found wandering.

40. A common behavioural symptom of dementia is wandering[54] and Ms Foster, Chief Operating Officer of Arcare Pty Ltd acknowledges in her witness statement (point 32) dated 9 July 2013 that *'in the absence of chemical and physical restraint, it is often difficult to ensure that there are adequate staff numbers to always assist an individual resident with walking.'*

41. Additional therapies designed to relax and help Mrs Montalto with her agitation included an aromatherapy care plan developed by an aromatherapist consultant in July 2009. This involved daily hand massage and one-on-one diversional therapy with a therapist. Mrs Montalto had also spent time in the Snoozelan Multi-Sensory Unit, however she did not enjoy this, and so it was discontinued in July 2010.

Review and implementation of safety measures after 31 May 2011

42. Delegates of ACSAA attended Arcare Hampstead for an unannounced visit on 10 June 2011. Standards investigated were human resources management, information systems, clinical care, emotional support and living environment. ACSAA found Arcare Hampstead complied with the assessed standards. Arcare Hampstead was audited by ACSAA on 28 and 29 November 2011. Arcare Hampstead met 44 of the 44 expected outcomes of accreditation standards and is accredited for three years until 20 February 2015.

---

[54] Press, D & Alexander, M., Treatment of behavioural symptoms related to dementia. Up to Date. Accessed 19 November 2013.

43. Safety measures implemented by Arcare Hampstead following the death of Mrs Montalto:

- removal of any objects from the courtyard capable of tripping residents;
- all light bollards along edges of pathways that posed a potential falls risk to residents were removed from courtyards;
- the base of the fountain has been filled with large rocks and there is currently no water running from the fountain;
- all other water features in Arcare sites have been filled with river rocks to remove water associated risks;
- the edges of all courtyard pathways have been identified with bright yellow paint;
- an occupational health and safety audit tool was utilised to ensure that hazards and environmental deficiencies were appropriately identified and rectified. The tool was expanded to encompass outside areas;
- staff were offered counselling and support;
- training for all staff on their legal responsibilities to accurately report and document any adverse event;
- the Arcare Staff Handbook has been updated to stress individual employee legal responsibility to document and report any adverse event;
- information sessions were provided advising staff of their responsibilities to report to Arcare senior management any concerns involving local facility management;
- amendments to the incident reports and incident management flowchart to ensure all staff are aware of their requirements to report and record all incidents involving a resident's death;
- upon investigation of Mrs Montalto's lifestyle care plan during a mortality review, a gap was identified between allied health practitioner advice and updates to care plan. In order to address this gap, the mobility and risk audit tool was amended in October 2011 to include a check of congruence between allied health practitioner recommendations and implementation via the lifestyle care plan;
- a computerised care plan is being rolled out across all Arcare sites, which includes a workflow notification to be sent to the registered nurse when any review and/or recommendation is made by an allied health practitioner to prevent gaps in future;

- Arcare Hampstead identified that families of residents had a lack of knowledge and understanding of dementia, and subsequently organised resource material and mounted a wall display to provide more information. This improved the understanding of dementia for families of residents, and resulted in a settling effect for them;
- a safety list for Arcare Hampstead landscape gardeners with guidelines to assist and benefit resident safety;
- a review of roster and staffing levels to ensure sufficient staff were in place at all times to meet residents needs, safety and comfort;
- an additional staff member is now rostered on the afternoon shift, as a 'floater'. Whilst other staff are rostered to care for specific residents, the floater is available to assist wherever needed most during the shift;
- a review of the processes for monitoring and supervision of residents in the courtyard; and
- an official warning to the staff member still employed at Arcare Hampstead who breached policy and procedure by falsifying medication records and progress notes. This staff member was required to undertake additional training in ethics, medication management and legal requirements relating to documentation and health records.

44. Professional development education and training provided to staff at Arcare Hampstead in 2011 included:

    5 April 2011, Sensitive care for challenging behaviours.

    11 May 2011, 21 day assessment process – Charting continence, behaviours and assessment.

    24 May 2011, Behaviour documentation (charting and progress notes).

    15 June 2011, Sensitive care for challenging behaviours.

    8 November 2011, Behaviour documentation.

    23 November 2011, Behaviour charting and documentation.

Conclusions

45. The circumstances surrounding the death of Mrs Montalto were most regrettable, however Arcare Hampstead have provided education to staff and implemented numerous reviews and changes to improve safety, resident care and staff communication.

46. Arcare Hampstead was registered by ACSAA as an accredited residential aged care facility at the time of the death of Mrs Montalto on 31 May 2011. Subsequent to Mrs Montalto's death, an unannounced visit by ACSAA on 10 June 2011 found that Arcare Hampstead complied with the assessed standards, and a complete audit on 28 and 29 November 2011 resulted in accreditation awarded to Arcare Hampstead until 20 February 2015.

47. Recommendations from the physiotherapist assessment on 21 April 2011 – that staff should always assist Mrs Montalto with walking, as well as regularly directing Mrs Montalto to a sitting position if found wandering – were instigated due to an increase in the frequency of Mrs Montalto sustaining falls. Whilst likely appropriate, these recommendations would not have been able to be effectively applied due both to Mrs Montalto's very frequent wandering (a symptom of her dementia), and Jasmine Unit staffing levels that, despite being determined as adequate by ACSAA, could not provide constant assistance to Mrs Montalto as she walked around Jasmine Unit.

48. An additional staff member is now rostered during the afternoon at Arcare Hampstead, designated as a 'floater', available to assist where ever is most needed during the shift. This 'floater' is supplementary to the ACSAA Standard 1.6: Human Resources Management requirements.

49. The poor communication from Arcare Hampstead staff to Dr Elberg relating to the mechanism of injury appears to have resulted from an assumption by then Facility Manager Ms Cathy Condon that Mrs Montalto died due to a heart attack when it was obvious that she could have drowned or otherwise sustained an injury from falling into the pond. This misleading and incorrect information was then passed on to another staff member not immediately in attendance, who contacted Dr Elberg by phone, omitting the vital information that Mrs Montalto had been discovered in the base of the water-filled fountain. Subsequently, Dr Elberg did not advise any emergency treatment be undertaken.

50. The Victorian Department of Health publication, 'Dementia-friendly environments: A guide for residential care – Gardens and outdoor spaces checklist'[55] highlights good practice for quality dementia care. After the implementation of additional safety measures, the courtyard at Arcare Hampstead now achieves many of these recommendations. Noted in the checklist is the recommendation for 'unimpeded access for people with dementia to outdoor areas', and 'safe water feature (without a hazardous pond or stones)'.

51. While several physical measures were implemented to improve the safety of the internal courtyard including locking access doors, the fountain, though now devoid of pooling water remains a concern. Having regard to the evidence and despite the assertion that the doors to the courtyard are now locked, I could not be confident that residents might still inadvertently access and ambulate outside. The base of the fountain is wide and low to the ground, potentially making it difficult for the residents of Jasmine Unit to observe this hazard. Though the fountain is located in the garden bed, its proximity adjacent to the path remains a risk for residents who may fall and land on the fountain or the large rocks now housed in its base, as well as for ambulating residents who wander from the path.

52. The apparent ease with which Ms Condon was able to have other registered and non registered staff participate in the cover up of and omission of the real details of Mrs Montalto's death not only to Arcare management but also Dr Elberg, the family and external investigators suggested an underlying failure in the culture of Arcare; a culture that was reactive rather than proactive regarding the safety of residents.

53. It is good that Arcare employ a significant number of staff from culturally and linguistically diverse (CALD) communities, some of whom were relatively recent arrivals and for whom this may have been their first job in Australia. In these circumstances however it is all the more incumbent upon an organisation to appreciate and understand that it is not just a matter of appropriate policies and protocols; they must also acknowledge and recognise that staff could be more susceptible to manipulation and exploitation unless a culture and structure is in place to ensure that strong organisational moral values are upheld particularly in an aged care environment providing care for those who are amongst the most vulnerable in our community.

[55] http://www.health.vic.gov.au/dementia/images/a2z/checklist20.pdf

Finding

Having considered all the evidence and submissions, I find that Mrs Montalto unfortunately died from immersion in circumstances set out in this finding.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

The numerous improvements in physical safety, information, education, policy, staffing and communication implemented by Arcare Hampstead in response to the death of Mrs Montalto were extensive, however there are opportunities for further improvement including the following:

- Reportable deaths information for staff

  Arcare have reviewed and added to the *Verification of Death Assessment* form and the Employee Information Guide regarding what constitutes a reportable death. However, according to Ms Foster, *Arcare has updated its staff handbook to advise staff of the requirements to report all suspected 'reportable deaths' to either the Regional Manager, State Manager or Chief Executive Officer.*[56] This is appropriate, however it remains that the initial assessment of whether a death is reportable remains with the staff. This can also be considered appropriate if the staff involved in identifying *all suspected 'reportable deaths'* be then referred to the overarching management structure to make a final decision, requiring more information and education to this staffing group, especially the specific articulation of deaths related to or possibly related a fall.

- Safety of the courtyard at Jasmine Unit

  Whilst acknowledging the actions undertaken by Arcare to improve the safety of the courtyard following the death of Mrs Montalto, there remains opportunity for improvement. The Worksafe audit, whilst focussed on the safety in general, does not appear to have been completed with the main consumer of this area in mind or using a specific evidence based tool.[57,58] People with dementia and an increased falls risk, as was Mrs Montalto, require a

[56] Statement of Kay Foster, page 9.

[57] Fleming, R, 2011. An environmental audit tool suitable for use in homelike facilities for people with dementia. Australasian Journal on Ageing, Vol 30 No 3 September 2011, 108–112.

specific review. It remains that Mrs Montalto tripped and fell into the fountain. It was clear in the notes of Mrs Montalto that she was prone to falls, irrespective of tripping hazards. Despite the evidence of a policy requiring the locking of access doors to the courtyard this may not be sufficient given the evidence that I heard. Therefore, retaining the fountain in the courtyard also retains the hazard.

- Arcare actions regarding staff actions

  Ms Condon has been identified as the leader in the cover up of the details of Mrs Montalto's death, other registered and non-registered staff participated and in so doing, did not work within the Australian Nursing and Midwifery Board Code of Ethics or Code of Professional Conduct. In addition, the personal care attendants, administration staff and the registered nursing staff did not comply with their Arcare employment requirements. This collective disregard for professional and employment requirements and guidelines, suggests a culture of personal rather than resident focused care. Acknowledging the correspondence from Rachel Mathison, Delegate of the Secretary [59] to not investigate because the matter is subject to legal proceedings, an investigation into the response by Arcare to the actions taken by registered and unregistered staff in their employ in the specific context of the aged residential care sector is appropriate.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

To enable accurate identification of *suspected 'reportable deaths'* by staff to then refer to Arcare management for clarification, and to improve the governance of reporting, monitoring and recording of resident deaths, Arcare should :

1. Review the *Verification of Death Assessment* form to include a tick box or information regarding the requirement to report a death that was or may have been associated with a fall, to the coroner.

   - Include in the *Examples of reportable deaths to the coroner include* in the Arcare Employee Information Guide, a death that was or may have been associated with a fall.

[58] Moore, K, Hill, K, Robinson, A, et al, 2011. The state of physical environments in Australian residential aged care facilities Australian Health Review, 2011, 35, 412–417.

[59] Correspondence to Approved Provider, Australian Government Department of Health and Ageing Aged Care Complaints Scheme dated 5 August 2011.

- Undertake regular audits (no less than 6 monthly) of the circumstances of death of a sample of residents who have died and not identified as a reportable death, until Arcare is satisfied the new system is effective in capturing all reportable deaths.

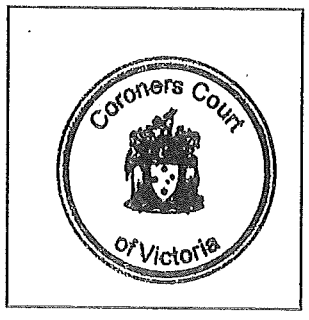
2. The Department of Health checklist regarding dementia-friendly environments recommends that outdoor spaces may contain a safe water feature, without a hazardous pond or stones. Due to the proximity of the non-operational, stone laden fountain to the courtyards path, removal of the fountain from this location, as well as any other similarly positioned and dimensioned objects in the courtyard that would be a potential risk to the residents of the Jasmine Unit at Arcare Hampstead.

3. The Australian Government Department of Health and Ageing Aged Care Complaints Scheme undertake an investigation into the actions of Arcare once the activities undertaken by registered and unregistered staff regarding Mrs Montalto's death were known. The investigation should include whether referral to the appropriate agencies to review individual professional registration[s] is a reasonable expectation within the *Aged Care Act* 1997 and certified provider receiving subsidises by the Australian Government.

I direct that a copy of this finding be provided to the following:

The Family of Caterina Montalto
Senior Constable Stuart Yin, Investigating Member of Victoria Police
Minister for Department of Health and Ageing
The Director, Commonwealth Department of Health, Ageing and Aged Care Division
Dr Lilian Elberg, Collins Street Medical Centre
Arcare Pty Ltd

Signature:



HEATHER SPOONER
CORONER
Date: 18 December 2013