IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 001620

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PHILIP JOHN ROBERTS HEWITT

Delivered On:	14 May 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	3 February 2015
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Police Coronial Support Unit	Senior Constable Paul Collins, assisting the Coroner.

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of PHILIP JOHN ROBERTS HEWITT

AND having held an inquest in relation to this death on 3 February 2015

at Melbourne

find that the identity of the deceased was PHILIP JOHN ROBERTS HEWITT

born on 31 July 1947

and the death occurred on 6 May 2012

at Bellden Lodge, 383 Maroondah Highway, Croydon North, Victoria 3136

from:

I (A) ACUTE TRAUMATIC SUBARACHNOID HAEMORRHAGE

I (B) SINGLE PENETRATING INJURY TO THE RIGHT ORBIT

in the following circumstances:

Background

1. Philip John Roberts Hewitt was a 64-year-old man who was living in a 'Special Residents Services' facility called Bellden Lodge at the time of his death. Bellden Lodge is a residential facility that caters for elderly people and people with mental ill health.

2. Mr Hewitt had been diagnosed with schizophrenia in his early twenties and had thereafter been in the care of various psychiatric institutions around Victoria. Mr Hewitt commenced residing at Bellden Lodge in 2006, initially in a single room. At some stage he was moved to a shared room, where he shared with one resident for a period of time, before he was moved into a room with Mr Ronald James Watson approximately three months before his death.

3. On 6 May 2012, Mr Hewitt died from acute traumatic subarachnoid haemorrhage after Mr Watson stabbed him in the right eye.

Ronald James Watson

4. Mr Watson was born in 1946, and had sustained an acquired brain injury in the late 1960s, which dramatically affected his cognitive functioning. Following the brain injury, Mr Watson spent some time in a hospital psychiatric facility. He was then released into the care of his

parents until he was again admitted to psychiatric care in 1996, after he set a colleague's home on fire.

5. Mr Watson spent time in different residential care facilities, from which he regularly absconded. In 1998, Mr Watson, who had by that stage been diagnosed with chronic paranoid schizophrenia and was suffering from 'Organic Brain Syndrome', began refusing medication. Mr Watson began suffering increased delusions, and began accusing members of the Healesville community of murder. He was detained involuntarily for a period.

6. On different occasions from 2000 onward, Mr Watson threatened to kill several people, including a roommate, a number of co-residents and a medical practitioner who was giving him an injection. On at least 11 occasions, Mr Watson threatened to stab or poke the intended victim (most often a co-resident) in the eye with a knife. On most of these occasions, Mr Watson stated that his reason for threatening to kill was to have police attend so that he could tell them about a murder of four people, in which he stated he was previously involved.

7. In November 2000, Mr Watson assaulted a co-resident with a coat hanger that he had fashioned into a knife. Mr Watson's Community Treatment Order was revoked on that occasion.

8. Mr Watson had resided at Bellden Lodge since 2004 and was considered to be good humoured, generous with fellow residents and friendly. Staff members reported that Mr Watson had not been violent before killing Mr Hewitt, and that they had no reason to fear him.

Events of 5 and 6 May 2012

9. At approximately 2.15pm on 5 May 2012, Mr Watson again threatened to a Bellden Lodge staff member, Nurse Vu, that he would kill someone that night, stating '*I want to see the police*' and '*I want to go to jail*'.[1] Nurse Vu did not believe Mr Watson, as she thought he was joking.

10. At approximately 4.00pm, Mr Watson phoned his sister, Ms Lynette Rodwell. They discussed football for a period, before Mr Watson suddenly changed the conversation, stating that he '*had to get to the police to let them know about the drugs, and the four bodies*'.[2] Mr Watson then stated, '*I've killed four people and I know where the bodies are buried and they won't*

[1] Statement of Ms Dianne Vu, Exhibit 15, coronial brief page 76.

[2] Statement of Ms Lynette Rodwell, Exhibit 15, coronial brief page 57.

take any notice of me'.[3] Ms Rodwell responded by stating that the police would not believe that he would do something like that. Mr Watson suggested that he might have to kill someone '*to get to them*' (the police).[4] Ms Rodwell dismissed the situation as Mr Watson had previously raised the topics but had never shown any signs of acting on them.

11. At approximately 7.20pm, Mr Watson spoke to another staff member, Nurse Chen, telling her he would not see her the following day as he was going to speak to police.[5] Nurse Vu, who had overheard the comment, asked him whom he wanted to kill, and whether he was referring to his roommate. Mr Watson replied, '*yes, Philip*'.[6]

12. Other residents at the facility observed Mr Watson to be agitated and acting strangely throughout the evening. One resident stated that he told her he was '*going to get in trouble (that night)*'.[7]

13. At 12.05am on 6 May 2012, the duress alarm in Mr Watson and Mr Hewitt's shared room was activated. As Nurse Vu was approaching the room, she found Mr Hewitt standing in the dining room covered in blood. Mr Hewitt was covering his eye with his hands. Nurse Vu called emergency services and returned to help Mr Hewitt, who had by that time collapsed to the floor.

14. While Nurse Vu was on the phone to emergency services, Mr Watson approached her and told her that he used a knife to poke Mr Hewitt's eye. Nurse Vu asked Mr Watson to return to his room until the police arrived, which he did.

15. When police attended, Mr Watson stated to them, '*I killed him*'.[8] When police members asked him what he killed Mr Hewitt with, he replied, '*a knife, it is in his eye*'.[9]

16. Mr Watson was arrested, and stated to a police member that he '*did it to get to court*'.[10] He further stated, '*I can't ring the police from here, all I get is the Mooroolbark Police and I*

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[3] Statement of Ms Lynette Rodwell, Exhibit 15, coronial brief page 57.

[4] Ibid.

[5] Statement of Ms Zhi (Cassie) Chen, Exhibit 15, coronial brief page 90.

[6] Statement of Ms Dianne Vu, Exhibit 15, coronial brief page 77. Nurse Vu states that she recalled the conversation taking place at around 6.30pm, not 7.20-7.25pm as Nurse Chen recalled.

[7] VARE statement of Ms Rhonda Crawford, Appendix D to the coronial brief page 278.

[8] Statement of LSC Philip Rushford, Exhibit 15, coronial brief page 147.

[9] Ibid.

[10] Ibid page I49.

want the city'.[11] Mr Watson was conveyed to the Ringwood Police Station and was deemed unfit for interview.

Criminal proceedings

17. The circumstances surrounding Mr Hewitt's death were fully investigated by police, and Mr Watson was charged with murder in respect of Mr Hewitt's death.

18. On 6 May 2013, a jury found that Mr Watson was not fit to be tried. On 23 May 2013, Mr Watson was found not guilty of murdering Mr Hewitt due to mental impairment. He was placed on a custodial supervision order.

Purpose of a Coronial Investigation

19. This finding is based on the totality of the material the product of the coronial investigation of Mr Hewitt's death. That is, the brief of evidence compiled by the Coroner's Investigator Detective Sergeant Heath Biram, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions. All of this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

20. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be guilty of an offence.[12] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable may have been committed in connection with the death.[13]

Findings as to uncontentious matters

21. In relation to Mr Hewitt's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that Philip John Roberts Hewitt, born on 31 July 1947,

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[11] Statement of LSC Philip Rushford, Exhibit 15, coronial brief page 150.

[12] Section 69 *Coroners Act 2008* (Vic).

[13] Section 49(1) Coroners Act 2008.

aged 64, died at Bellden Lodge, 38 Maroondah Highway, Croydon North, Victoria 3136, on 6 May 2012.

22. Nor was the medical cause of death contentious. On 6 May 2012, an autopsy of Mr Hewitt's body and post mortem CT scanning (PMCT) were performed by Senior Forensic Pathologist Dr Malcolm Dodd at the Victorian Institute of Forensic Medicine, who formed the opinion that the cause of his death was *acute traumatic subarachnoid haemorrhage* secondary to *single penetrating injury to the right orbit.*[14] Dr Dodd stated that the post mortem examination revealed the presence of a single incised injury to the lower right eyelid region, and that '*internal examination showed acute subarachnoid haemorrhage which involved the inferior surfaces of the right and left temporal lobes of the brain and in particular, surrounded the brainstem*'.[15]

23. Dr Dodd concluded that '*it is acknowledged that acute traumatic subarachnoid haemorrhage, in particular surrounding the brainstem, may lead to a sudden reduction in the cardiorespiratory drive, leading to full cardiac arrest and death.*'[16]

24. Post mortem toxicological analysis of blood revealed the presence of olanzapine at ~0.2mg/L and pericyazine at ~0.1mg/L. Both substances were also detected in urine. The presence of ethanol (alcohol) and other common drugs or poisons was not detected.[17]

Inquest

25. An inquest into Mr Hewitt's death was held on 3 February 2015.

26. The witnesses at inquest were:

- Detective Sgt Heath Biram, Coroner's Investigator
- Ms Erica Hewitt, sister of Mr Philip Hewitt
- Dr Peter Janovic, treating general practitioner (GP)
- Mr Steven Yang, Proprietor Bellden Lodge
- Mr Dennis Gaylard, Co-ordinator Supported Residential Program, South and Eastern Regions, Department of Health.

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[14] Statement of Dr Malcolm Dodd, Exhibit 15, coronial brief page 216.

[15] Ibid page 217.

[16] Ibid page 218.

[17] VIFM toxicology report, Exhibit 15, coronial brief page 219.

Issues at inquest

27. The scope of the inquest was to examine a number of questions raised by Mr Hewitt's family, being the following:

    - Were Mr Hewitt and Mr Watson appropriate clients of Bellden Lodge?
    - Did the care and management of Mr Hewitt and Mr Watson meet the required standards applied to the Lodge?
    - Why were there no written policies for staff to follow in relation to risk assessment, change of rooms for clients, and responses to threats?
    - How was it possible for either Mr Watson or Mr Hewitt to consent to a room change without family involvement, and why was there no family involvement in the decision making about the room change?
    - What was the staff training, both generally and specifically in relation to mental health?
    - What did the legislative regime require in relation to staff training for this level of Supported Residential Service (SRS)?
    - Have there been any changes at Bellden Lodge since Mr Hewitt's death?
    - What was the departmental view in relation to the compliance by the Lodge with its obligations under legislation?

28. The primary focus of evidence at the inquest was on the obligations of Mr Yang, the proprietor of Bellden Lodge, under the applicable legislative regime.

29. The evidence of Mr Gaylard was helpful and comprehensive. He was able to provide context for the role, work and obligations of the Lodge within the legislative regime. I turn to that issue now.

Bellden Lodge

30. Bellden Lodge was, at the time of Mr Hewitt's death, a Department of Human Services approved SRS facility for the aged and patients diagnosed with mental illnesses who required ongoing care. The facility consisted of 46 individual rooms, of which six were double rooms, each shared by two residents. Carers were rostered to stay on site on a rotating basis, to provide around the clock care for the residents.

31. Exhibit 5, a report prepared by Mr Gaylard on behalf of the Department of Health and Human Services in January 2015 (the report), sets out in detail the legislative context applicable to Bellden Lodge at the time of Mr Hewitt's death. The document states in its preamble that

> *[s]upported residential services (SRS) are private businesses that receive no direct funding from any level of Government. The accommodation of residents in SRS is subject to private agreements between the proprietors and the residents, or their legal representatives, made in the context of the legislative framework in place at the time.*[18]

32. The documents point out that, at the time, Bellden Lodge was an SRS registered and regulated under the *Health Services Act 1988 (Vic)*. In 2010, the *Supported Residential Services (Private Proprietors) Act 2010 (Vic)* was passed and commenced on 1 July 2012. It replaced the Health Services Act as the relevant legislative framework.

33. In the report, Mr Gaylard gave detailed answers to the following questions:

- Was Bellden Lodge a registered SRS?
- Did it comply with all relevant standards?
- Were Mr Hewitt and Mr Watson suitable clients?
- Should written risk assessments have been done on clients?
- Should the attending GP have had a role in this process?
- Did Mr Hewitt receive suitable care?
- Should Mr Hewitt's family have been involved in the change of room?
- Should Bellden Lodge have written policies in relation to contacting family, police and GP at appropriate times?
- What should staff have done when Mr Watson threatened to kill Mr Hewitt?
- Was training of staff appropriate?
- Should Bellden Lodge have conducted a review of this death?
- Did the Department of Health conduct any review?

34. Both the report and Mr Gaylard's oral evidence constitute a comprehensive set of responses to the questions. Mr Gaylard was a credible, reasonable and well-informed witness and I accept

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[18] Department of Health and Human Services *Report to Coroner re Death of Philip Hewitt* dated January 2015, Exhibit 5, coronial brief page 248.1 and Appendix A to this finding.

his evidence. Rather than set out the contents of the report, I attach it to this finding at Appendix A.

35. By way of summary, Mr Gaylard's evidence was as follows:

- Bellden Lodge was a registered SRS at the time. It was registered to accommodate a maximum of 53 residents; 39 in single rooms and 14 in shared rooms. It caters to (as it did then) the 'pension level' segment of the SRS market, which means that its clients are people on low or fixed incomes like pensions, and '*the fees are less than or equal to the maximum amount of the single person pension plus rent assistance.*'[19] This includes residents with physical, psychiatric and intellectual disabilities, elderly residents and those who are homeless or at risk of homelessness.
- In relation to compliance, departmental records showed that a series of unannounced inspections at Bellden Lodge during the twelve months prior to Mr Hewitt's death revealed no breaches relating to the care or support of residents.
- In relation to whether Mr Hewitt and Mr Watson were suitable clients of the SRS, Mr Gaylard emphasised that SRS' are private businesses and that agreements to reside there are voluntary; negotiated between the proprietor and the resident and/or the resident's legal representative. He emphasised that the department '*had no role in determining whether a resident was a suitable client at the time of commencement of their residency*'[20] and that the department '*was not involved in determining the suitability or otherwise of either resident after they moved to Bellden Lodge*'.[21] This remains the case under the new legislation.

36. Mr Gaylard noted that after Mr Hewitt's death, the department was notified that both Mr Hewitt and Mr Watson had schizophrenia diagnoses and that both were being managed by their general practitioner, Dr Janovic. He made the point that a census of Victorian SRS' was conducted for the department by an external agency in 2013, and that one of the findings of that census was that 59 per cent of residents of pension level SRS' were reported to have a psychiatric disability.[22] He stated that it was therefore not unusual for residents of a pension

[19] Inquest transcript pages 73-4.

[20] Ibid page 60.

[21] Ibid pages 60-1.

[22] Ibid page 61.

level SRS to have psychiatric disabilities such as those that has been reported or experienced by both Mr Hewitt and Mr Watson.[23]

37. On the question of what actions Bellden Lodge staff should have taken when Mr Watson threatened to kill Mr Hewitt, Mr Gaylard stated that it was the department's expectation that the proprietor would secure appropriate healthcare for Mr Watson, if they held concerns that they were not able to manage his care needs.[24] The department was not made aware of Mr Watson's homicidal ideation until after the incident, despite authorised officers routinely asking at the beginning of inspections, whether there were any residents where the proprietor felt they needed assistance.[25]

38. Mr Gaylard then dealt with the question of whether in the light of that fact, written risk assessments had been conducted for both residents. He noted that there is no specific legislative requirement for written risk assessments to be prepared by the proprietor, and that at the time, section 106(a) of the Health Services Act required that the proprietor prepare an ongoing care plan for each resident.[26] There was such a plan in place for Mr Watson, although it was inspected by department inspecting officers on 7 May 2012, and was found not to contain any reference to Mr Watson's threats to kill or homicidal ideation.[27]

39. Understandably, this was a critical issue from Ms Hewitt's point of view, and she queried why it was that the care plan made no reference to an apparent history of homicidal ideation and threats to kill on Mr Watson's part. Ultimately, this question was not answered satisfactorily.

40. Mr Steven Yang is the Proprietor of Bellden Lodge, and has been since 2006. He was asked how much he and Bellden Lodge staff knew and understood of Mr Watson's history of expressing homicidal ideation.[28] In answer to this, Mr Yang testified that he and other staff did know that Mr Watson had expressed threats to kill others.[29] However, in Mr Yang's statement, he states that Mr Watson had never shown any indications of violence towards him and that he had never heard Mr Watson threaten anyone at Bellden Lodge.[30] At inquest, Mr Yang

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[23] Inquest transcript page 61.

[24] Ibid page 65.

[25] Ibid page 66.

[26] Ibid page 62.

[27] Ibid.

[28] Ibid page 124.

[29] Ibid.

[30] Statement of Mr Steven Yang, Exhibit 10, coronial brief page 70.1.

clarified that whilst he had never heard Mr Watson make specific threats to staff or residents, he did speak generally about threatening to kill people, referring often to '*drug dealers*'.[31]

41. Mr Yang was not able to convincingly explain why Mr Watson's known homicidal ideation was not referred to in his care plan. He explained that the information he did know at the time of preparing the care plan included Mr Watson's diagnosis of paranoid schizophrenia, that he was suffering from delusions and homicidal ideation, but that he was stable.[32] He did not know the precise history and details of Mr Watson's threats to others.[33] He did accept that the care plan has a risk assessment function.[34]

42. It was conceded by Mr Yang, and it is clear from the progress notes which form part of the care plan for Mr Watson, that on 14 December 2009, Mr Watson '*started talking randomly about "murder" and stated that he will murder Nippen* (another resident)'.[35] Consequently, Dr Janovic, who was the treating GP for both men, refused to administer the normal monthly injection on the day until the police were first called.

43. A Crisis Assessment and Treatment (CAT) Team was called at 2.30pm that day. The notes refer to Mr Watson's chronic delusion, and he was admitted to hospital at 2.45pm that afternoon. Despite this being on the Bellden Lodge record, Mr Yang insisted, throughout his evidence, that he and other staff had always treated Mr Watson's comments about murder as being made in jest, and had always regarded his homicidal ideation as '*joking*'.[36] This was the view formed by Mr Yang and by his staff because, as they saw it, Mr Watson never acted on this ideation. He agreed that he himself heard Mr Watson talk about '*[trying] to kill some drug dealer*'.[37]

44. When it was put to Mr Yang that he knew very well about Mr Watson's delusions and homicidal ideation in 2009, he considered that he did (by reference to the notes referring to 14 December 2009), and agreed that he knew that Mr Watson suffered delusions. Mr Yang

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[31] Inquest transcript page 126.

[32] Ibid pages 126-7.

[33] Ibid page 127.

[34] Ibid pages 116-7. Mr Watson's care plan is Exhibit 6 and the Bellden Lodge progress notes in relation to his care are Exhibit 7.

[35] Bellden Lodge SRS Progress Notes for Mr Watson, Exhibit 7, coronial brief pages 1465-70.

[36] Inquest transcript page 125. *So for eight years he consistently joked about killing people, or your thought he was joking?---Yes....* And at page 126: *I want to clarify with you now, you say that you and the other staff heard these threats about killing---?---Yes. ---so often, that you thought it was just the normal way he spoke?---M'mm. And that it was threats, is that correct?---Yes. Including yourself?---Yes.*

[37] Ibid page 120.

further accepted that Mr Watson suffered from his delusions so much so that all of the staff at Bellden Lodge had become accustomed to him talking about killing, and considered that he was joking.[38]

45. There is no doubt that Mr Yang and relevant members of his staff, including Ms Vu, who overheard the explicit threat relating to Mr Hewitt on the night of the death, always believed that Mr Watson was joking when he made homicidal references. It appears that they were prepared to take the same attitude towards the threat, even when it became absolutely explicit on the night of Mr Hewitt's death. Clearly, this is unsatisfactory and, in his own way, Mr Yang conceded as much.

46. When asked about what Mr Yang did in order to find out Mr Watson's medical or criminal history, it became clear that there was not a practice of routinely obtaining that history prior to admission, or at the time of admission of the client.[39] In essence, he said that the only information gathered by the Lodge is from the resident's GP.[40] I will deal later with Dr Janovic's evidence on the amount of information GPs themselves had at hand about Mr Watson and Mr Hewitt.

47. On the question of whether Mr Yang would do things differently now, he initially said he would not. However, he conceded that the Lodge should be obtaining as much of the mental health history of its residents as possible, and agreed that this was especially important given the significant number of residents at the Lodge who suffered from psychiatric illness.[41]

48. When asked later whether he had implemented a practice to obtain more information about a person's mental health history when they become residents than previously, Mr Yang stated that their practice now is to ask for, and obtain, as much of the person's history as possible. He explained that if the person were referred by their case manager, support worker, hospital or some other organisation, this information could be easily obtained. However, if the person had approached the Lodge on their own, or with a family member or friend, then it was difficult for the Lodge to obtain any further information aside from what the person disclosed or the information forthcoming from their treating GP.

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[38] Inquest transcript page 123.

[39] Ibid page 128.

[40] Ibid page 129.

[41] Ibid page 128.

49. I pay particular note to Mr Yang's response to the following question put by my assistant, SC Collins:

> *Is it fair to say that without getting a resident's or a potential resident's history, that actually places all the other residents in danger; you agree with that?---Yes. If the person's dangerous person, yeah.*[42]

50. Mr Yang agreed that it was a dangerous practice to accept a resident who suffers from schizophrenia without knowing their history, and that that was what happened in the circumstances that led to Mr Hewitt's death.[43]

51. He went on to describe the difficulties that are sometime encountered because of the operation of privacy laws or privacy constraints. He accepted that from a business perspective it is difficult to turn down a client but rejected the proposition that it was financial reasons driving acceptance of clients without full enquiry.[44] I accept that there can be difficulties obtaining relevant information, but it is clear that proprietors of an SRS have the clear discretion to refuse admission until they are satisfied about a person's history and satisfied that they can provide them with a safe environment. They are under no obligation to take a prospective client if the information they seek is not forthcoming. This is clear from the evidence given by Mr Gaylard.

52. Importantly, Mr Yang stated that if he cannot obtain the relevant information about a person's history now, his practice is that he won't have them at Bellden Lodge. He also said that if they felt that a person was dangerous, they would be asked to leave.[45] Giving examples of this, he said that he had asked two people to leave in the previous few weeks before the inquest. He said he did that because those involved had a psychiatric history and he was worried that they could be dangerous to other residents. He was worried about safety; not specifically about homicide.[46]

53. Towards the end of his evidence, Mr Yang was asked if the same situation had arisen now (being Mr Watson making threats towards Mr Hewitt), whether Mr Watson would have been asked to leave. He responded as follows:

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[42] Inquest transcript pages 129-30.

[43] Ibid page 130.

[44] Ibid page 131.

[45] Ibid.

[46] Ibid page 132.

Ah, Mr Watson is a little bit different about it. Mr Watsons always took - talk about things look like he is joking and we not really - but Mr Watson different about other people, somebody have agitated or something else about. Mr Watson never had agitated, everything's happened in my period of time in Bellden Lodge. Only the (indistinct) talking. That's how we just reckon - that's just joking about it.

I think I understand. You're saying that it depends on what they do - - -?---Correct.[47]

54. As noted earlier, the persistent failure to see any 'red flags' in relation to Mr Watson's commentary about homicide and threats of murder in my opinion reveals a failure to recognise dangers which were apparent. It is understandable from one point of view that frequently repeated, seemingly entirely hollow threats will be progressively more and more ignored and taken less and less seriously. However, an explicit threat to kill a particular individual on a particular night should never have been treated that way and, in my view, it was a clear failure to recognise a danger and a clear failure to provide a safe environment on the part of the Lodge.

55. Even when asked what he thought Nurse Vu should have done when Mr Watson reported to her that he was going to kill Mr Hewitt, and was going to kill him in a very particular way, Mr Yang replied,

> *[w]e just think about the Mr Watson joking at the time as well. Mr – Mr Watson has been talking this way to the staff thereafter he goes to – after 6 o'clock he got to the TV rooms, have a watching TV, into the community with everybody as the normal. Then after he ... go to bed. That's as it happen every night, every day, so that's way we reckon something just the normal and it's just the talking.*[48]

56. To be fair to Mr Yang, it is important to note that towards the end of his evidence, on the question of taking threatening behaviour seriously and responding appropriately, he said that after Mr Hewitt's death, he instructed all staff to seek assistance from management, or to make a report to the CAT team or police, if '*anything's happened, whatever, any joking, anything*'.[49] Bellden Lodge has no written protocol to this effect.[50]

57. Mr Yang was an honest witness. He is clearly competent in English but it is never easy to give evidence in a second or third language. He was, and is considered by the department to be competent in his running and management of Bellden Lodge and I can understand the department's perspective. There had been some compliance failures on relatively minor

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[47] Inquest transcript page 132.

[48] Ibid page 134.

[49] Ibid page 143.

[50] Ibid.

matters. Mr Hewitt's death of course is a dramatic single event in the history of this SRS, and it highlights issues of training and management. I have already observed that treating the specific threat on the night of Mr Hewitt's death as a joke (despite the history of unfulfilled threats), was completely unacceptable.

Training

58. Understandably, Ms Hewitt raised the question of whether staff were adequately trained to deal with contingencies, threats and risks posed when clients suffer a mental illness, and in particular, suffer from paranoid/delusional/schizophrenic conditions.

59. One of the matters not covered in Mr Gaylard's report, but the subject of questions at inquest, was the training of staff, the obligations of proprietors in respect of training and what changes, if any, had been made in relation to training since Mr Hewitt's death.

60. Mr Gaylard's evidence was that the proprietor of an SRS had a responsibility under the Health Services Act to ensure that '*adequate and appropriately trained staff were employed at the service*'.[51] The department's role in this respect was to monitor '*service outcomes*' and '*require remedies if any identified deficits were seen to be caused by inadequate training*'.[52] He explicitly stated that this role did not extend to monitoring the training needs of individual SRS staff, however the department provided guides and reference materials to assist managers to train their staff.[53] Mr Yang's evidence was that there is no compulsory mental health component of the training that staff receive[54] either before they commence employment at the Lodge or during that employment.

61. I canvassed with Mr Gaylard the possibility of a recommendation that there be a change in the legislation or the introduction of a requirement for a training regime or package, focused on mental health. By that, I was referring to the ability to understand, recognise and respond to risks posed because a person is suffering from a mental illness (in Mr Watson's case, homicidal ideation flowing from a delusional schizophrenic condition). Mr Gaylard's evidence was that there is a requirement that SRS staff be appropriately trained to perform their roles and provide the care and support that they provide, as with any other business. In Mr Gaylard's view, it was a matter for the proprietor to ensure appropriate training and

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[51] Inquest transcript page 67.

[52] Ibid.

[53] Ibid pages 67-8.

[54] Ibid pages 113-4.

education, having identified issues associated with the particular care needs of their residents.[55] Mr Gaylard further stated that the department has for some time provided a range of free training options for SRS proprietors and their staff, in a range of care-related areas, and that in his view, the department is '*actually going over and above its responsibility and already trying to assist proprietors as far as it reasonably can in training their staff*'.[56]

62. In my opinion, it should not be up to the proprietor, in his or her discretion, to ensure that staff are sufficiently trained to recognise and appropriately respond to risks posed by persons who are suffering a mental illness. Proprietors were, and are, required to provide a safe environment for their clients. Dismissing as a joke, thereby effectively ignoring an explicit threat of homicide directed at a fellow resident by another, was a clear departure from compliance with the central obligation of providing a safe environment. On this matter it is appropriate to refer to the evidence of Mr Gaylard again, regarding whether any requirement existed for an SRS to be advised of a person's history before accepting them as a resident:

> *[t]here's no specific regulatory requirement for them to make any particular investigations, but proprietors are required to provide a safe, and what at the time was described as home-like environment for their residents, so they need to know enough about a person to make a judgment on whether that person is going to ... be safe themselves and/or interfere with the safety or their other residents.*[57]

63. Mr Yang himself agreed with the proposition that it would be highly desirable for his staff to receive training in recognising serious mental health issues and risky behaviour, and knowing what to do, noting that 90 per cent of his residents suffered from a psychiatric illness or mental ill health.[58] He also agreed that the environment would be safer if staff could better identify mental health risks.[59]

64. In my opinion, it is unsatisfactory for the department to simply devise a range of guides and reference material for SRS proprietors and staff for training purposes and then leave it to the proprietors as to whether they ensure that their staff use the materials, and become trained in recognising and dealing with problems that might arise.

65. There are already a number of obligations placed on SRS proprietors, and it would make sense from a safety, and potentially from a death prevention point of view, for a requirement that a

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[55] Inquest transcript page 146.

[56] Ibid page 147.

[57] Ibid page 103.

[58] Ibid pages 113-4.

[59] Ibid page 114.

specified type of training be delivered to staff to ensure that they reach a level of competence and awareness in relation to mental health issues and risk identification. This would assist the staff to deliver a 'safe environment'. In my view, mandated training of that nature would not be incompatible with the private business model.

66. It would be speculation to suggest that Nurse Vu would necessarily have reacted differently to Mr Watson's threats on the evening of the murder of Mr Hewitt, had she been specifically training in recognising risks associated with threats made by mentally ill people. However there would be a reasonable prospect that such training would have led to her treating that particular threat differently from others which were of a more general, less specific and seemingly less urgent nature. In any event, all that can be reasonably be done should be done to ensure that staff have the benefit of training which would enable them to support, manage and provide a safe environment for a very challenging client group.

67. On this issue, Mr Yang has done his best and has done reasonably well. He has insisted on a level of training for staff which will increase the prospect of staff responding appropriately to a risk flowing from the mental illness of a resident. He and other SRS proprietors should, as a matter of compliance, be required to take the course of action he has.

Dr Janovic

68. Dr Janovic, who was both Mr Hewitt and Mr Watson's GP, was an honest and broadly reliable witness. He was, however, vague as to whether he had ever read, or sought a mental health history for Mr Watson. Both men were long-term patients. He was entirely credible as to the observations he had made about Mr Watson and Mr Hewitt in the past. His actions had indeed been reasonable for ensuring that there was a CAT team intervention in 2009 when there was a homicide threat made by Mr Watson. He was vague as to whether he had actively sought and thoroughly familiarised himself with the mental health history of his patient, Mr Watson. However, I accept that he considered himself sufficiently versed in Mr Watson's history to discharge his obligations as a treating GP. He had far less to do with Mr Hewitt than he did with Mr Watson.

69. As Dr Janovic said in evidence, he considered Mr Watson to be '*a stable, generally compliant paranoid schizophrenic who was easy to manage*'.[60] His only treatment of Mr Hewitt was the requirement to administer a flu injection. However, he only saw him on the one occasion.

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[60] Statement of Dr Peter Janovic, Exhibit 4, coronial brief page 68.

70. When asked about Mr Watson's paranoid schizophrenic episodes in the past and various examples of homicidal ideation, he stated that he was always diligent, but that '*eight years of behaviour which, apart from one episode of aberrant behaviour, was generally very stable, reasonable, compliant ... I don't know whether I would've done anything different in all honesty*'.[61]

71. As to whether he believed he should have known the full psychiatric history of Mr Watson, and whether there may have been restrictions or impediments to him obtaining that history, Dr Janovic said that it was always '*good to know*',[62] but often difficult to obtain especially with patients who had been transient. Dr Janovic was of the view that GPs and other treating doctors would be assisted by having a patient's medical record automatically provided to them.[63]

72. Dr Janovic went on to make the point that he is not always, routinely, aware of the full medical history of a person treated at an SRS such as Bellden Lodge. Ultimately he said that whilst it would be prudent to enquire about their history, particularly any forensic history (by, for example, asking the proprietor or contacting the patient's previous facility), it was not always possible to obtain it. Dr Janovic noted that it would be reasonable to assume that the patient might not be the most reliable in providing their treating doctor with that information.[64]

73. I accept Dr Janovic's evidence on these matters. He considered Mr Watson a compliant patient. He said that over the course of about 8 years of treatment and involvement with Mr Watson, the issue of risk flowing from Mr Watson's forensic history had been brought up with him '*twice maybe but not in any real aggressive manner*'.[65] He implied that he had never been made aware of the more specific and repetitive threats apart from, of course, being engaged in the 2009 matter. By the time of this incident, he considered Mr Watson's overall behaviour to have stabilised.

74. Dr Janovic made the compelling, and fairly obvious point that at the very least, staff could have reacted on the night by ensuring that the men were separated and in separate rooms. They could have done this even if they were entirely sceptical about whether Mr Watson

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[61] Inquest transcript page 34.

[62] Ibid page 37.

[63] Ibid pages 38-9.

[64] Ibid page 43.

[65] Ibid page 46.

would carry out the threat and even if they considered that he was still joking; in other words, they should have taken an elementary precautionary measure.

The change of room

75. Mr Hewitt moved into the SRS in 2006. He was suffering schizophrenia and considered to be antisocial. He preferred to spend time alone. He was placed in a single room by himself but later, unbeknownst to his family, moved to another room where he began co-sharing. In early 2012, he was moved again, into Mr Watson's room. This was confirmed by Mr Yang in his statement. The question is whether Mr Hewitt's family should have been informed of the change of room and/or involved in the decision-making process. They were not and they should have been. As Mr Gaylard pointed out, section 108(F)(1)(e) of the Health Services Act required that Mr Hewitt's next of kin and guardian (if any) be informed of any proposal to relocate him to another room at the SRS. This obligation remains the same under the current (new) legislation.

76. Ms Hewitt's evidence on this issue was that she spoke to Mr Yang on Monday 7 May 2012, and that Mr Yang told her that Mr Hewitt '*shared some times and didn't mind sharing*'.[66] She stated that after Mr Hewitt moved to Bellden Lodge, '*he proudly showed us his own single room and ensuite. In the past he'd always had shared accommodation. I have always assumed that he had continued residing in a single room as he never said anything more.*'[67] Ms Hewitt explained that when Mr Hewitt was in previous accommodation, she had been notified of a room change, but that this had not occurred at Bellden Lodge. Further, Ms Hewitt would have preferred being consulted, rather than notified, as she felt that Mr Hewitt needed to remain in a single room.[68]

77. I accept that Ms Hewitt was particularly upset about the fact that her brother had been moved without consultation with the family. This clearly should not have happened. There should have been consultation. Mr Yang accepted as much.

78. Ms Hewitt made a number of points about staffing at Bellden Lodge – she considered the Lodge to be understaffed. Whilst on the whole of the evidence it was not understaffed at the time, I note Mr Yang's evidence as to changes he has made as to staffing numbers; in

[66] Statement of Ms Erica Hewitt, Exhibit 2, coronial brief page 48.

[67] Inquest transcript page 22.

[68] Ibid page 27.

particular that he has increased the night staffing by one, so that there are no less than two staff members on duty each night. I commend him for taking this action.

79. I accept that both Ms Hewitt and her mother were devastated by Mr Hewitt's death. I thank Ms Hewitt for her active involvement in this case, and for posing a number of important questions that warranted consideration during the investigation and inquest.

Conclusion

80. This was a preventable death. It could have been prevented if Nurse Vu had reacted differently to the specific threat made by Mr Watson that he would kill Mr Hewitt that very night. The fact remains that she did not react in a preventative way to ensure that there was at least separation and risk reduction; however, she was not specifically trained on assessing risks posed by people with mental ill health. Nurse Vu clearly had substantial experience 'on the ground' at the Lodge and was no doubt a competent and conscientious person, and I note that she is has undertaken further training since Mr Hewitt's death.

81. Ms Hewitt very compassionately expressed her sympathy to Nurse Vu. It was not Nurse Vu's fault that the two men had been placed in the same room and it was certainly not her fault that she had not been trained to recognise the risk posed by Mr Watson on this occasion as compared with previous occasions. Although the threat could not have been more explicit and specific, Nurse Vu's response was that Mr Watson was '*just teasing and laughing*'.[69] I must accept that this was her honest and genuine belief and it would not be fair to attribute blame to her. Ultimately, she lacked the training to properly assess the risk.

RECOMMENDATIONS

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

1. Given that 59 per cent of pension level SRS residents were reported to have a psychiatric illness or disability, I recommend that the Department of Health and Human Services give consideration to mandating mental health training for staff, (or at least for more senior staff) in Supported Residential Services. The training should be at least sufficient to enable staff to recognise serious threats, interpret threats and take appropriate action.

[69] Statement of Ms Dianne Vu, Exhibit 15, coronial brief page 77.

2. I further recommend that the Department of Health and Human Services give consideration to incorporating in the Supported Residential Services compliance regime a requirement that proprietors insist on relevant staff undertaking such training.

I convey my sincere condolences to Mr Hewitt's family and friends for his death in 2012.

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

Ms Ethel Hewitt, Senior Next of Kin

Ms Erica Hewitt, Senior Next of Kin

Mr Dennis Gaylard, Department of Health and Human Services

Mr Brian McDowell, Department of Health and Human Services

The Hon Jill Hennessy MP, Minister for Health

The Hon Martin Foley MP, Minister for Mental Health

Dr Pradeep Philip, Secretary, Department of Health and Human Services

Detective Sgt Heath Biram, Victoria Police, Coroner's Investigator

Senior Constable Paul Collins, Police Coronial Support Unit.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 14/5/15

Appendix A

Department of Health and Human Services Report to Coroner re Death of Philip Hewitt

January 2015

Exhibit 5

Department of Health and Human Services

Report to Coroner re Death of Phillip HEWITT in Bellden Lodge Supported Residential Service on 6 May 2012 – Case 1620/12

January 2015

Preamble

Supported residential services (SRS) are private businesses that receive no direct funding from any level of Government. The accommodation of residents in SRS is subject to private agreements between the proprietors and the residents, or their legal representatives, made in the context of the legislative framework in place at the time.

At the time of Mr Hewitt's death, SRS were registered and regulated under the *Health Services Act 1988* (the HS Act). However, starting in 2008 these arrangements had been subject to an extensive legislative review process, which proposed that new SRS specific legislation should be developed to target and strengthen protections and supports to this particular sector and its clients.

As a consequence the *Supported Residential Services (Private Proprietors) Act 2010* (the SRS Act) was passed in 2010 and commenced on 1 July 2012, replacing the HS Act as the relevant legislative framework. Regulations were also made under the SRS Act on 1 July 2012. The features of this new regime are discussed at length at the conclusion of this report.

Was Bellden Lodge a registered SRS?

Departmental records show that at the time of Mr Hewitt's death, Bellden Lodge was a registered SRS under Part 1, Division 3 of the HS Act. Registration was transferred to the proprietor TY2 Pty Ltd in February 2006, Mr Jian Jun (Steven) Yang being the sole director at that time and since that date.

Bellden Lodge was registered to accommodate a maximum of 53 residents, 39 in single rooms and 14 in shared rooms.

Bellden Lodge catered to, and still caters to, the pension-level segment of the SRS market which can include residents with psychiatric, intellectual and physical disabilities, elderly residents and those who are homeless or at risk of becoming homeless.

Did it comply with all relevant standards?

Departmental records show that Authorised Officers (AOs) appointed under the HS Act had conducted five unannounced inspections at Bellden Lodge during the 12 months prior to Mr Hewitt's death.

Departmental records indicate that no breaches relating to the care or support of residents were identified as a result of these inspections. However a number of maintenance and cleanliness matters were recorded as being raised with the proprietor for attention following an audit conducted in May 2011.

The department was not advised of any Community Visitor notifications during the 12 months prior to the incident. The Community Visitor Program is managed through the Office of the Public Advocate.

Were Phillip HEWITT and Ronald WATSON suitable clients?

SRS are private businesses and agreements to reside in them are voluntary arrangements negotiated between the proprietor and the resident (or his or her legally appointed representative). The department therefore had no role in determining whether a resident was a suitable client at the time of commencement of their residency. This is also the case currently under the SRS Act.

Section 107 of the HS Act provided that if a proprietor was aware, or ought reasonably to have been aware, that a resident required more health care than could be provided at the SRS, the proprietor must take all reasonable steps to ensure the appropriate health care is provided.

If those attempts were unsuccessful, the proprietor was then required to advise the department without delay of the needs of the resident. In exceptional circumstances, and in line with the range of powers of AOs granted under section 147 of the HS Act, an AO may also have made a report that a resident appeared to be in need of health care that could not be provided at the SRS pursuant to section 108(b) of the HS Act.

In both cases, pursuant to section 108(c) of the HS Act the department would then arrange to have the resident in question medically examined. If the department considered that further care should be provided, it would make appropriate arrangements for further care as authorised by section 108(d) of the HS Act.

Departmental records indicate that no section 107 or section 108(b) notification was made in relation to either Mr Hewitt or Mr Watson at any time. The department therefore was not involved in determining the suitability or otherwise of either resident after their move to Bellden Lodge.

Certain residents in SRS are also clients of mental health services. In such cases the department has a protocol to provide guidance to SRS and mental health services regarding information sharing and referral practices between the respective services.

Mr Watson had had periodic involvement with Eastern Mental Health Services (EMHS) prior to the incident. EMHS has advised that at the time of the incident neither Mr Hewitt nor Mr Watson were receiving treatment from EMHS.

However, departmental records indicate that AOs had been advised after Mr Hewitt's death that both he and Mr Watson had schizophrenia diagnoses and that both were being managed by the same General Practitioner (GP).

A Census of Victorian SRS was conducted for the department by an external agency in 2013. One of the findings of that Census was that 59 per cent of residents in pension level SRS were reported to have a psychiatric disability (2013 Census, Figure 74). This was broadly consistent with the results of previous census' conducted in 2008 and 2003. It was therefore not unusual for residents of pension level SRS to have psychiatric disabilities such as those it has been reported were experienced by both Mr Hewitt and Mr Watson.

Should written risk assessments have been done on clients?

There was no specific legislative requirement for written risk assessments to be prepared by the proprietor.

Section 106A of the HS Act required that the proprietor prepare an ongoing care plan for each resident that recorded the health and support needs of the resident as well as the services to be provided to the resident to assist with those needs. Such a care plan was in place for Mr Watson, though AOs of the department inspected the plan on 7 May 2012 and it made no reference to what now appears were Mr Watson's threats to kill or homicidal ideations.

The service's care/support plans generally required improvement to ensure they better described and met resident need. AOs worked with the proprietor to assist them to understand their legislative requirements and improve the quality of the care/support plans.

Should the attending GP have had a role in this process?

Section 106A(6) of the HS Act required that Mr Hewitt's health service providers be consulted in the preparation of his ongoing support plan and any changes made to that plan.

The proprietor has advised that Mr Hewitt's GP was involved in the preparation of the ongoing care plans, however, review by the department indicates that there was no documented evidence of this involvement accompanying the care plan.

Did Mr HEWITT receive suitable care?

Under the HS Act, proprietors were responsible for ensuring residents received suitable care.

The department had a role in monitoring that each resident had a care plan as required under section 106A of the HS Act, but this did not involve the department assessing each resident's needs. Therefore, in the absence of any complaints or notifications under section 107 or section 108(b) of the HS Act, the department is not able to make a statement as to how well a particular care plan reflected a resident's needs or whether the services subsequently provided to that resident were suitable for his or her needs.

The department is not aware of any concerns raised by Mr Hewitt, his family or anyone else involved with him about the standards of care that he was provided by either the SRS or his GP prior to his death.

Should Mr HEWITT's family have been involved in the change of room?

While section 108F(1)(e) of the HS Act required that Mr Watson's next of kin and guardian (if any) be informed as soon as practicable of any proposal to relocate him to another bedroom at the SRS, the decision to change rooms was one for the proprietor and residents involved. There was no legislative requirement for the proprietor to advise Mr Hewitt's family of a proposal for another resident to move into the twin share room (though the department would consider it good practice for a family to be advised of proposed changes to any resident's living arrangements).

The proprietor has since advised that Mr Watson's room mate had made complaints about Mr Watson being up late at night and being noisy which disturbed the room mate's sleep. In order to address this, the proprietor asked Mr Hewitt whether he would mind Mr Watson moving into his room because Mr Hewitt was occupying a twin share room alone. The proprietor advised that Mr Hewitt agreed to this arrangement, though the department is not aware of any third party witness who might be able to verify what was discussed between Mr Hewitt and the proprietor. There was no requirement in the HS Act for the proprietor to keep a record of such an agreement or discussion with Mr Hewitt.

The proprietor has advised that they consulted Mr Watson's family regarding the intent to relocate rooms as per 108F(1)(e) of the Act, but again this cannot be verified by reference to records as, to the department's knowledge, the proprietor did not keep a record of that consultation. There was no requirement in the HS Act for the proprietor to keep records of the consultation.

Should Bellden Lodge have written policies in relation to contacting family, police and GP at appropriate times?

Under the HS Act there were notification and consultation requirements relating to a number of different circumstances, but there was no specific requirement that comprehensive written notification policies be prepared by the proprietor.

Notification of (and in some cases, consultation with) residents' relatives, next of kin or guardian were variously required in relation to:

- Residential statements (s.106)
- Ongoing support plans (s.106A)
- Notices to vacate (s.106C)
- Significant illness, injury or incident involving the resident (s.108F(1))
- Intention to discharge or terminate residency or relocate to another bedroom (also at s.108F(1))
- Death of the resident (s.108F(4)).

Consultation with, or notification of, residents' health service providers were variously required in relation to:

- Ongoing support plans (s.106A)
- Maladministration or non-administration of prescribed medications (s.108C and r.19(1)(e) of the Health Services (Supported Residential Services) Regulations 2001)
- Administration of non-prescribed medication (s.108C and r.20(a))
- Significant sign of deterioration of the resident's health status (s.108F(3)).

There were no specific requirements under the HS Act relating to notification of, or consultation with, Victoria Police.

The new SRS Act has similar notification and consultation requirements, however the new Act introduces the concept of a 'person nominated'. This person is nominated by the resident to receive information relating to the resident's accommodation and personal support. (If the resident has a guardian, the guardian makes the nomination.)

What should staff have done when Mr WATSON threatened to kill Mr HEWITT?

The department's expectation would be for the proprietor to secure appropriate health care for Mr Watson should they have concerns that they were not able to manage his care needs. In the event that they were unable to secure these supports the department would expect that the proprietor would contact the department to seek further assistance in accordance with section 107 of the HS Act.

The department was not made aware of Mr Watson's homicidal ideations until after the incident. This is despite AOs routinely asking at the beginning of inspections whether there were any residents that the proprietor felt they needed assistance with.

- On 7 May 2012 the proprietor advised AOs that Mr Watson had a history of voicing non-specific intentions to kill but had never demonstrated intention to carry out these threats. The department was not then and is not now aware of any specific threats to kill being directed at Mr Hewitt.

- AOs interviewed staff member Dianne on 7 May 2012 who stated that Mr Watson had a history of threatening to kill and had informed her that he had killed 4 people. At interview Dianne stated that she spoke with Mr Watson's sister who informed her that this was untrue and 'this was just the way Ron spoke'.

- On 7 May 2012 AOs inspected the Ongoing Care Plan of Mr Watson and this made no reference to his threats to kill or homicidal ideations. At this inspection a transfer form was sighted which was completed as a result of a transfer from Elizabeth William SRS and dated April 2004. That form included a statement that Mr Watson had a case manager from Murnong Community Mental Health Clinic and had delusions of being a murderer.

Under section 108F of the HS Act the proprietor was required to maintain an accurate and up to date record of the particulars of any incident involving behaviour by a resident which threatened the safety of the resident or other residents or staff, and to notify the next of kin and guardian (if any) as soon as practicable. In this case, the proprietor has advised that records of incidents in which Mr Watson threatened to kill were not made because staff had come to accept this behaviour as 'normal' for Mr Watson and there was not considered to be a threat to other residents.

In line with commencement of the new SRS Act in July 2012, the department has had a focus on assisting SRS proprietors to understand their obligations in relation to incident reporting. The department will consider whether any further actions in respect of Belilden Lodge's potential or identified breaches of the HS Act should be undertaken (eg in respect of incident reporting and care plans), and how it can best support the service in the best interests of all residents, following the conclusion of this inquest.

Was training of staff appropriate?

Proprietors had a responsibility under section 108L of the HS Act to ensure that adequate and appropriately trained staff were employed in the service. The department's role in this respect was to monitor service outcomes and require remedies if any identified deficits were seen to be caused by inadequate training.

This role did not extend to monitoring the training needs or training attendance of individual staff in SRS.

However, the department provided a range of guides and reference material for SRS proprietors and staff, including the document "Meeting the Need – a guide to providing quality care in SRS", with specific modules relating to Care Planning and responding to Behaviours of Concern.

The department also had a free training program for SRS proprietors and staff on a range of topics including Care Planning and managing difficult behaviour.

It was a matter for the proprietor to make use of the guides and reference material and ensure that their staff could provide the best possible care and support for residents.

Should Bellden Lodge have conducted a review of this death?

The department recognises that it is good practice that following this incident the SRS conduct a review of the care and support of Mr Hewitt and Mr Watson, to determine if the SRS has met their legislative obligations regarding staff competency and internal procedures relating to resident care.

However, there was no requirement under the HS Act for Bellden Lodge to conduct a review of Mr Hewitt's death.

Did the Department of Health conduct any review?

AOs visited the service on 7 May 2012 at which time they interviewed staff and undertook an inspection of the SRS records. It was identified at the time of the incident that the care/support plans required improvement to ensure they better described and met resident need. AOs worked with the proprietor to assist them to understand their legislative requirements. There was also extensive support by Supporting Connections workers in terms of individual and group counselling as well as proprietor, family and staff support.

As noted at the commencement of this report, the department conducted an extensive review of the regulatory framework for SRS, and new legislation now governs this sector. The SRS Act and associated Regulations came into effect on 1 July 2012, after Mr Hewitt's death.

The main features of the new SRS Act are outlined below and include:

- Regular renewal of registration replaced by clearer application requirements and risk based monitoring and enforcement processes;
- Accommodation and personal support standards re-framed in terms of expected outcomes for residents, with proprietors determining how outcomes are achieved;
- Prescribed staffing requirements, including minimum staff numbers and training requirements;
- Prescribed reportable incidents process introduced for
    - An unexpected death of a resident
    - A serious injury of a resident
    - A fire or other emergency event
    - An alleged serious assault (sexual or physical);

- Proprietors' complaints system must be consistent with principles of the Act;
- Strengthened requirements for management of residents' fees and other monies paid;
- New provisions for ending residential and service agreements and issuing notices to vacate;
- New enforcement mechanisms (undertakings, compliance notices and infringement notices).

Section 7(3) of the SRS Act requires the Act "be interpreted as far as possible, in a manner that gives effect to the principles specified in subsection (2)", they being:

(a) The individual rights of residents should be respected by recognising a resident's right to –
   i. Privacy; and
   ii. Freedom of expression; and
   iii. Fair and equal treatment; and
   iv. Dignity and respect; and
   v. Freedom from abuse, neglect or exploitation;

(b) Proprietors should support residents to live as independently as possible by –
   i. Recognising the resident's rights to make decisions, provided those decisions do not unreasonably affect the rights of others; and
   ii. Supporting them to participate in decisions regarding the services they receive; and
   iii. Allowing them the right to choose their service providers; and
   iv. Recognising their right to participate in activities involving a degree of risk;

(c) Proprietors should support residents as far as possible by –
   i. Providing residents with information that will assist in decision making; and
   ii. Facilitating access to activities;

(d) Proprietors should provide safe and comfortable surroundings and ensure that support services take account of the needs of individual residents as far as possible.

Within the context of those principles, the SRS Act establishes specific responsibilities for proprietors in relation to:

- The development, review and carrying out of individual support plans for residents that detail the resident's health and personal support needs as well as the services to be provided to assist the resident with those needs (s.57).
- Minimum accommodation and support standards (s.59).
- Monitoring of residents' health care and personal support issues and taking steps to ensure that appropriate care and services are provided (ss. 60 and 61).
- The employment of adequate and appropriately trained staff (s.64).

In order to assist proprietors to understand their responsibilities under the SRS Act and to assist them to support and care for residents appropriately, the department has provided a range of resources to the sector at no cost.

Those resources include the document *Operating a supported residential service, a guide for proprietors*, and training for proprietors and staff in a range of relevant

subject areas. A more complete list of industry-wide resources can be found at the departmental website: www.health.vic.gov.au

The department has funded the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) since 2007. This program brokers funds and other supports through non-government organisations to enhance the viability of pension level SRS like Bellden Lodge and assist them to improve lifestyle, amenity and safety outcomes for residents.

The additional supports available to businesses like Bellden Lodge through SAVVI include the funding of Supporting Connections workers to attend SRS where there are residents with complex or unmet needs and assist proprietors with linking residents to appropriate, external service agencies. It is important to note that this additional support does not replace or diminish the responsibilities of proprietors to meet all their obligations to residents under the SRS Act.

The department has also implemented a targeted, risk based monitoring and compliance program for AOs appointed under the SRS Act. AOs are employed in regional offices. As well as responding to issues as they arise at local SRS, they undertake planned targeted compliance reviews in areas of concern. Those SRS with poor compliance histories or larger numbers of complaints made about them have more planned reviews than more compliant facilities and ones with fewer complaints.

Volunteer Community Visitors from the Office of the Public Advocate are also empowered by the SRS Act to visit SRS and query whether services are being delivered to residents in accordance with the principles of the Act as well as the accommodation and support standards prescribed under the Act (section 184). They may also query the status of any complaint, issue or concern raised by or on behalf of a resident and advocate for change to address residents' issues.

The department has regular meetings with the Community Visitors Program/Office of the Public Advocate, as well as with regional AOs, to review and discuss responses to sector wide issues and risks. The department continues to adjust its SRS program (policies, risk based process and training) accordingly.

The department is confident that the new legislative framework will be significant in managing the risks inherent in SRS; which are private businesses providing accommodation to complex and often vulnerable clients, like Mr Hewitt and Mr Watson.