IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5215

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Bruce Vernon Taylor
Date of birth:	27 November 1964
Date of death:	15 or 16 October 2018
Cause of death:	1(a) Complications of old brain injury in prior motor vehicle incident
Place of death:	7 Sandalwood Retreat, Frankston South, Victoria

INTRODUCTION

1. On 15 or 16 October 2018, Bruce Vernon Taylor was 53 years old when he passed away in his sleep. At the time of his death, Mr Taylor lived in shared assisted accommodation managed by Accommodation and Care Solutions (**ACARES**). He received funding through the National Disability Insurance Scheme.

THE CORONIAL INVESTIGATION

2. Mr Taylor's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Taylor's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. I also obtained statements from Mr Taylor's disability support worker, and his doctor.

6. This finding draws on the totality of the coronial investigation into Mr Taylor's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 16 October 2018, Bruce Vernon Taylor, born 27 November 1964, was visually identified by his disability support worker, Cindy Edwards.

8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Senior Forensic Pathologist, Dr Michael Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 23 October 2018 and provided a written report of his findings dated 4 December 2018.

10. The post-mortem examination revealed a remote brain injury but no evidence of any acute injury that could have contributed or led to death. Dr Burke identified changes in keeping with the history of a remote head injury sustained in a motor vehicle incident.

11. There was no evidence of any natural disease process that could have contributed or led to death.

12. Dr Burke explained that individuals with a significant head injury may develop epilepsy. Epilepsy can be associated with sudden and unexpected death. He believed Mr Taylor's mechanism of death was due to a seizure-induced cardiac arrhythmia or respiratory arrest.

13. Toxicological analysis of post-mortem samples identified the presence of citalopram (an antidepressant).

14. Dr Burke provided an opinion that the medical cause of death was *"1(a) Complications of old brain injury in prior motor vehicle incident"*.

15. I accept Dr Burke's opinion.

Circumstances in which the death occurred

Background

16. As a child, Mr Taylor sustained a severe traumatic brain injury in a motor vehicle incident. The acquired brain injury significantly affected his cognitive and mobility function. He

suffered weakness and right-sided partial paralysis. His speech was affected, and he required a modified diet.

17. In 2011, Mr Taylor moved to shared assisted accommodation at 7 Sandalwood Retreat, Frankston South (**Sandalwood**), where he received one to one care and assistance with his activities of daily living. There were eight other residents at Sandalwood, all of whom had disabilities resulting from road trauma.

18. Andy Gabriel, Accommodation Manager, recalled Mr Taylor was a beloved member of Sandalwood. He loved art and was very proud of his work and participated in an art exhibition. He was also involved in the local community.

19. Cindy Edwards, disability support worker, fondly remembered Mr Taylor as a happy and child-like joker. He enjoyed his strict routines and she described their relationship as comfortable.

20. In the 12 months preceding his death, Mr Taylor's cognitive and physical health deteriorated steadily. His communication, mobility, and incontinence significantly worsened, and he lost a considerable amount of weight. He suffered a number of falls, some of which required hospital attendance.

21. In an effort to determine the cause of this deterioration, Mr Taylor's general practitioner, Dr Peng-Kung Yang, referred him to a number of specialists who conducted various investigations. Ultimately it was thought the deterioration was due to the progression of Mr Taylor's acquired brain injury, for which there was no specific treatment. Psychoactive medications (which had been prescribed for aggressive behaviour) , Lexapro (escitalopram, an antidepressant), and Epilim (sodium valproate, an anti-seizure medication) were gradually weaned and then ceased without adverse effect in an effort to improve Mr Taylor's cognitive function. Dr Yang explained that Epilim may cause drowsiness or the appearance of reduced cognitive ability.

Circumstances of death

22. During the weekend before his death, Ms Edwards noticed that Mr Taylor's mouth and chin had stiffened to the point where he was having difficulty opening and closing his jaw.

23. On the evening of 15 October 2018, Ms Edwards noted she felt *"unhappy about Bruce being more rigid and stiff with his left hand."* She intended to organise a medical consultation as Mr Taylor did not appear *"right or normal"*.

24. At approximately 8.10am the next morning on 16 October 2018, Ms Edwards found Mr Taylor deceased in bed. He had passed away sometime during the previous night or that morning.

REVIEW OF CARE AND FURTHER INVESTIGATIONS

Whether Mr Taylor's epilepsy medication was ceased appropriately

25. Given the pathologist, Dr Burke, believed the mechanism of death may have been due to a seizure-induced cardiac arrhythmia or respiratory arrest, I requested the Court's Health and Medical Team (**HMIT**), to review whether the decision to cease Mr Taylor's epilepsy medication (Epilim) was appropriate.

26. The HMIT noted that medical records indicated that staff at Sandalwood had not witnessed Mr Taylor suffering any seizures for a number of years.

27. In September 2017, Dr Deepa Rajendran, neurologist, reviewed Mr Taylor due to his declining health. Dr Rajendran noted that an electroencephalograph (**EEG**)[2] had been performed recently and *"there have been no witnessed seizures for a long time"*. Dr Rajendran suggested organising a magnetic resonance imaging (**MRI**)[3] scan of the brain[4] under general anaesthetic and obtaining Epilim blood levels. Dr Rajendran noted:

> *A component of his symptoms could be due to seizure activity and it would be worthwhile to try to optimize his anti-epileptic medication. However, it is also possible that a component of his deterioration is due to the acquired brain injury progressing and there is not much we can do about it.*

28. On 8 February 2018, Dr Mia Rowe, clinical neuropsychologist, reviewed Mr Taylor. An MRI had been performed on 24 November 2017, which had indientified atrophy consistent with past trauma.

29. Consultant physician in rehabilitation medicine, Dr Lisa Sherry, provided a comprehensive letter to Mr Taylor's general practitioner, Dr Yang, in March 2018 that noted:

> *Bruce has steadily declined over the past few years. His decline started with a change in his behaviours but is now more physical and affecting his mobility. ... The MRI does*

[2] Medical test used to measure the electrical activity of the brain, via electrodes applied to the patient's scalp.
[3] An MRI uses a magnetic field and radio waves to take pictures of the body's interior.
[4] MRI brain was sought for investigation into eight months of recurrent falls with urinary incontinence, lower limb weakness and worsening aggression.

not reveal cause of his decline. ... I suspect that he has early onset dementia due to previous brain injury.

...

As Bruce's cognition is declining, I recommend weaning and ceasing psychoactive medications. ... Consideration should be given to stopping the Lexapro and Epilim. I have found no definitive diagnosis of epilepsy.

30. Dr Sherry recommended to wean and cease Seroquel (quetiapine, an antipsychotic), Lexapro, and Epilim while monitoring behaviour. Dr Sherry reviewed Mr Taylor in her consulting rooms on 2 May 2018 with a nurse from ACARES and a support worker. In her follow-up letter to Dr Yang, Dr Sherry noted:

> *I note that you have substantially decreased the Seroquel dose since my original assessment. ... After his Seroquel has ceased, I recommend reducing his Lexapro to 10 milligrams daily for one to two weeks and then ceasing. Following this it would be possible to wean the Epilim to 500 milligrams twice daily.*

31. In July 2018, Dr Wajih Bukhari, neurology consultant, reviewed Mr Taylor with Ms Edwards. Dr Bukhari noted that Ms Edwards had never seen Mr Taylor suffer a seizure or lose consciousness. He recommended reducing the sodium valproate dose from 700 to 500 milligrams in the hope it would improve Mr Taylor's cognitive abilities.

32. Dr Sherry reviewed Mr Taylor in her consulting rooms on 12 September 2018 with Ms Edwards. In her letter to Dr Yang, Dr Sherry reported that Mr Taylor's mobility and communication remained profoundly reduced and the diagnosis was likely early onset neurological degeneration following his traumatic brain injury:

> *The Seroquel was stopped in the last three months and the Epilim dose was reduced more recently with no adverse effects. As Cindy sees Bruce all week, her opinion that his behaviour is stable is likely to be accurate. There is no history of seizures at this low dose the Epilim is unlikely to be providing antiepileptic effect. I recommend weaning the Epilim by changing to 200 milligrams twice daily and then stopping.*[5]
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> ...

[5] The medication chart indicates that Epilim was reduced from 500 milligrams to 200 milligrams on 25 September 2018.

Reduce Epilim to 200 milligrams twice daily for 1-2 weeks, then cease.

33. Dr Yang reduced Mr Taylor's Epilim to 200 milligrams twice a day at the time of the surgery consultation on 25 September 2018. Dr Yang re-wrote Mr Taylor's medication chart on 2 October 2018. The medication chart indicated that Epilim was to be stopped on 10 October 2018, which accorded with Dr Sherry's advice to reduce the dose to 200 milligrams twice daily for one to two weeks before ceasing.

34. An unheaded sheet of paper attached to Mr Taylor's Sandalwood file dated 10 October 2018 stated, *"All staff. Bruce has ceased Epilim. Please be observant of any tremors. Cindy"*. The mediation 'Webster care' print-out on 16 October 2018 did not include Epilim.

35. The HMIT noted it was unclear from the records if Mr Taylor had a history of epilepsy or when it was diagnosed. It may have been initiated to prevent seizures, which are known to occur in persons with an acquired brain injury. However, appropriate investigations and neurology review occurred prior to the dosage reduction and cessation. Mr Taylor's Epilim dose was being reduced in a controlled manner under the guidance of Dr Sherry with no ill-effect observed. No seizure activity was noted throughout the time of Epilim reduction, cessation, or proximate to Mr Taylor's death.

36. The HMIT concluded the management of the reduction in dose of Epilim was considered and careful. The HMIT did not identify any areas for prevention. I agree with the HMIT's advice.

Investigation by the Disability Services Commissioner

37. After Mr Taylor's death, the Disability Services Commissioner (**DSC**) commenced an investigation. The DSC is an independent body that has the power to inquire and investigate any matter relating to the provision of disability services or regulated disability services to a person who was receiving these services at the time of their death. The jurisdiction of the DSC is an important oversight of a particularly vulnerable group of persons in our community. Whereas the coronial jurisdiction is limited to the surrounding circumstances of death, which are in turn limited to events which are sufficiently proximate and causally related to the death, the jurisdiction of the DSC expands to services provided to the deceased during their lifetime, whether or not those services are connected with the death. I also note that section 7(a) of the Act requires me to avoid necessary duplication of inquiries and investigations. I have therefore determined that there has been no need to mirror the DSC's investigations.

38. As a result of its investigation, the DSC made a number of findings relating to the care provided by ACARES. In summary, these were:

(a) inadequate record keeping. The DSC found that there were extended periods where no case notes were made. Where notes were made, they did not meet ACARES's own reporting requirements at times. There was also an absence of health plans to support Mr Taylor's known health conditions of incontinence, anxiety, dysphagia, and his falls risk, his behaviour support plan was significantly out of date and did not reflect his recent decline in health, and Mr Taylor's meal and diet charts were not maintained. The DSC found ACARES's failure to update Mr Taylor's assessments and plans likely impacted negatively on the care he received. Staff did not have current information available to them to provide the best care to Mr Taylor;

(b) poor standard of care was provided to Mr Taylor. This included:

(i) Mr Taylor had not seen a dentist since 2014. Referring to Mr Taylor's significant weight loss and his diagnosis of dysphagia, the DSC noted that a common cause of nutrition and swallowing issues is poor oral health. I note that the post-mortem examination reported Mr Taylor's mouth was *"normal"*;

(ii) there was a report that Mr Taylor had been left in bed all day on an occasion shortly before his death because his carer did not arrive. There was no incident report;

(iii) Mr Taylor had indicted a wish to attend church on Sundays. The DSC found no evidence this had ever occurred;

(iv) in March 2017, Mr Taylor's general practitioner completed a mental health care plan so that he could access psychological counselling. The DSC found no evidence that this had been arranged;

(v) the DSC found no evidence that Mr Taylor's significant weight loss had been referred to a nutritionist or dentist;

(vi) Mr Taylor did not have a comprehensive health care plan despite his declining health and ACARES acknowledged a deficit in policy pertaining to management of deteriorating health; and

(vii) specialist recommendations were not followed, which included ensuring Mr Taylor consumed thickened fluids and a modified diet of soft moist food;

(c) inadequate attention to Mr Taylor's communication needs. Mr Taylor's communication abilities steadily declined in the months before his death yet his communication assessment and plan was not reviewed after January 2018 and staff did not receive any training as to how to maximise his abilities. The DSC also identified that there was no way for residents at Sandalwood to alert staff during the night if they needed assistance for toileting or other issues;

(d) inadequate staff supervision, support, and training; and

(e) Sandalwood was unsuitable accommodation to meet the needs of nine residents, including Mr Taylor.

39. ACARES was provided an opportunity to respond to the DSC's draft adverse comments. ACARES provided a written response, which the DSC incorporated into its final report. ACARES also expressed concerned that the DSC used the Department of Health and Human Services's (**DHHS**) Residential Services Practice Manual (**RSPM**) as a benchmark to assess service quality given that non-DHHS service provides are not required to follow the RSPM. ACARES noted that it had been audited against and met the DHHS Human Services Standards.

40. The DSC noted that assessments of service quality made during investigations are distinct and separate from the DHHS audit and assurance process and it was appropriate to use the RSPM given ACARES was certified to provide disability services for shared residential accommodation and in-home care, alongside other legislative and policy requirements, to investigate the quality of the disability services provided to Mr Taylor.

41. The DSC subsequently issued a Notice to Take Action to ACARES to improve the deficiencies identified during its investigation. The DSC required ACARES to address 13 action points, which included arranging an independent review of all behaviour, health, support, and communication plans for each of the residents, arranging annual health examinations, arranging dental examinations if residents have not had one for more than a year, arranging an audit of progress notes to ensure compliance with legislative and policy requirements, providing staff training and supervision, installing a call bell alert system at Sandalwood, and developing guidelines and policies similar to the RSPM to provide guidance regarding practice issues, specifically in relation to the deficiencies identified by the DSC.

42. In March 2020, the DSC confirmed that ACARES had implemented all but one of the actions. The requirement to develop RSPM-type guidelines and policies was expected to be completed in July or August 2020.

43. At my request, in July 2020 Senior Constable Jeff Dart from the Police Coronial Support Unit wrote to ACARES and requested an update as to the implementation of the final action point.

44. On 13 August 2020, I received a report from Antonia Albanese, Executive General Manager – Disability Accommodation and Care at Zenitas, which appears to be the new parent company of ACARES. Ms Albanese provided a report outlining the implementation of the 13 action points. The implementation of the outstanding action point had commenced but was still in progress as it had been affected by delays due to an organisational restructure and COVID-19. The report noted:

> *ACARES (in collaboration with its associated entities) will develop a Residential Services practice manual. ACARES management has now completed a GAP analysis based on the Residential Service Practice Manual. The analysis has identified areas that require further development to existing policies and procedures.*
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> ...
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> *ACARES has also engaged external consultants ... to engage staff and clients of ACARES (and related entities) in an evaluation of accommodation and in-home services. ... [P]rincipal consultants ... will review ACARES documentation, meet with accommodation clients, families, and staff to evaluate current practice across ACARES. The evaluation will seek to uncover good practice for implementation more broadly, along with identifying areas for improvement.*

45. Ms Albanese confirmed that the final manual would be supported with staff education and training. In the meantime, interim policies and procedures had been implemented to address recognition and response to deterioration.

46. In February 2021, I provided Zenitas with an opportunity to comment on draft comments I proposed to make in this finding. On 18 March 2021, Ms Albanese expressed her disappointment with the care Mr Taylor received before his death. She noted:

> *Since joining the Zenitas Healthcare Group in 2018, Accommodation & Care Solutions (ACARES) has been on a client safety and quality outcomes transformation*

journey. The improvements that we have implemented ensure appropriate standards in relation to quality of care are underpinned by the right capability, processes and procedures. This includes a robust clinical and quality focus by senior leadership, and oversight by the Board.

47. Changes have included:

(a) the implementation of a revised operating structure which includes a national resource with a dedicated focus on quality and safety and an expanded network of Regional Clinical Managers to improve client safety and quality outcomes;

(b) establishment of a Quality, Risk, Safety, and Clinical Governance Committee and development of supporting policies and procedures;

(c) enterprise-wide risk, quality, and incident management systems and reporting;

(d) training for staff to clarify incident reporting obligations, expectations, and processes; and

(e) rolling audits of higher risk and complex client situations

48. I thank Ms Albanese for her candour in acknowledging the shortcomings in Mr Taylor's care experience. I am satisfied that the changes made by Zenitas will help prevent similar care deficiencies for their other clients.

FINDINGS AND CONCLUSION

49. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Bruce Vernon Taylor, born 27 November 1964;

(b) the death occurred on 15 or 16 October 2018 at 7 Sandalwood Retreat, Frankston South, Victoria, from complications of old brain injury in prior motor vehicle incident; and

(c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. I am satisfied that ACARES staff took Mr Taylor to all the medical appointments Dr Yang arranged.

2. For the reasons outlined in the DSC report, I am not satisfied that all of Mr Taylor's medical, emotional, and spiritual needs were met.

3. The concerns regarding the quality of care Mr Taylor received relate to the quality of life he enjoyed rather than to his cause of death.

4. People with a disability are often a vulnerable part of our community, and often without a voice. Despite state and federal legislation and policies in place, people with a disability continue to be treated without, or with little, regard to their rights, freedoms, and dignities. Too many times, the quality of care endured by people with a disability neglects their human spirit and dignity.

5. In April 2019, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability was established in response to community concern about widespread reports of violence against, and the neglect, abuse and exploitation of, people with disability. Public hearings began in November 2019 and will continue until December 2021. The Royal Commission expects to deliver its final report to the Australian Government by 29 April 2022, which will recommend how to improve laws, policies, structures, and practices to ensure a more inclusive and just society.

6. I welcome the establishment of the Royal Commission and direct a copy of this finding be provided to the Royal Commission for their use and reference.

I convey my sincere condolences to Mr Taylor's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Leanne Law, senior next of kin

Russell Taylor, senior next of kin

Dr Oeng-Kung Yang (care of Avant Law Pty Ltd)

Zenitas

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Senior Constable Gary Northfield, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 31 March 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** (the Act), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within six months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.