Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2021 6058

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

Inquest into the death of: RUSSELL LESLIE JAMES HEWAT

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	5 September 2024
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing Dates:	9 – 13 October 2023 and 23 – 24 April 2024
Appearances:	Mr Andrew Imrie of Counsel on behalf of Aruma Disability Services. (MinterEllison) Ms Stella Gold of Counsel on behalf of West Gippsland Healthcare Group. (K&L

	Gates)
	Ms Erin Gardner of Counsel on behalf of Peninsula Health. (Meridian Lawyers)
	Mr Arjunan Thangarajah of Counsel on behalf of H1 Healthcare. (Blue Rock Law)
	Mr Michael Sayers on behalf of Mr Ejikeme Godson Okoli. (Slater & Gordon Lawyers)
	Ms Kelly McKay of Counsel on behalf of Ms Christie Pentland. (Barry Nilsson Lawyers)
	Mr Christopher Lees of Counsel on behalf of Ms Candice Roeder (Barry Nilsson Lawyers)
Counsel Assisting:	Leading Senior Constable Premala Thevar, Police Coronial Support Unit

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I, AUDREY JAMIESON, Coroner having investigated the death of RUSSELL LESLIE JAMES HEWAT

AND having held an Inquest in relation to this death on 9 – 13 October 2023 and 23 - 24 April 2024

at Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006

find that the identity of the deceased was RUSSELL LESLIE JAMES HEWAT

born on 28 April 1988

died on 6 November 2021

at Warragul Hospital, West Gippsland Healthcare Group, 41 Landsborough St, Warragul VIC 3820

from:

1 (a) ASPIRATION PNEUMONIA IN THE SETTING OF RECENT COVID-19 INFECTION

In the following summary of circumstances:

Russell Leslie James Hewat lived in a supported accommodation setting because of his reliance on others for support and care due to vulnerabilities associated with his disabilities. He died following a decline in his health proximate to having been discharged from hospital. The standard of the delivery of care provided to him in that time was questioned by the facility in its internal review of the death and warranted the holding of an Inquest.

BACKGROUND CIRCUMSTANCES

1. RUSSELL LESLIE JAMES HEWAT[1] was 33 years of age at the time of his death. He was born with complex disabilities including Autism Spectrum Disorder, Down Syndrome, intellectual disability, visual impairment, and a congenital heart defect. Russell was unable to communicate verbally, had high care needs and throughout his life required assistance and support in all aspects of daily living. His medical history also included hypothyroidism, dysphagia and he had experienced episodes of aspiration

[1] With the permission of Suzanne Stewart, foster mother and Glenn Hewat, father, Russell Hewat was referred to as "Russell" during the course of the Inquest. For consistency I have referred to him as Russell throughout the Finding save where I have determined that formality required the use of his full name.

pneumonia. Russell was legally blind due to bilateral cataracts and had permanent eye damage from self-harming behaviours.

2. At 6 years of age, Russell was relinquished from his birth parents, and he was placed into the care of his foster mother, Suzanne Stewart (**Ms Stewart**). Ms Stewart became Russell's full-time carer.

3. Between 7 to 18 years of age, Russell attended the Latrobe Special Development School for students with intellectual disabilities in Traralgon.

4. At 22 years of age, Russell moved out of the care of his foster mother, Ms Stewart, and into a Supported Independent Living (**SIL**) Home run by Aruma Disability Services (**Aruma**) in Cooper Street, Traralgon. Despite this change of care and his living arrangements, Russell maintained a very close relationship with Ms Stewart.

5. In December 2020 Russell was moved to another Aruma SIL Home, "Willows" in Normanby Street, Warragul. Willows is a purpose-built residential building, consisting of two self-contained units. Russell shared his home unit – Unit 1, with one other Aruma resident[2], and the adjoining home unit – Unit 2, was shared by three other Aruma residents. The units were separated by the staff office/sleepover room. There is a hallway entrance with individual doors into each unit. For the most part, the residents from Units 1 and 2 did not interact.

6. Due to his complex disabilities and health needs, Russell required assistance and support in all aspects of daily living from his support workers.

7. Although Russell could not communicate verbally, he would communicate by pointing at things and leading others by the hand to show them what he wanted. He also had some limited sign language skills.

8. Russell moved around independently and did not require any mobility aids despite some difficulties walking on uneven surfaces due to his vision impairment and poor depth perception.

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[2] Aruma staff generally referred to the people under their care as "customers". Throughout the Inquest the adjectives "customer", "client" and "resident" were used interchangeably as descriptives for the same cohort. "Participant" – referencing a NDIS participant was used by Mr Darryl Wood. For consistency, I have referred to Russell and the other occupants of Willows as "**residents**".

9. Russell's dysphagia necessitated a soft diet of pureed foods and thickened fluids. To minimise the risk of choking, he was required to be seated in an upright position for all meals and drinks and his access to foods and drinks also required close monitoring.

10. Russell displayed a range of behaviours associated with his complex disabilities. He would self-harm and exhibit combative behaviour when he was feeling distressed, anxious, scared, or unsafe with the triggers arising from such situations as a change to his routine, unfamiliar environments, or multiple failed attempts to communicate his wants. Such behaviours included scratching his face, poking his eyes with his fingers or knuckles and hitting his throat or head with the side of his hand or a closed fist.

11. Russell was particularly fearful of medical practitioners, medical procedures and hospitals. Consequentially, he was often provided with sedation to enable medical examinations, blood tests, dental care, and necessary hygiene procedures such as nail trimming and haircuts.

12. Prior to the COVID-19 pandemic Russell attended a day program for adults five days a week in Newborough run by Statewide Autistic Services (**SASI**). Russell enjoyed the routine of the day program, his hobbies of playing guitar and organ piano and his regular visits with Ms Stewart.

13. Russell was a National Disability Insurance Scheme (**NDIS**) participant.

SURROUNDING CIRCUMSTANCES

14. On 3 October 2021, Russell became unwell and was transported by ambulance to Warragul Hospital, West Gippsland Health Care Group (**WGHG**), where he tested positive for COVID-19 infection.

15. Due to Russell's complex disabilities, administering medical treatment to him was difficult. Russell did not like being touched, having anything placed near his face, or even allowing nursing staff to check his temperature. Russell was non-compliant with staff attempting to take clinical observations and would frequently remove any oxygen-supportive devices fitted to assist his breathing.

16. Following admission to WGHG, Russell's condition further deteriorated due to COVID-19 infection, and on 4 October 2021, he was placed in an induced coma to

allow intubation. He was subsequently transferred to the Intensive Care Unit (**ICU**) at Frankston Hospital, Peninsula Health.

17. Russell remained under sedation and artificially ventilated until 13 October 2021. He was later transferred to a general medical ward.

18. On 19 October 2021, Ms Stewart was able to visit Russell for the first time since his admission to the Frankston Hospital. She observed self-inflicted scratches on Russell's face indicating to her that Russell was distressed at being in hospital.

19. On 20 October 2021, Russell was medically cleared for discharge. The following day a multidisciplinary team that form the acute rehabilitation program (**ARP**) at Peninsula Health, met for the first time to discuss how Russell *was on the ward, what his care needs were and what interventions or assessments may be needed to progress his rehabilitation and commence the discharge planning*.[3]

20. Assessment of Russell's functionality proved challenging for the ARP Team as he remained resistive to engagement with hospital staff to enable a full assessment.[4] However, it was a collectively held opinion of the stakeholders involved with Russell *that Russell's engagement and support needs would be better met in the supported accommodation with familiar carers within an environment that was familiar to him*.[5]

21. On 28 October 2021, a complex Discharge Planning meeting was held. Aruma staff members Mr Darryl Woods, Russell's NDIS support coordinator, Elaine Burke, the Service Manager responsible for Willows and two other SILs, and Marita Carew, Aruma's Regional Manager also participated in this meeting. Discussion revolved around the need for additional funding, additional carers including that the hospital would refer Russell to post-acute physiotherapy and occupational therapy and the plan for ambulance transfer of Russell back to Willows.[6]

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[3] Transcript of proceedings (**TP**) at page 26.

[4] TP at page 29.

[5] TP at page 31.

[6] TP at page 38.

22. On Monday 1 November 2021, Russell was discharged from the Frankston Hospital and transferred back to Willows residence. He had experienced physical deconditioning whilst in hospital and was no longer able to ambulate unassisted. He remained capable of repositioning himself in bed but became exhausted easily.

23. On the day of his discharge from Frankston Hospital, Monday 1 November 2021, Aruma Regional Manager, Marita Carew (**Ms Carew**), sent an email[7] to the Willows specific email address[8], at 7.34 pm with the intention that it was to be disseminated to all Willows staff by instructing that the email should be printed.[9] The email outlined Russell's changed care needs post-discharge from hospital and the additional supports he required from staff. It included the instruction that night shift staff check Russell half-hourly throughout the night, record the checks, and contact "000" if they observed a deterioration in his condition.

24. On Wednesday 3 November 2021, Russell's right leg was noted to be red, swollen, and hot to the touch. An ambulance was called, and Russell was conveyed to Warragul Hospital, WGHG, where he was diagnosed with a deep vein thrombosis (**DVT**). Russell was commenced on anticoagulant medication and admitted to the hospital overnight.

25. On 4 November 2021, Russell was assessed to be medically fit to be discharged back to his residence. The discharge plan was for 3 months of anticoagulation and for follow up with his general medical practitioner (**GP**).

26. Senior Physiotherapist of the short term stay and emergency department at Warragul Hospital, Ms Brooke Cleeland (**Ms Cleeland**), arranged with Willows to do a home visit on 5 November 2021, with the Occupational Therapist manager, Sue Aberdeen (**Ms Aberdeen**) after Russell was to be discharged from the hospital. Ms Cleeland stated that the purpose of the home visit was to provide Russell with appropriate equipment at home, and to provide carer training to his carers.[10]

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[7] See page 327 Coronial Brief (**CB**).

[8] willows@aruma.com.au

[9] According to Ms Burke, the Willows specific email address could be accessed by staff, at the site on a centralised computer which is located in the office – TP at page 194.

[10] Exhibit 4 – Statement of Brooke Cleeland dated 21 June 2023, TP at page 68.

IMMEDIATE SURROUNDING CIRCUMSTANCES

27. On Friday 5 November 2021 at approximately 9.00 am, Russell was discharged from Warragul Hospital and transferred back to the Willows residence via ambulance. He was accompanied in the ambulance by Caterina Durso (**Ms Durso**), the House Supervisor at the time. Ms Durso said that Russell was quite calm during the ambulance transfer, held her hand and was not coughing.[11] On his return to Willows, Russell was moved into his Unit on the ambulance stretcher and transferred directly from the stretcher onto a Hi Lo bed that was in place in his room.[12]

28. At approximately 1.30 pm, Ms Cleeland and Ms Aberdeen attended Willows for a home visit and met with three of Russell's usual carers.[13] New equipment including a commode, pressure cushions and a wheelchair[14] and instruction on how to use the equipment and how to provide bed-based care[15] was provided to the carers. Ms Cleeland was able to complete a physical assessment of Russell with the assistance of his carers as he appeared to Ms Cleeland to be more relaxed than when he was in hospital and was more responsive to directions from his carers. Ms Cleeland stated that she observed Russell capable of the movements of spontaneously roll and sit up in bed without difficulty although he remained unable to ambulate. She also observed him eat a bowl of food. She did not observe any difficulties with swallowing or any coughing, and his breathing seemed normal.[16] Ms Cleeland and Ms Aberdeen left Willows at approximately 2.45 pm.[17]

29. At 4.45 pm, Aruma staff member Kim Gale (**Ms Gale**), recirculated Ms Carew's email dated 1 November 2021 to staff at the Willows email address.

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[11] TP at page 329.

[12] TP at page 301.

[13] Ms Cleeland believed the carers to be Amanda and Kim and the floor manager, Rina was also present – see Exhibit 4 – Statement of Brooke Cleeland dated 21 June 2023, TP at page 75.

[14] TP at page 70.

[15] TP at page 72.

[16] Exhibit 4 – Statement of Brooke Cleeland dated 21 June 2023, TP at page 74, 78, 80.

[17] TP at page 75.

30. Aruma had arranged for extra supports for Russell in the form of an active night shift member to solely observe him throughout the night. This was arranged through H1 Healthcare agency (**H1**). The staff member provided to perform this role was Ejikeme Godson Okoli (**Mr Okoli**). This was in addition to the usual staffing of an inactive (sleepover) night shift staff member. Mr Okoli was engaged to work from 8.00 pm, 5 November 2021 to 7.00 am, 6 November 2021.

31. Prior to Mr Okoli's arrival, Russell was being supported by Aruma staff members Ms Gale, Christie Pentland (**Ms Pentland**) and H1 staff member Nyabol Choul (**Ms Choul**). All staff caring for Russell were provided with information regarding Russell's condition and advised to contact "000" if there was a deterioration in his health.

32. At approximately 8.00 pm, Russell was administered medication by staff which he coughed and vomited up.

33. At approximately 8.30 pm, Russell again vomited, necessitating the complete change of his bedding and bed clothes by staff.

34. At approximately 10.00 pm, H1 staff member Ms Choul completed her shift and left the residence. Aruma staff member Ms Pentland completed her evening duties and then commenced the sleepover component of her shift.

35. Between 8.30 pm and 4.00 am Mr Okoli observed and noted on the observation sheet that Russell was *awake, coughing, vomiting, screaming, and choking*. Mr Okoli also recorded that Russell was displaying *behaviours of concern* which Mr Okoli reported as Russell hitting himself in the face and throat.

36. From approximately 5.30 am, Mr Okoli recorded that Russell was sleeping.

37. Mr Okoli monitored Russell throughout the night. No calls were made to the Aruma after-hours on-call service or to "000", and Mr Okoli did not wake up Ms Pentland to convey any concerns about his observations about Russell's condition.

38. On Saturday 6 November 2021 at 6.00 am, Aruma staff member Ms Pentland commenced her morning shift.

39. Aruma staff members Stephen Mercier (**Mr Mercier**) and Candice Roeder (**Ms Roeder**) arrived for duty commencing at 7.00 am. Ms Roeder arrived approximately 10

minutes earlier than the start of her shift in order to receive a handover. She spoke to Mr Okoli about his active overnight shift with Russell and received the observation sheet. Mr Okoli completed his shift at 7.00 am and left the residence shortly after.

40. Ms Roeder went to Russell's room to check on him and found that his body temperature appeared normal to the touch and his breathing was normal. He appeared very tired. Ms Roeder woke Russell to give him his medication at approximately 7.30 am and 8.00 am and again sometime between 8.30 am and 9.30 am to give him some breakfast, each time with no ill effects – no vomiting or breathing difficulties.

41. At 10.00 am staff member Ms Gale arrived for duty. Shortly thereafter Russell's foster mother and foster sister arrived at Willows to visit Russell.

42. At approximately 10.30 am, after being given a thickened cordial drink, Russell appeared to be having difficulty breathing. In consultation with Ms Roeder and after observing Russell's condition, Ms Gale called for an ambulance.

43. Russell was taken by ambulance to the Warragul Hospital and assessed by medical staff. The provisional diagnosis was that it was likely that Russell had pneumonia from possible aspiration.[18] Following discussion between medical staff and Russell's foster mother, Ms Stewart, the decision was made that invasive intervention was not in Russell's best interests. Russell was transitioned to palliative care.

44. Russell was admitted to the medical ward. He died later that evening on 6 November 2021.

JURISDICTION

45. Russell Leslie James Hewat's death was a reportable death under section 4 of the Coroners Act 2008 ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

[18] See statement of Dr Vaitilingam – CB at page 45.

46. In addition, West Gippsland Healthcare Group – Warragul Hospital reported the death on the grounds that Russell Leslie James Hewat was a person who immediately before death was a person placed in custody or care as defined in section 4(2)(c) of the Act.

47. The death of Russell Leslie James Hewat did not strictly fall within the purview of section 52(2) of the Act[19] as immediately before his death he did not fall within the definition of "a person placed in care" as it is defined in sections 3 and 4 of the Act. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of *person placed in custody or care* in section 3(1) of the *Coroners Act 2008* to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended. The Coroners Regulations 2019 were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. The amendments also introduced an associated reporting obligation under Regulation 8 for a person who: (ii) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a Coroner or the Institute.

48. While Russell was not formally 'in care' at the time of his death on 6 November 2021, he was an SDA resident residing in an SDA-enrolled dwelling at the time of death. If reported today, his death would be considered to be an 'in care' death that requires additional steps be taken in the coronial process, including that an Inquest (public hearing) be held unless the coroner considers the death was due to natural causes, and that the Findings into the circumstances of death be published on the internet. It is of significance that the Coroners Regulations have now been updated to capture the passings of potentially vulnerable persons such as Russell, with these enhanced

[19] Section 52(2) of the *Coroners Act 2008* provides for when a Coroner must hold an inquest into a death and includes when the deceased was, immediately before death, a person placed in custody or care.

investigative processes, to ensure that any issues associated with their care are appropriately and independently canvassed by the Coroners of this state.

49. Nevertheless, section 52(1) of the Act further provides that a Coroner may hold an Inquest into any death that the Coroner is investigating. Coroners have absolute discretion as to whether to hold an Inquest. However, a Coroner must exercise the discretion in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

50. Having regard to the known circumstances including that Russell Leslie James Hewat, a person with significant disabilities residing in a supported residential home/SIL and was dependant on the care of others for all activities of daily living, it was appropriate, on several grounds, for an Inquest to be held.

PURPOSE OF THE CORONIAL INVESTIGATION

51. The Coroners Court of Victoria is an inquisitorial jurisdiction.[20] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[21] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [22]

[20] Section 89(4) of the *Coroners Act 2008*.

[21] Section 67(1) of the *Coroners Act 2008*.

[22] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

52. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[23] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[24] These are effectively the vehicles by which the prevention role may be advanced.[25]

53. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

STANDARD OF PROOF

54. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[26] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and

[23] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[24] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[25] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[26] (1938) 60 CLR 336.

- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

55. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

56. On 12 November 2021, Russell Leslie James Hewat was visually identified by his foster mother, Suzanne Stewart.

57. The identity of Russell Leslie James Hewat was not in dispute and required no additional investigation.

Medical Cause of Death

58. On 17 November 2021, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an autopsy on the body of Russell Leslie James Hewat. Prior to the autopsy Dr Lynch had available to him the Victoria Police Report of Death to the Coroner (Form 83), the e-Medical Deposition Form and medical records from West Gippsland Healthcare Group, the post-mortem computed tomography (CT) scan and information from the VIFM contact log. Following the autopsy Dr Lynch also had available to him the medical records from Peninsula Health and the VIFM toxicology report.

59. Dr Lynch completed a medical examiner's report in respect of the same on 15 February 2022.

Post-mortem examination

60. Dr Lynch commented that at autopsy there were a number of significant natural disease processes identified. The lungs showed bilateral pneumonic change with evidence of acute bronchopneumonia. There was the suggestion of increased fibrous tissue in places, but widespread organising pneumonic change was not observed. Also noted,

was focal adrenalitis, a markedly atrophic thyroid gland, cerebral oedema and sagittal sinus thrombosis.[27]

61. Dr Lynch also reported that post-mortem microbiology grew Streptococcus agalactiae and the post-mortem imaging showed bilateral increased lung markings and cerebral oedema.

Toxicology

62. Post-mortem toxicological analysis detected hydromorphone, 7-aminoclonazepam, hydroxyrisperidone, quetiapine, midazolam and ketamine. No suitable ante-mortem specimens were available from the admitting hospital.

Forensic pathology opinion

63. Dr Lynch noted that some concerns in respect of the care Russell received at the facility where he resided had been recorded in the VIFM contact log but further stated that based on the information available to him at the time of completing his report, there was no evidence to suggest death is due to anything other than natural causes. Dr Lynch ascribed the medical cause of death of Russell Leslie James Hewat to aspiration pneumonia in the setting of recent COVID-19 infection.

Aruma Disability Services Internal Investigation

64. On 10 November 2021, Aruma suspended Ms Pentland's employment on the grounds that she was identified as somebody who may have engaged in conduct in the workplace that gave rise for concern for Aruma. The suspension was pending the outcome of an investigation and the correspondence[28] advising Ms Pentland of her suspension also stated that if the allegations against her were substantiated her employment could be terminated. The allegations related to potential breaches of Aruma's MEAN policy – mistreatment, exploitation, abuse and neglect policy – for which there was stated to be zero tolerance for.

[27] Medical Examiner's Report of Dr Matthew Lynch dated 15 February 2022 – CB at page 9.

[28] See Exhibit 7 – Letter from Aruma to Christie Pentland dated 10 November 2021.

65. Following Russell's death Aruma Disability Services undertook an internal investigation into the care and supports received by Russell at Willows home prior to his rehospitalisation on 6 November 2021. The investigation was conducted by Aruma Internal Investigator Robert Brown (**Mr Brown**) and centred on supports provided to Russell by staff during the period between 7:00pm on 5 November 2021 and 11:00am on 6 November 2021.

66. As part of this investigation, Investigator Mr Brown conducted interviews with Aruma staff members and H1 agency staff involved in Russell's care. The internal investigation found that allegations of neglect by some staff members were substantiated. The allegations related to Failure to Access Medical Care and a Failure to Act, in that the concerned staff members failed to call an ambulance or escalate Russell's care when his deterioration was obvious.

67. Mr Brown made recommendations to Aruma as a result of the findings of the investigation.

Conduct of my Investigation

68. The investigation and the preparation of the Coronial Brief was at the outset undertaken by Senior Constable Donavan Headspeath on my behalf and completed by Leading Senior Constable Thevar, Police Coronial Support Unit (PCSU).

INQUEST

Direction Hearing/s

69. Direction Hearings were held on 10 May 2023, 18 July 2023 and 1 September 2023 prior to the commencement of the Inquest. The Interested Parties were given the opportunity to raise any issues in relation to the proposed Scope of the Inquest and the proposed witness list.

70. At the 1 September 2023 Directions Hearing the proposed Scope of the Inquest was discussed and I stated that the breadth of the Scope reflected that I had not had any

concessions from any of the Interested Parties about what happened to Russell, and how it was that he came to pass.[29]

71. The Inquest was listed to commence on 9 October 2023 for five consecutive days.

72. Subsequently, and prior to the conclusion of my Inquest, Direction Hearings were held on 9 November 2023 and 1 February 2024.

73. A further two days were listed for Inquest on 23 and 24 April 2024, the latter day for closing submissions from the Interested Parties.

ISSUES INVESTIGATED AT THE INQUEST

74. The **Scope** of the Inquest centred on:

    (i) Should Russell have been discharged from Frankston Hospital on 1 November 2021 in his condition?; and

    - What were his medical needs at this time; and
    - What consideration was had as to whether Aruma Services had adequate supports to manage his medical needs?

    (ii) Should Russell have been discharged from Warragul Hospital on 5 November 2021 in his condition?; and

    - What were his medical needs at this time;
    - Could these be adequately met by the supports able to be provided at Aruma Services; and
    - What other options, if any, were available?

    (iii) Was Aruma Services the appropriate service provider for Russell at this time?; If so, why? If not, why?; and

    - What steps did Aruma put in place to manage Russell's needs;

[29] Transcript of Directions Hearing on 1 September 2023 at page 12.

- What was the Care Plan put in place once he returned from hospital on 5 November 2021;
- Did Aruma Services staff and H1 Agency staff comply with the Care Plan;
- What training and/or induction was provided to H1 Agency staff; and
- Should H1 Agency staff and/or Aruma staff called an ambulance earlier – if so, when?

(iv) Was Russell's death preventable and are there any prevention opportunities?

***Viva Voce* Evidence at the Inquest**

75. *Viva voce* evidence was obtained from the following witnesses:

- Fiona Douglas[30] – Occupational Therapist, Frankston Hospital, Peninsula Health.
- Melanie Cook[31] – Registered Nurse, West Gippsland Healthcare Group.
- Brooke Cleeland[32] – Physiotherapist, West Gippsland Healthcare Group.
- Marita Carew[33] – Regional Manager, Aruma Disability Services (now retired).
- Elaine Burke[34] – Service Manager for South-East Metro Region, Aruma Disability Services (now Manager of Shared Living, Aruma Disability Services).
- Darryl Wood[35] – Support Coordinator, Aruma Disability Services.

[30] Exhibit 1 – Statement of Fiona Douglas dated 16 June 2023.

[31] Exhibit 3 – Statement of Melanie Cook dated 23 August 2023.

[32] Exhibit 4 – Statement of Brooke Cleeland dated 21 June 2023.

[33] Exhibit 5 & 6 – Statements of Marita Carew dated 15 March 2022 and 16 June 2023 respectively.

[34] Exhibit 8 – Statement of Elaine Burke dated 31 August 2023.

[35] Exhibit 9 – Statement of Darryl Wood dated 4 September 2023.

- Caterina Durso[36] - Customer Engagement Coordinator/ House Supervisor (now working only as a Disability Support Worker).
- Kim Gale[37] – Disability Support Worker, Aruma Disability Services.
- Christie Pentland[38] – Disability Support Worker, Aruma Disability Services.
- Nyabol Choul[39] – Disability Support Worker, H1 Healthcare.
- Ejikeme Godson Okoli[40] – Disability Support Worker, H1 Healthcare.
- Candice Wei Ying Roeder[41] – Disability Support Worker, (Aruma Disability Services at the time).
- Ashleigh Creighton[42] – General Manager of Quality Safeguarding and Practice, Aruma Disability Services.

MATTERS ARISING FROM THE *VIVA VOCE* EVIDENCE

Aruma's staff and their knowledge of Russell's recent illness and needs

76. The role of Aruma's Support Coordinator, Darryl Wood (**Mr Wood**) involved *liaising between the NDIA, NDIS participants, their families and service providers to coordinate support services for participants.*[43] Mr Wood was involved in Frankston Hospital's discharge meeting because the hospital had insisted that he attend. He made some notes of the meeting in respect of matters that involved him directly or *stood*

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[36] Exhibit 10 – Statement of Caterina Durso dated 2 October 2023.

[37] Exhibit 12 – Statement of Kim Gale dated 21 September 2023.

[38] Exhibit 14 – Statement of Christie Pentland dated 26 June 2023. Following an application pursuant to s57(1) *Coroners Act 2008*, a Certificate pursuant to s57(3) was granted to Ms Pentland.

[39] Exhibit 16 – Statement of Nyabol Choul dated 23 August 2023. Ms Choul's evidence was facilitated through the assistance of a Nuer interpreter.

[40] Exhibit 18 – Statement of Ejikeme Godson Okoli dated 23 August 2023. Following an application pursuant to s57(1) *Coroners Act 2008*, a Certificate pursuant to s57(3) was granted to Mr Okoli – see Exhibit 17 – Letter from NDIS Quality and Safeguards Commission to Mr Okoli dated 2 June 2023.

[41] Exhibit 19 – Statement of Candice Wei Ying Roeder dated 14 December 2023.

[42] Exhibit 20 – Statement of Ashley Creighton with attachments dated 1 February 2024.

[43] Exhibit 9 – Statement of Darryl Wood dated 4 September 2023.

out[44]. He was not involved with the rostering of staff for Russell or with any aspect of his care; his only involvement was to advise that there was available NDIS funding that Willows could use for additional staff members if required and when required.[45] Mr Wood was not informed about Russell's readmission to hospital on 5 November 2021 and although he thought that he should have been informed he was gracious to attribute this information-sharing breakdown possibly to Elaine Burke's leave during that week as he had a good working relationship with Ms Burke. Similarly, Mr Wood said that he was not contacted to participate in Aruma's internal review nor was he notified of it. He attributed this to that his role with any NDIS participant ceases on the day of their passing.[46]

77. Although retired since April 2022, Ms Carew gave evidence about her role as Regional Manager for Aruma and that this role did not include being involved in the day-to-day delivery of care to its residents. She did however know Russell, and had met him a few times she said.

78. Ms Carew had not personally gone to see Russell on his return to the SIL House. The email that she sent to the "All Staff" email address at Willows on 1 November 2021, advising staff how to care for Russell post discharge, was based, she said on information she had been told by other staff at Willows. This included the advice to "not pushing Russell to walk", which she said was based on information provided to her by staff that Russell crawled from the ambulance back into the house on his return from hospital.[47] The Incident Report relating to locating Russell "on the floor" outside, including that he crawled back into his home, was completed by Ms Durso who was at Willows when Russell returned from hospital. However, Ms Durso could not recall giving Ms Carew any information about this incident that would support the content of Ms Carew's email about Russell's condition and care needs.[48] Ms Durso offered that it may have been Disability Support Worker (**DSW**) Amanda Mapleson who had

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[44] TP at pages 2019 – 220.

[45] TP at page 219.

[46] TP at page 225.

[47] TP at page 116 – 125.

[48] TP at page 284.

accompanied Russell home in the ambulance, who gave that information to Ms Carew. She could not recall any other details of Russell's return from Frankston Hospital despite her own *viva voce* evidence that she was quite surprised and distressed about the "on the floor" and "crawling" incident.[49] Ms Durso did recall that she would not have had much, if anything, to do with Russell once he was back in Unit 1 as her shift finished shortly thereafter although she agreed with Counsel Assisting that being the Community Engagement Coordinator or house supervisor at the time, that it was *most likely* that she would have gone and checked on Russell and informed herself of how he was before she went off duty.[50]

79. Ms Carew was unable to identify the source of the detail about Russell's condition and care needs that she had depicted in her email to all staff. Similarly, the information she provided to all staff in that same email on 1 November 2021 was not reflective of the information contained in the Discharge Summary from Frankston Hospital.

80. Prior to Russell falling ill with COVID-19 in October 2021 Ms Roeder said that a cough was not part of Russell's usual presentation. Similarly, she had never observed Russell vomit after eating or drinking even though he had a tendency to eat and drink too fast.[51]

Handover/information sharing

81. Ms Carew was cognisant of the staff handover expectations at all Aruma residences stating that *the expectation is that there is a time allocated for handover and the staff that are the most familiar with the people living in the service would provide that handover to incoming staff*.[52] Ms Elaine Burke (**Ms Burke**) agreed with Mr Imrie of Counsel that even though handover occurred at the beginning of the shift, there is also communication during the shift,[53] it is constant communication she said, and she agreed

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[49] TP at page 290.

[50] TP at page 287.

[51] TP for 23 April 2024 at pages 4 – 5.

[52] TP at pages 104 – 105.

[53] TP at page 201.

that it was a team approach.[54] Ms Gale made a similar comment in her statement to the Court.[55]

82. Mr Imrie offered to the Court that the issue of handovers in the disability sector was fraught.[56] The significant issue appearing to be that the DSW did not get paid for any additional time either before or after their shift to enable time for a handover. Ms Roeder stated that she would always come onto her shift at least 10 minutes earlier to receive a handover so the staff member – in this case Mr Okoli – could leave on time at the end of his shift, 7.00 am. She also said that most staff at Willows would either ask or expect a handover but the fact they were not paid for time outside their rostered shift was *an issue as a lot of staff were always on time and so if the person after you came in and you did a quick handover…..it would be really basic and really fast* as the person's shift had finished and they wanted to go home.[57] According to Ms Roeder *Aruma did not tell us formally that we needed to do a handover. It was just expected from your shift*[58] although she later conceded that Aruma had given her some training when she started with them that there was a requirement of staff to ensure that they passed on relevant information to an incoming staff member.[59]

83. This lack of consistency of approach to handover likely caused by the lack of financial recompense for the time spent I suspect, devalues the importance of handover in a care delivery workplace operating on shifts. A culture where any handover is dependent on an individual DSW deciding to attend their workplace early or leave late because they believe handover to be important is neither efficient for ensuring the sharing of information across the shifts and nor is it equitable. The employer, Aruma Disability Services, is responsible for creating such a haphazard culture amongst its own workforce.

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[54] TP at page 202.

[55] Exhibit 12 - Statement of Kim Gale dated 21 September 2023.

[56] TP for Directions hearing on 9 November 2023, at page 6.

[57] TP for 23 April 2024 at pages 17 – 18.

[58] TP for 23 April 2024 at page 18.

[59] TP for 23 April 2024 at page 21.

After-hours contacts

84. In responding to questions about the after-hours service available to support Aruma staff, Ms Carew stated that the Community Engagement Coordinators (**CEC**), that cover the Gippsland area, are rostered to this position and staff requiring after-hours support would telephone the rostered CEC. This service was available to staff for an emergency or even something they are unsure about or for questions that they might have, and the CEC would provide the staff member with the information they need and provide support.[60] The next level of support for staff after-hours was to a service manager, who also participated in an after-hours roster. Escalation to a service manager was available for staff *if something significant occurs* - a death or a resident is admitted to hospital *under serious circumstances* – and then the service manager would escalate that information to the regional manager. [61] Staff were also aware, advised Ms Carew, that they could ring the NURSE-ON-CALL telephone advice service and ring "000".[62]

85. Ms Burke advised that the after-hours procedure was in the office at Willows and available for all staff including Agency staff – it sits above the Communications Book and is shown to Agency staff by Aruma staff when they start their shift.[63] Ms Burke stated that there was also a poster on the wall explaining the after-hours procedure and a booklet – also in the office.

86. According to Ms Burke communication about the residents between staff and in particular between shifts was facilitated by SCOUT, a computer program accessible by Aruma staff working at Willows. "Everything" about the resident was on SCOUT from goals set during NDIS planning meetings, appointments and a daily file note depicting what the resident had done/not been able to do *et cetera*. The expectation was that staff were supposed to enter notes on SCOUT at every shift.[64] Staff were not required to log onto SCOUT at the beginning of their shift because usually, *at the start of the shift they*

[60] TP at page 108.

[61] TP at page 109.

[62] TP at page 110.

[63] TP at page 176.

[64] TP at pages 169 – 170.

would have a handover conversation with whoever is already on shift.[65] Later in her *viva voce* evidence while under cross examination from Ms McKay of Counsel, Ms Burke conceded that SCOUT was relatively new in November 2021 and *staff were still getting used to it* and *it was not being used all the time when it ought to have been – some staff were avoiding using the computer system because it was quite a cumbersome program to use.*[66] Ms Durso gave similar evidence about SCOUT[67] and also agreed with Ms McKay that *there were some glitches in the system.*[68] Ms Pentland admitted that she had not made any entries into SCOUT on either 5 or 6 November 2021.[69]

87. This computerised system of communication for staff about the residents appeared from Ms Burke's evidence to be one within a suite of modes of communication for Aruma staff but unfortunately, I was left with the impression that although Aruma was attempting to depict the computerised system as a communication tool worthy of note, that status was clearly not given to it by Aruma's staff.

88. Also, within the suite of communication tools available to Willows staff was the Communications Book.[70] This Communications Book would be used where, if there were, for example, any changes to a resident's supports, or a resident had an appointment (although I was also informed that there was a Diary used to reflect the residents upcoming appointments[71]); these changes would be handwritten into the Communications Book and the expectation, according to Ms Burke was that it would be read at the beginning of every shift. Ms Durso gave similar evidence[72] as did Ms Gale.[73] It was not an expectation that something had to be written about each resident

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[65] *ibid*

[66] TP at page 196.

[67] TP at pages 268 – 269.

[68] TP at page 320.

[69] TP at page 463.

[70] TP at page 321 (Ms Durso agreed with Ms McKay that it was not a physical bound book but a folder with paperwork in it.)

[71] See also *viva voce* evidence of Ms Gale – TP at page 356.

[72] TP at page 269.

[73] TP at page 354.

on each shift in the Communications Book, its purpose was to provide a resource if something specific needed to be passed on/if there was a change *or something that you need to be aware of.*[74] Ms Gale said that she was *constantly writing in the Communication Book.* She said that that was "her thing" to be *constantly writing messages and things in there.*[75] Ms Gale emphasised on several occasions that she communicated *effectively via written and verbal* means and that she always filled out the Residential Services Shift Report form, which she believed was in place at the time of Russell's passing, whereas other witnesses were unable to state that it was in place, with as much certainty. Ms Gale boldly stated that *I always fill these out, constantly. I'm the only one in the house, really, that writes in these.* She volunteered that she was *not joking* making that comment but then immediately conceded that others did write in this form *but not as detailed* as her, that she put a lot more information into these forms in comparison to other staff.[76] Conversely, Ms Pentland said she did not think there was anything called a "communications folder " or "communications book" but there was a "daily shift report book" which she described as having similar functions that other witnesses had credited to the "Communications Book".[77]

89. The Communications Book was located on the desk in the office[78] and accessible to all staff including Agency staff. Also, in the office and available to both Aruma and Agency staff was each resident's Home and Living Folder which included all the resident's details from next-of-kin, dental records, health assessments and funding agreements. There was no expectation that staff coming onto a shift must review the Home and Living Folder – if something critical had changed to the resident's plan Ms Burke said that there would be a verbal conversation would be expected to occur and an

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[74] TP at page 171.

[75] TP at page 354.

[76] TP at pages 357 – 358.

[77] TP at page 465.

[78] According to Ms Burke, the office is also the staff room and the room where the passive sleepover staff member sleeps – TP at page 205.

email would also be sent to the staff as well. *If it was critically important, it would be printed and with the comms book.*[79]

90. The status of this Communications Book at Willows was not demonstrable – it was never offered to me to support the contentions of, in particular Ms Gale, and when I called for the Communications Book, in particular the entries for the days between 1 November and 6 November 2021 I was subsequently informed that the pages for those dates were blank. The legal representatives for Aruma were unable to provide an explanation.[80]

Rostering

91. The staff from Willows were not *ad idem* about whether they worked as a team across both units or if their responsibilities were tied to the unit they were rostered to work in on their shift. Ms Durso appeared somewhat flummoxed about this situation with Willows' staff.[81] Ms Roeder was quite clear about this issue in her *viva voce* evidence – that the roster specified whether you had to work your shift in Unit 1 or Unit 2.[82] Ms Roeder said that she worked predominately in Unit 1 so was very familiar with Russell.

92. In relation to the responsibilities of the sleepover shift Ms Durso said that the expectation was that if you heard a noise or someone knocked on the office door you would get up – she said that you could not ignore something like a knocking at the door – *You are still there for a reason: to be looking after the welfare of the customers*.[83] And she further said that this expectation extended to staying up after 10.00 pm if a resident was unwell. If this did occur, the after-hours contact person could be notified/called upon; the contact details of all the after-hours contact people/organisations were kept in the after-hours book in the office.[84] Ms Durso also

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[79] TP at page 172.

[80] TP for Directions Hearing on 1 February 2024 at pages 7 – 8.

[81] TP at page 248.

[82] TP for 23 April 2024 at page 4.

[83] TP at page 254.

[84] TP at page 257.

said there was the ability to claim for the time that you became "active" during your rostered sleepover.[85]

93. The decision to engage an Agency staff member to monitor Russell overnight on 5 November 2021 was consistent with the directive of Ms Carew and an acknowledgement that Russell remained compromised by his recent illness and hospitalisation. He was deconditioned and a long way from his pre-illness functionality. However, the decision to engage Agency staff for this purpose appears contrary to what was known of Russell's self-harming behaviours – that they often occurred in response to changes with carers. Ms Durso in her initial communications with H1 Healthcare was to request a DSW who was familiar with Willows but when she was informed by H1 Healthcare that such a person could not be located, Ms Durso requested that the agency DSW be familiar with Aruma. In responding to a question from Counsel Assisting if any consideration had been given at that stage to switching the staff members around so that someone from Aruma could be the active staff member that night, Ms Durso responded – *not that I recall, no*.[86]

94. Having commenced her shift at Willows at 2.30 pm, H1 Healthcare agency staff member, DSW Ms Choul confirmed that Ms Gale showed her where Russell's room was, explained to her that Russell had recently returned from hospital after contracting COVID-19 and that he was sick and could not currently walk. Ms Gale also showed Ms Choul where the kitchen was, that Russell could not eat solid foods, only pureed foods, and she also showed Ms Choul Russell's Home and Living Folder. According to Ms Choul, Ms Gale instructed Ms Choul to sit on a lounge chair outside Russell's room – she was tasked to look after only Russell[87] and to report to the Aruma staff if there were any problems with him.[88]

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[85] TP at page 256.

[86] TP at page 300.

[87] TP at page 547.

[88] TP at page 549.

95. Ms Choul's impressions of Russell when she first arrived for her shift was that he was drowsy/like he wanted to sleep, his tongue was out and his breathing was heavy.[89] Ms Gale explained that it had been a very busy day and that she had to leave the home to pick up other residents from their daily activities, so she only had time to give a brief handover to Ms Choul. She told Ms Choul to stay outside Russell's room on the chair that had been placed there and to watch him and if there were any changes to his breathing or he was vomiting, it had to be reported. Ms Gale could not recall if she mentioned to Ms Choul anything about Russell coughing.[90] Ms Choul said that Russell was coughing *on and off, on and off like that until the time he was taking his meal. Then his cough increases*.[91] She had given Rusell some pumpkin puree that Ms Gale had provided to her to give to Russell and then his coughing changed *because he was having difficulty swallowing*. Ms Choul stated that she went outside to find Ms Gale who was with Ms Pentland at the time, to report this to her – that Russell was eating and coughing and some of it was coming out, that his coughing seemed to be increasing with his eating. According to Ms Choul, Ms Gale advised her that this was normal for Russell to be coughing when he was eating.

96. According to Ms Gale she recalled that Ms Choul had a conversation with her about Russell before she finished her shift at 8.00 pm. Ms Choul had sought Ms Gale out in Unit 2 to tell her she was concerned about Russell – that he had been vomiting. Ms Gale said that she immediately went to check on Russell but that *he was fine*. She said there was *no vomit* and *nothing to be concerned about at that point in time*.[92]

97. When Mr Okoli arrived for his active shift at Willows at approximately 8.00 pm, he said he could hear Russell coughing from outside the house. He was worried about COVID-19 being active within the house and he telephoned his employer, H1 Healthcare to seek clarification. The presence of the "yellow bins" on Willows property added to his disquiet as he knew these bins were used for COVID-19 contaminated materials. He said that H1 tried to reassure him that Russell had had COVID-19 but that

[89] TP at pages 536 – 537.

[90] TP at page 373.

[91] TP at page 538.

[92] TP at page 374.

he had passed his infectious period.[93] Mr Okoli said that he was really worried about contracting COVID-19, that he would not have taken the shift if he had known that Russell had had COVID-19 and he was not satisfied by what he had been told by H1 because he could hear the cough from outside the house.[94] He said that he nevertheless decided to do his shift as he had driven 99 kilometres for it. He said he remained worried throughout his shift *because the coughing did not stop* – Russell kept coughing on and off. Mr Okoli said Russell looked distressed, *was so pale, he looked so really really sick.*[95]

Handover to Mr Okoli

98. The question of who provided or who should have provided a handover to Mr Okoli remained unclear. Ms Gale, in her interview with the internal investigator Mr Brown, said she had given Mr Okoli a quick rundown about the situation with Russell. He was arriving late for his 8.00 pm start and Ms Gale was leaving Willows as her shift had finished at 8.00 pm. By the time Ms Gale made her statement for the Court she could not specifically recall speaking to Mr Okoli but she did recall that she had told Ms Pentland that she would need to handover to the active night shift staff member. Ms Gale denied that she had told Ms Pentland that she would do that handover.

99. Mr Okoli was unsure who provided him with a handover. He said when he arrived there were three women, one of whom was Ms Choul and two other women who were Aruma staff members, one of whom finished her shift a couple of minutes after he arrived. But he was certain that it was an Aruma staff member and may have been the two of them that provided a handover, not Ms Choul.[96] Mr Okoli said that he was not told much just that his duties were to observe Russell and he was also told that his coughing was normal. He was given some background information about Russell including that he had spent 40 days in hospital and had just returned to Willows from hospital that day. Mr Okoli confirmed that he had been provided with the overnight

[93] TP at page 573.

[94] TP at page 574.

[95] TP at page 576, 602.

[96] TP at page 581.

observation sheet to complete. He could not recall if he had been provided with any other written material about Russell.

100. Before completing her shift, Ms Choul overheard a conversation Mr Okoli was having with Ms Pentland about his concerns about Russell. According to Ms Choul, Mr Okoli was trying to confirm with Ms Pentland that he could wake her up during the night if he was concerned or Russell deteriorated but Ms Pentland had responded that she was not there to do an active shift, that she would be sleeping and was not there to be woken up.[97]

101. Mr Okoli did not believe that Russell had got worse throughout his shift – he said that Russell's *coughing was bad even before I entered the house, as I could hear it from outside*. He said that he had *observed bad coughing and wheezing but as Russell did not eat any food or take any drinks during my shift with him so he did not have anything to choke on. Russell's coughing was bad on and off throughout the shift, until he fell asleep*.[98] Mr Okoli clarified that his use of the words "gasping" and "choking" on the overnight observation sheet could be attributed to grammatical error and his inability to use the most appropriate ways to explain his observations.[99] Mr Okoli had previously explained that English was his second language - he was born in Nigeria and that his first language was Igbo. He also confirmed that Russell had not vomited after 10.00 pm otherwise he would have written that on the observation sheet.[100]

102. Mr Okoli also explained what he meant by "behaviours of concern" that he had documented on the overnight observation sheet and this had referred to Russell hitting himself with his hand to the face, head and neck[101] and that he would only be doing this sometimes whereas, his cough was *more consistent*.[102] Mr Okoli also explained that his use of the words *screaming* and *gasping* on the observations sheet were most likely due

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[97] TP at page 559.

[98] Exhibit 18.

[99] TP at page 571.

[100] TP at page 603.

[101] TP at page 585, Exhibit 18 – Statement of Ejikeme Godson Okoli dated 23 August 2023.

[102] TP at page 587.

to his inability to find the actual word in English to explain his observations of Russell. Mr Okoli said he did not ring for an ambulance or wake the sleepover Aruma staff member, Ms Pentland, because he was reassured by Aruma staff that there was nothing wrong with Russell's coughing. He also stated that he did not believe it was for the casual staff, who did not know Russell's history, but more so for the organisational staff to ring for an ambulance. He reflected that *if I knew what I know now, maybe I would have presumed to call an ambulance.*[103]

103. Mr Okoli confirmed that he left Willows at 7.00 am on 6 November 2021 and that he was 100 percent sure that he handed over the observation sheet document and that there must have been a conversation with one or two people and then he was told he could leave.[104]

104. Ms Burke said that it was the responsibility of the Aruma staff member to provide support to any Agency staff. In these circumstances, it was Ms Pentland's responsibility. She was the only Aruma staff member in the house available to check on the Agency staff in Unit 1 up until the time she started her Sleepover shift at 10.00 pm. Similarly, she was the only Aruma staff member in the house between 6.00 – 7.00 am that could ensure the Agency staff member and Russell were okay, did not require anything additional or that the Agency staff member did not need a break.[105]

105. Ms Roeder confirmed that when she commenced her shift at 7.00 am on 6 November 2021, she went to Unit 1 where she had been rostered and received a verbal handover from Mr Okoli as well as receiving the overnight observation sheet from him. She said that she recalled noting that Russell had a really unstable night and that he had gone to sleep at about 5.00 am. She said that she was a bit concerned about what Mr Okoli had recorded because this was not Russell's usual presentation – she had never seen him sick before.[106] Ms Roeder said that she discussed Mr Okoli's observations of Russell

[103] TP at page 592, 595.

[104] TP at page 603.

[105] TP at page 204.

[106] TP for 23 April 2024 at page 15.

and that he told her that Russell *was coughing and he was awake for most of the night.*[107]

Documentation

106. A recurring theme in the evidence of Willows' staff was the lack of appreciation about the importance of documentation. The Regional Manager, Ms Carew made no notes, neither contemporaneous or retrospective about her discussions with health care professionals from either Frankston or Warragul Hospital around discharge planning for Russell despite being the senior management person co-ordinating Russell's return to his home. The concept of an *aide memoir* and a means of communication that documentation contributes to in the health care setting appears to have been absent from regular or accepted practice at Willows and I assume, other Aruma premises given that Ms Carew advised that she was the Regional Manager of approximately 30 residential premises. The irony of Ms Carew's evidence that she could not recall/could not remember and/or could not specifically remember who she spoke to at either of these hospitals or the exact content of those discussions, was not lost. Ms Cleeland and Ms Cook on the other hand made contemporaneous notes of their conversations with Ms Carew, gave oral evidence and maintained their recollections. The evidence of Ms Cleeland and Ms Cook are preferred to that of Ms Carew's.

107. Ms Durso had also suffered a loss of memory about the detail of events around Russell's return from Frankston Hospital despite having completed an Incident Report about Russell being "on the floor" outside and left to crawl back into Willows from his transport. Ms Durso often remarked that "it was such a long time ago" to support her inability to remember specifics. Ms Burke on the other hand said in her *viva voce* evidence that she had kept notes – just her scribbles – about the numerous conversations she had had with Frankston Hospital staff prior to Russell's discharge but she had shredded them during a renovation clear up of her study at her own home.[108] A somewhat regrettable action given Russell's death was still under investigation by the Coroner – the fact of which I felt compelled to raise with Aruma's Counsel, Mr Imrie

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[107] TP for 23 April 2024 at page 7.

[108] TP at page 179.

that it was concerning that Aruma had not retained documentation pertaining to Russell's passing when they were fully aware that his death was being investigated as a reportable death.[109] Ms Gale's memory fluctuated during the course of her *viva voce* evidence and in particular around questions about whether there was a system in place at the time of being allocated/assigned to a particular Unit for one's shift; she had no recollection of there being such a system despite reference in her own statement to the Court about assignment to a Unit.[110] Overall, Ms Gale's memory of the events and conversations she had or did not have with other staff, agency staff, who was working where and who was responsible for giving handover was fraught with her response "I do not recall" given with monotonous regularity. She did concede that she remembered things that she saw, like Russell sitting up in bed, but could not remember conversations. She thought that she had perhaps *blocked a lot of it out* despite agreeing that it was a big day – *it was pretty traumatic*.[111]

Russell's overall presentation

108. In relation to the question whether Russell should he have been returned to hospital earlier than mid-morning on 6 November 2021, Ms Gale said that there was nothing concerning about Russell's cough on the afternoon of 5 November 2021 – *because if there was, I would've called an ambulance just like I did the next morning*. Ms Roeder said that when she first went into Russell's room on the morning of 6 November 2021, she was close enough to him to see that his breathing was normal. Later she woke him at 7.30 am to give him his medication at which time she thought that Russell appeared slightly more groggy than usual but otherwise there was nothing unusual about him.[112] By 8.00 am when Ms Roeder was giving Russell his next round of medications she said, *he was responding to me so he was more awake than previous medications*.[113]

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109 TP at pages 331 - 332

110 TP at pages 396 – 399.

111 TP at page 424.

112 TP for 23 April 2024 at pages 8 - 9.

113 TP for 23 April 2024 at page 9.

109. From around 10.30 am when Russell's foster mother and foster sister arrived for a visit Ms Roeder said that Ms Gale had been in and out of Russell's room and that she had even gone to the front door with Ms Roeder to let Russell's family in. She said that Ms Gale then retrieved a photo album at Ms Stewart's request and then returned to Russell's room with it. Ms Gale was still in Russell's room when he had a drink of thickened cordial and started to experience some difficulties drinking it.[114]

110. Ms Gale said that the cough she heard on the morning of 6 November 2021 *was a different cough – you could hear the mucus in his chest.* Ms Gale went on to volunteer that *there was a little bit of a cough* on 5 November 2021 and that she raised *that with the OT and the physio, and, they seemed to think it was part of the post-COVID recovery*. She said, *they heard it too*. [115] Ms Gale remained adamant that the allied health professionals from Warragul Hospital had heard Russell cough that afternoon despite being advised by Counsel Assisting that this was contrary to the evidence of Ms Cleeland. Ms Gale continued that Russell had started coughing, *a little bit* after he had been provided with some pureed food but that *it wasn't a concerning cough. There was no vomiting. He wasn't aspirating. Nothing was coming back. Nothing seemed like it was going back down.* Ms Gale further stated that if it had been concerning, she would have escalated it, but Ms Durso was also there at the time.[116] Ms Gale stated that *you know when someone's aspirating. You can hear it* – she indicated that her experience enabled her to hear aspiration and distinguish it *between a cough and when someone's struggling because something is stuck.*[117]

Restorative and preventative measures

111. Ms Burke was not aware of any changes, including to handover procedures, occurring at Willows following the Recommendations contained within the internal review undertaken by Mr Brown, save for she had herself been involved in, supporting staff and arranging EAP, the employee counselling service. She had no recollection of the

[114] TP for 23 April 2024 at page 10.

[115] TP at page 370.

[116] TP at page 371.

[117] TP at pages 371-372.

outcome of the internal review having ever been discussed with her despite that she was in a management role and still actively involved with Willows until July 2022.[118] Ms Durso could not recall if she had personally made any changes to how she did things or how Willows was run under her supervision following Russell's death. She too had not seen Mr Brown's Executive Summary of his investigation and was not aware of his Recommendations or if they had been implemented including that she did not receive any new training about handovers and she was not aware if anything changed about the way handovers were done at Willows. Ms Durso did acknowledge that she had been given a telephone number for EAP, stating – *Yeah, that we could get counselling due to the circumstances*.[119] Consistent with the evidence of Ms Burke and Ms Durso, Ms Gale also gave evidence that she had not seen the Executive Summary of Mr Brown's investigation until *a couple of months* before giving her evidence. She did not know whether the Recommendations had been acted upon but had *a little bit of an idea* of Ms Pentland's situation and although she was not a part of any "debrief", she said that *Aruma managers always inform us to seek assistance from EAP*.[120] And perhaps even more surprising is that Ms Pentland had not been provided with Mr Brown's Executive Summary of his internal investigation despite that she had been stood down by Aruma prior to the investigation but was also the subject of an arising Recommendation. Ms Pentland saw Mr Brown's report for the first time through her legal representatives for this Inquest.[121]

112. On 23 April 2024, Mr Ashley Creighton (**Mr Creighton**), General Manager, Quality, Safeguarding and Practice at Aruma gave evidence at the resumed Inquest. In relation to a shift handover policy, he said that this had been continually reviewed – the process having been developed over 2023 and 2024, approved in April 2024 and that they were in the implementation phase. Reading from an email sent to his legal representatives on 19 April 2024, Mr Creighton said *the consistent shift handover process that has been put in place includes the shift handover guidelines and a daily communication book*

[118] TP at page 207.

[119] TP at page 312.

[120] TP at pages 390 – 391.

[121] TP at page 475 – 476.

template. These are both being developed.[122] The purpose of the new process was in part to ensure consistent handovers occur at the start and end of every shift with the guidelines providing detail of the type of information that must be conveyed during a handover. The daily Communications Book he said was a *principal document* in this process and although it is a template that can be customised to suit a particular service *it can be used to record handover information on as well as daily shift duties and tasks*. The communication book is an interim measure until the implementation of a new electronic record system, replacing SCOUT, occurs. Some work had also gone into developing a deteriorating health screening tool, but assessment of this tool indicates that it is more geared towards clinicians which the DS workers are not. A *Stopwatch Poster* has been implemented in place of the screening tool he said. Mr Creighton also informed me that a clinical practice and governance unit has been set up within his business unit, staffed by two nurses, one who is a registered nurse in a clinical nurse consultant role. He said one of the nurses is responsible for health policy and procedure and the other for health advocacy. The aim of this unit he explained was to provide support to staff in situations such as *unsafe or unplanned hospital discharges*.[123]

113. And although I have referred to Mr Creighton's evidence under the heading of "Restorative and Preventative Measures", Mr Creighton was not prepared to solely attribute any advancements/reviews and/or reforms to handover procedures and guidelines to be solely precipitated by Russell's passing.[124] He said he could not put his finger on what came first but did concede that there had *been a contribution – and particularly learnings in – in the incidents of what occurred in relation to Russell's passing that have contributed to the continuous improvement in certain facets of that*.[125]

[122] TP for 23 April 2024 at page 24.

[123] TP for 23 April 2024 at page 29.

[124] TP for 23 April 2024 at pages 43 – 46.

[125] TP for 23 April 2024 at page 44.

COMMENTS

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

1. The issues identified and agreed upon with the Interested Parties, as constituting the **Scope** of the Inquest into the death of Russell Leslie James Hewat have been addressed through the *viva voce* evidence of thirteen witnesses, material contained within the Coronial Brief[126] and closing submissions from Counsel Assisting and Counsel for the Interested Parties. Matters specifically related to the **Scope** are to be found within the body of this Finding under the headings **Matters arising from the viva voce Evidence, Comments** and the formal **Findings,** but for clarity I will refer to the specific **Scope** issues again:

   (i) <u>Should Russell have been discharged from Frankston Hospital on 1 November 2021 in his condition; and</u>

   - <u>What were his medical needs at this time; and</u>
   - <u>What consideration was had as to whether Aruma Services had adequate supports to manage his medical needs?</u>

   (a) There was no dispute that Russell had been medically cleared to be discharged from Frankston Hospital to return to Willows on 1 November 2021. There was no evidence that he required any acute medical supports at that time. Prior to his discharge there had been significant input from the hospital's multi-disciplinary team. The hospital acknowledged that they had had trouble engaging and developing rapport with Russell and with the aim of progressing his rehabilitation, it was determined that a return to the familiarity of his home with his usual carers with further allied health follow-up assessments, was likely to achieve the best outcome for Russell. The complex discharge planning meeting held on 28 October 2021 between Frankston Hospital staff and Aruma managers Ms Carew and Ms Burke, and Aruma NDIS Support Co-ordinator Mr Wood, discussed planning around Russell's discharge. On the history provided to the hospital staff it did not appear that Russell's care needs had materially changed even though they had not had the opportunity to observe his functioning out of

[126] Exhibit 21.

bed, due to Russell's resistance to the same. Similarly, Aruma staff had been unable to visit and observe Russell for themselves prior to discharge due to COVID-19 restrictions still in place at the hospital. Provision for increased supports for Russell was recommended along with the plan for further allied health intervention including referrals to Warragul Health from the hospital's physiotherapist and occupational therapist for an ongoing rehabilitation program. In addition, prior to Russell's discharge, Mr Wood contacted the NDIS to seek additional funding for supports for Russell and a COVID-19 related review of his NDIS plan was initiated. Further, his discharge from Frankston Hospital was delayed for several days to ensure that sufficient staff were available at Willows to support Russell's return.

(b) I am satisfied that appropriate consideration was given to whether Willows had adequate supports to manage Russell's needs at that time.

(ii) Should Russell have been discharged from Warragul Hospital on 5 November 2021 in his condition; and

- What were his medical needs at this time;
- Could these be adequately met by the supports able to be provided at Aruma Services; and
- What other options, if any, were available?

(a) Having returned to Willows from a prolonged period of hospitalisation on 1 November 2021, Russell was presented to Warragul Hospital Emergency Department on 3 November 2021 with a swollen right leg and a rash on his face. He was diagnosed with deep vein thrombosis to the right leg. No pulmonary embolism was identified, and he was deemed suitable for outpatient management with anticoagulation medication to reduce his risk of the DVT increasing or progressing to a pulmonary embolism. He was medically cleared to return to Willows with the need for ongoing allied health supports also being deemed necessary and were the subject of discussions between hospital staff and Aruma staff. Peninsula Health's occupational therapy and physiotherapy teams were also consulted given his recent admission and discharge from Frankston Hospital. Warragul Hospital personnel were of a similar view to Frankston Hospital in that

it was considered that Russell was unlikely to engage in rehabilitation activities within the hospital environs given his distress about being in hospital and his lack of engagement with hospital staff. Warragul Hospital staff also recognised that Russell was functionally deconditioned so he was admitted to the short stay unit to enable him to also stay overnight on 4 November 2021 and to allow time for additional staff to be rostered to support Russell's return home and for the delivery of additional equipment to Willows. A home visit by allied health staff to Willows was arranged for the day of Russell's discharge so that training could be provided to Aruma staff on how to use the additional equipment. Russell was transferred back to Willows on 5 November 2021. He was accompanied in the ambulance by Aruma Client Engagement Coordinator, Ms Durso.

(b) As Ms Gold of Counsel submitted, there was no evidence Aruma staff were not able to assist with the administration of Russell's anticoagulant medication, that they were not able or willing to participate in the training or use of the additional equipment or that any staff expressed concerns about receiving Russell back to Willows.[127]

(c) I am satisfied that it was appropriate to discharge Russell from Warragul Hospital on 5 November 2021, that sufficient consideration was given to whether Willows had adequate supports to manage Russell's needs at that time and that the additional provision of a home visit and education to Aruma staff on the use of new equipment including a Hi-Lo bed, commode and pressure cushions, addressed any perceived or possible shortcomings in supports available to Russell at Willows on his return.

(iii) <u>Was Aruma Services the appropriate service provider for Russell at this time; If so, why? If not, why? and</u>

- <u>What steps did Aruma put in place to manage Russell's needs;</u>

(a) Aruma Disability Services had been the service provider for Russell for several years. Willows was his home – the environment and the staff were familiar to him, and it was well recognised that Russell did not cope well with an unfamiliar

[127] TP for 24 April 2024 at pages 77 – 78.

environment or carers he was not familiar with, particularly if they did not understand what he was trying to communicate to them. In such instances Russell's distress and/or frustrations were acted out in self-harming behaviours. As indicated above, steps were put in place by Aruma to manage Russell's needs including their willingness to participate in education from Warragul Hospital allied health professionals to train them in the use of the new equipment. They also put in a request for additional staff through H1 Healthcare agency.

(b) I am satisfied that Aruma was the appropriate service provider for Russell as at the time he was medically cleared to be discharged from Warragul Hospital and I am satisfied that they had cooperated with and taken the advice of Warragul Hospital allied health professionals to take appropriate steps to manage Russell's needs.

- <u>What was the Care Plan put in place once he returned from hospital on 5 November 2021;</u>

(a) Although there were plans in place for a further home visit from the hospital's rehabilitation team the following week to provide further training around bed-based therapy for Russell, Aruma's Care Plan was articulated in an email prepared by Ms Carew for Russell's return to Willows on 1 November 2021 and merely re-sent by Ms Gale through Willows staff email address with the instruction that the email needed to be shown to the active nightshift staff rostered to support Russell overnight. The email "Care Plan" lacked the authority that a document might have although it covered a number of issues including instructions about positioning Russell for sleeping, use of a commode chair, and for adherence to Russell's mealtime assistance plan, recording of observations and that "000" should be called if Russell deteriorated. This email also included comment about Russell's energy levels, that he was not able to stand independently, that his mattress should be on the floor, that staff should encourage Russell to bottom scoot or crawl rather than walk and that he would be sounding chesty but that was normal, and he should be encouraged to cough. Of the email's content, Ms Carew stated that it was based on information provided to her from Frankston Hospital, Russell's presentation on return to Willows and

from her experience in the disability sector. None of which could be substantiated or corroborated including that Ms Carew admitted that she had not herself gone to see Russell on his return to Willows. Sending an email with instructions on how to care for someone returning from hospital was somewhat amateurish and its dissemination totally dependent on staff reading the Willows email address. The direction given to print a hard copy of the email and for staff to sign it after they had read it could similarly not be substantiated. Ms Gale's action of resending of Ms Carew's email on 5 November 2021 was similarly amateurish and assumed everything was the same for Russell on the 5 November as it was on 1 November even so far as not amending the content to reflect that he now had a Hi-Lo bed obviating the "need" to place his mattress on the floor.

(b) The email from Ms Carew dated 1 November 2021 and resent by Ms Gale on 5 November 2021 only barely represents a "Care Plan" but I accept that its intention was to possibly alleviate concerns of staff about the change to Russell's health and functionality and to provide instruction to call Emergency Services if his condition deteriorated.

- <u>Did Aruma Services staff and H1 Agency staff comply with the Care Plan;</u>

(a) In so much that the email of Ms Carew dated 1 November 2021 and resent by Ms Gale on 5 November 2021 can be considered a "Care Plan", it is not apparent that it was complied with by Aruma staff or H1 Agency staff however, of import is the instructions related to the nightshift staff to check Russell every half hour throughout the night and to record those checks including his breathing – that it is stable, that he is in bed, warm and comfortable and to call "000" if he deteriorates.

(b) The evidence supports a conclusion that Mr Okoli did check Russell every half hour throughout the night and did record his checks. Mr Okoli could not recall being given any other documentation about Russell including the email that purports to be a "Care Plan". If Mr Okoli was not provided with the "Care Plan" it is difficult to scrutinise whether he complied with the remainder of the instructions. What is apparent from Mr Okoli's recorded observations is that

neither he nor the Aruma staff interpreted those observations as possible signs of deterioration.

- What training and/or induction was provided to H1 Agency staff;

(a) With regard to training more generally, Ms Burke said that was the responsibility of the Agency. There is a paucity of evidence that any training or induction was provided to the H1 agency staff about Russell or his needs. Mr Imrie ultimately conceded on behalf of Aruma *that it's accepted that the handovers to both agency staff, insofar as we have an understanding of exactly what occurred, do appear to have been less than ideal.*[128]

- Should H1 Agency staff and/or Aruma staff called an ambulance earlier – if so, when?

(a) On the afternoon of 5 November 2021, Physiotherapist Ms Cleeland provided a training session to Aruma staff members and did not observe Russell to be coughing. She did observe Russell sitting up and eating a bowl of food without difficulty and she did not observe him experience any difficulties with swallowing. I accept Ms Cleeland's account of Russell's condition as it was at that time and cannot accept Ms Gale's evidence that Ms Cleeland knew Russell was coughing. I am satisfied that during the time that the allied health professionals were at Willows on the afternoon of 5 November 2021, an ambulance was not required.

(b) Subsequent to the training session, into the evening of 5 November 2021, overnight and during the early morning of 6 November 2021, Russell's condition appears to have fluctuated although the evidence of the Aruma staff was inconsistent and even at odds with the concerns expressed by H1 Agency staff such that it is not possible to say, with any certainty, if there was an earlier point in time that an ambulance should have been called. Mr Okoli's observations of Russell, even before Ms Pentland started her sleepover shift, reflect a deterioration in Russell from the time of the training session. Prior to Mr Okoli's shift commencing, Ms Choul had sought out Ms Gale to articulate her concerns

[128] TP for 24 April 2024 at page 99, 106.

about Russell. Both Ms Choul and Mr Okoli's concerns were dismissed by Aruma staff. Ms Pentland neither personally checked Russell or reviewed Mr Okoli's observations of Russell prior to commencing her sleepover shift or in the morning of 6 November 2021 when she recommenced the "active" part of her shift. Her exchange of text messages with Ms Gale after Ms Gale had left the facility on 5 November 2021 did not prompt Ms Pentland to oversee all that was happening at Willows that night or take the advice of Ms Gale to contact the After Hours service.[129] Perhaps the explanation for Ms Pentland's "inactions" and/or apparent failure to "oversee" lies in her belief that she was rostered on for Unit 2 for a sleepover shift and that she is not employed, nor paid, to supervise anyone including an agency DSW. She was also possibly not fully cognisant of the most recent developments in relation to Russell's health that had occurred in the days preceding her shift commencing on 5 November 2021 having last worked at Willows on or about 19 September 2021. Furthermore, it is likely she did not receive a formal handover from Ms Gale.

(c) To her credit, Ms Pentland conceded that with the benefit of hindsight, she should have checked in with Mr Okoli before going to bed and again in the morning to ascertain how Russell was and that this did represent a lost opportunity.

(d) If the signs and symptoms as recorded by Mr Okoli in the evening of 5 November 2021, and through the night into 6 November 2021, had been interpreted as a deterioration of Russell's condition, then an ambulance should have been called in accordance with the instructions in Ms Carew's email "Care Plan".

(iv) <u>Was Russell's death preventable and are there any prevention opportunities?</u>

(a) Russell had a history of aspiration and proximate to his death he had a prolonged period of hospitalisation after having contracted COVID-19. But he was medically cleared to return to his home, Willows, by both Frankston Hospital, Peninsula Health and then days later by Warragul Hospital, West Gippsland Health. Between only the afternoon of 5 November 2021 and the morning of 6

[129] See CB at pages 95 – 96.

November 2021 Russell's medical condition significantly changed such that he required urgent transfer to hospital on 6 November 2021, and within hours of his admission was transitioned to palliative care. However, I cannot identify a specific event of aspiration that led to the development of pneumonia that might enable me to say it should have been acted upon and *apropos* of that action Russell's death would have been prevented.

(b) Prevention opportunities can be learnt from the examination of the circumstances of Russell's death, as we have done during the Inquest. The "opportunities" are the prevention of like deaths from like circumstances or in other words, has anything been learnt from Russell's death? I will address this issue in my formal Findings below.

2. Mr Creighton, perhaps unwittingly, summed up the tragedy of events surrounding the decline in Russell's health when responding to me about questions about handover/effectively communicating concerns, when he said:

I would say that there is variability because it is a perception that is held. It is a perception that someone has gained or gathering during the course of their shift and that can differ amongst people's perceptions on - on the health status of Russell, differed amongst multiple people working in the sector.[130]

CONCLUDING COMMENTS

3. Aruma's participation in the Inquest into the death of Russell Leslie James Hewatt was disappointing and not of a standard that I have come to expect of organisations/entities where a person in their care and receiving services from them, has been the subject of an Inquest. Aruma did little to assist me with my investigation. They did not offer up any information or documentation that could have contributed to providing a better understanding of the circumstances surrounding Russell's death. When specific documents were mentioned by one of Aruma's staff and then requested by me to be produced there was a somewhat repetition of the response that the document could not be located. They

[130] TP for 23 April 2024 at pages 41 – 42.

did not offer up appropriate witnesses until again a specific request was made to them.[131] Overall, the evidence of their staff members was unhelpful due to their almost contagious lack of memory of events over a period of less than one week, albeit in 2021 but it was the period of time where their long-term resident, Russell came home from hospital, returned to hospital, returned to his home and then ultimately was returned to hospital where he died shortly thereafter. Their collective evidence was of little value, and some unfortunately, unreliable. And although I appreciate that the passage of time affects the clarity of ones' memory, there was an air of almost rehearsed similarity of the phrase "I do not recall" and "it was such a long time ago". For example, despite Ms Gale's self-pronouncements of her professional approach to her position and to those in her care, a large part of her *viva voce* evidence was difficult to accept and at times she was evasive. I do however, acknowledge that Ms Gale's presentation may have been due to the stressful nature of being called to give evidence at an Inquest. There was an element to her presentation during the giving of her evidence that suggests she was overwhelmed – I am not suggesting that she purposely sought to misrepresent.

4. And, despite having held its own internal review and stood down Ms Pentland[132] immediately following Russell's passing, not one member of Aruma's staff that gave evidence at the Inquest had been provided with, or indeed read the investigator's Executive Summary nor were they aware whether any of his recommendations had been implemented by Aruma. And furthermore, and again despite their own internal review and the recommendations of their investigator, Aruma Disability Services did not make any concessions about the circumstances surrounding Russell's passing – an action which may have had the effect of minimising the need for certain, if not all witnesses to attend Court in person. The provision of appropriate concessions can, in certain circumstances even obviate the need for an Inquest. Consequentially, the Inquest into the death of Russell was protracted and a number of Aruma's own staff were required to attend Court and give evidence under oath/affirmation – a task that I am sure was daunting for them.

[131] See for example my discussion with Mr Imrie of Counsel - TP at pages 426 – 427 and again at TP at page 518 and 605. My discussion with Mr Knight, MinterEllison Lawyers at the Directions Hearing on 1 February 2024 - TP at pages 2 – 3.

[132] I also acknowledge that Mr Okoli was stood down by H1 Healthcare Agency on an allegation of neglect in his care of Russell in the days following Russell's death and before Aruma's internal review commenced.

5. Overall, I was disappointed how Aruma Disability Services presented itself during the Inquest into the death of Russell. Aruma is a provider of disability services to a vulnerable cohort of people in our community but rather than being reassured that they were a competent, caring and professional service provider I was left with a feeling of disquiet.

6. I acknowledge and applaud Disability Support Workers *per se* for the work they do and the care they provide to people such as Russell who have significant disabilities and who are dependent on DSWs for their activities of daily living. DSWs are not medically trained and so the standard of care expected in response to a "medical event" is of course much lower for the DSW than for a medically trained person. Consequentially, it is imperative that DSWs are sufficiently supported by their employer so that they can respond appropriately to a "medical event" when called upon to do so.

7. Predicting a change to outcomes based on surmising that the utilisation of an Aruma staff member to do the active overnight shift to "special" Russell is speculative, but on the evidence of Aruma's own staff, it would have been more apparent to an Aruma staff member who knew Russell, that any self-harming behaviours were not related to a change in carers but because he was distressed about something else and similarly, any changes or deterioration in Russell's wellbeing would have been more easily recognisable because of their familiarity with Russell. Those capabilities were not on the other hand, available to the Agency staff member, Mr Okoli.

Disability Royal Commission

8. Before I proceed to make my formal Findings I will touch on the outcomes of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability insofar as they relate to my investigation into Russell's death.

9. The Royal Commission was established in April 2019 and its Final Report including 222 recommendations was tabled by government in the Australian Parliament on 29 September 2023. Having considered the Final Report, I have noted recommendations that I hope will rectify some shortcomings in care I have identified during my investigation.

10. Recommendation 7.38 *Minimum service standards and monitoring and oversight of supported residential services and their equivalents* recommends that government

entities responsible for regulating supported accommodation services should develop and implement minimum service and accommodation standards, strengthen oversight mechanisms, and increase service-level monitoring activities. Those minimum standards should require all providers to develop support plans for each resident and keep up-to-date records of how services are delivered in line with support plans, to allow regulatory bodies to more effectively monitor the quality of supports and services by regulatory bodies. Monitoring and oversight mechanisms should require ongoing audits, establish compliance activities in response to audit results, and establish procedures to monitor services in response to complaints and incidents.[133]

11. The Victorian Government has indicated that it accepts in principle this recommendation and in July 2024 established the social services regulatory scheme. The scheme requires mandatory registration for all social services funded or provided by the Department of Families, Fairness and Housing and means minimum service standards will apply to supported residential services. The standards cover safe service delivery, safe service environment, safe workforce, service user agency and dignity, feedback and complaints, and accountable organisational governance.

12. Recommendation 10.8 *A national disability support worker registration scheme* recommends that the Australian Government should establish a national disability support worker registration scheme by 1 July 2028. The design of the scheme should consider, *inter alia*, a code of conduct and minimum standards for registered disability support workers, recognition and accreditation of workers' qualifications, experience, capabilities and skills, and continuing professional development requirements for disability support workers.[134]

13. The Australian Government indicated that this recommendation is subject to further consideration with a report with advice and recommendations informing their response. On 2 August 2024, the NDIS Provider and Worker Registration Taskforce published a report detailing it "supports worker registration" and suggests it be "mandatory",

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[133] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report* (2023), Volume 7.

[134] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report* (2023), Volume 10.

however stated that "further work needs to be done in co-designing with the disability and community sector" before it could be executed and implemented.[135]

14. I am hopeful that the implementation of these recommendations will promote and enforce the importance of handovers, documentation and escalation of concerns for both individual disability support workers and the organisations they are employed by – all issues I have been troubled by and have attempted to interrogate during the course of my investigation.

15. The Royal Commission also recommends the establishment of disability death review schemes. Recommendation 11.14 *Establishing disability death review schemes* recommends states and territory governments establish disability death review schemes including functions to monitor and review "reviewable deaths" of people with a disability, formulate recommendations to prevent or reduce reviewable deaths and the powers to scrutinise systems for reporting reviewable deaths, conduct own motion investigations, and refer identified concerns about conduct or service provision to relevant regulatory bodies. Recommendation 11.15 sets out what should be considered in formulating the definition of "reviewable death" and, relevant to Russell's circumstances, includes the death of a person with a disability living in supported accommodation at the time of their death. Recommendation 11.16 recommends that the Australian Government and state and territory governments enter into a national agreement regarding disability death reviews including information sharing, data collection and reporting requirements.[136]

16. The Victorian Government has accepted recommendations 11.14 and 11.15 in principle and will consider recommendation 11.16 further. It notes that they will work with the Commonwealth, states and territories to develop an appropriate scheme that would fulfil the recommendations, and to achieve a nationally consistent approach in the review and development of the legislation needed.

[135] NDIS Provider and Worker Registration Taskforce Advice, 2 August 2024, pages 92-93.

[136] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report* (2023), Volume 11.

17. The Australian Government has indicated that recommendation 11.16 is subject of further consideration, but recognises the importance of systemic reviews of the deaths of people with disability and have committed to work together with state and territory governments to further consider the appropriateness of a national agreement on disability death reviews alongside state and territory consideration and development of disability death review schemes consistent with recommendations 11.14 and 11.15.

18. While coronial investigations will continue to be a mechanism for the review of deaths of people with a disability, the establishment of a disability death review scheme would hopefully incorporate processes to be followed by providers and their staff which might help to enforce incident documentation, the timely escalation of concerns and the retention of relevant documents. I endorse these recommendations of the Royal Commission and I expect that they may go some ways to avoiding some of the exceptional shortcomings seen in my investigation into the death of Russell Hewat.

FINDINGS

Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

1. I find that the identity of the deceased is Russell Leslie James Hewat born 28 April 1988, a person with significant disabilities, residing at Willows, Aruma Disability Services, died on 6 November 2021 at Warragul Hospital, West Gippsland Healthcare Group, 41 Landsborough St, Warragul VIC 3820.

2. I find that the decision of Frankston Hospital, Peninsula Health to discharge Russell Leslie James Hewat on 1 November 2021 was reasonable and appropriate in the circumstances – he was medically cleared for discharge and significant consideration and consultation between the ARP allied health professionals and Aruma Disability Services staff occurred in preparation for his discharge. Accordingly, I make no adverse findings against Peninsula Health.

3. AND I find that the decision of Warragul Hospital, West Gippsland Healthcare Group to discharge Russell Leslie James Hewat on 5 November 2021 was reasonable and appropriate in the circumstances – he was medically cleared for discharge and significant consideration and consultation with Aruma Disability Services occurred

regarding his needs and Willows' capacity to provide for them. Accordingly, I make no adverse findings against West Gippsland Healthcare Group.

4. AND I find that Aruma staff failed to appreciate the significance of Russell James Leslie Hewat's symptoms of coughing and vomiting on his return from hospital on 5 November 2021 and significantly, failed to respond to and/or escalate the concerns of two agency disability support workers who I accept, raised their individual concerns to Aruma staff members about Russell Leslie James Hewat's health and the extent of his coughing and vomiting. Instead, I find that the Aruma staff members were dismissive of these expressed concerns.

5. AND although I accept that the Aruma staff members are not medically trained I find that they collectively had available to them information about Russell Leslie James Hewat that they did not share with the agency disability support workers, nor did they take the time to inform themselves about any benchmarks or clinical indicators for seeking advice and support to their decision making to ignore the concerns of the agency disability support workers.

6. AND although it is not possible to say *when* the aspiration event occurred that led to Russell Leslie James Hewat's unrecoverable deterioration it is also not possible to rule out that he aspirated on a number of occasions from the evening of 5 November 2021 and the morning of 6 November 2021 including possibly at the hospital. Whether there was one incident of aspiration or several incidents and at what point in time it/they occurred, is not possible or necessary for me to make findings on. However, I am able to find, on the weight of the evidence and on the balance of probabilities that the distress exhibited by Russell Leslie James Hewat and the change in his condition/presentation, albeit that it vacillated, was not appreciated, nor recognised as a deterioration and as a consequence, not acted upon as had been intended by the instructions of Ms Carew to call "000" if Russell's condition deteriorates. And consequentially, I find that there were opportunities lost to call an ambulance for Russell Leslie James Hewat at an earlier time.

7. AND I find that the failures of Willows' staff are indicative of a poorly supported workforce by Aruma Disability Services. The lack of definitive policies and procedures

in relation to handover responsibilities, documentation requirements, whether duty responsibilities were limited to one Unit or to the house as a whole and the responsibilities of the sleepover shift person created a culture of minimal responsibility towards the residents and for each other. Consequentially, I find that this unsupportive and somewhat chaotic workplace served as an opportunity lost to provide Russell Leslie James Hewat with earlier intervention.

8. AND I find that Aruma Disability Services were initially proactive in responding to the circumstances of Russell Leslie James Hewat's death by initiating an internal review. They also stood down the disability support worker who was in the house overnight between 5 and 6 November 2021. However, despite receiving the Executive Summary of their internal review dated 7 March 2022, I find Aruma Disability Services failed to inform their staff of the review findings and more significantly have failed to implement any changes to workplace practises that might improve the delivery of care to its residents and improve the culture of its' workforce. I find that Aruma Disability Services as an employer let its workforce down with the consequences that Russell Leslie James Hewat was let down.

9. AND save that I have commented and made Findings in relation to "staff" at Willows as was necessary by their involvement in the circumstances, my "adverse" comments and Findings should be seen to be directed at Aruma Disability Services and not at those individual employees.

10. Similarly, I make no adverse findings against the H1 Healthcare agency staff members, in particular Mr Okoli, who were similarly unsupported by Aruma Disability Services and I find that his failure to escalate his observations of Russell Leslie James Hewat was founded in the lack of a comprehensive handover and on reassurances he was provided that Russell's coughing was normal, despite expressing concerns about the same to Aruma staff.

11. I accept and adopt the cause of death as ascribed by Dr Matthew Lynch and I find that Russell Leslie James Hewat died from Aspiration Pneumonia in the setting of recent COVID-19 infection.

12. AND having considered all of the circumstances and applied the requisite standard, on the balance of probabilities, I am unable to find to a comfortable level of satisfaction, that the death of Russell Leslie James Hewat was preventable.

RECOMMENDATIONS

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

1. With the aim of promoting health and safety in the supported independent living disability sector where this vulnerable cohort are dependent on others for care, I recommend that Aruma Disability Services advance, without further delay, the implementation of a handover policy that is both rigorous and supports its workforce to effectively deliver handover between shifts by providing appropriate compensation to facilitate this handover crossover time.

2. With the aim of promoting health and safety in the supported independent living disability sector where this vulnerable cohort are dependent on Disability Support Workers who are not medically trained and hold only a basic First Aid Certificate, I recommend that Aruma Disability Services implement and mandate training on escalation - escalation on the type of situations and/or change in conditions that should be escalated by disability support workers.

I express my condolences to Russell's family for their loss.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

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

Suzanne Stewart

Glenn Hewat

MinterEllison on behalf of Aruma Disability Services

Barry Nilsson Lawyers on behalf of Ms Christie Pentland and Ms Candice Roeder

Blue Rock Law on behalf of H1 Healthcare

Mr Michael Sayers, Slater & Gordon Lawyers on behalf of Mr Godson Okoli

K&L Gates on behalf of West Gippsland Healthcare Group

Meridian Lawyers on behalf of Peninsula Health

NDIS Quality and Safeguards Commission

Victorian Disability Worker Commission

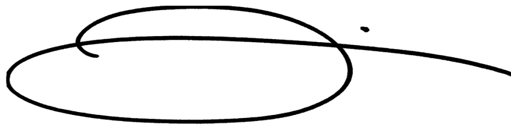
National Disability Insurance Agency

The Hon Bill Shorten MP, Minister for the National Disability Insurance Scheme

The Hon Amanda Rishworth MP, Minister for Social Services

The Hon Lizzie Blandthorn MP, Victorian Minister for Disability

Signature:



AUDREY JAMIESON

CORONER

Date: 5 September 2024

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 6 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.