FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2719/08

Inquest into the Death of CLAUS J NEFF

Delivered On:	21st October, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne 3000
Hearing Dates:	17th June, 2010, 25th June, 2010
Findings of:	PETER WHITE
Representation:	- Neil Murdoch, Barrister, acting for Southern Cross Care - Paul Halley, Solicitor, acting for Ms Jean-Francois - Landers and Rogers, instructing solicitor - DLA Phillips Fox, instructing solicitor
Place of death:	Dandenong bound train track between Webster Street and Dandenong Train Station Dandenong, Victoria 3175
Police Coronial Support Unit (PCSU):	Sergeant Tracy Weir

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2719/08

In the Coroners Court of Victoria at Melbourne

I, PETER WHITE, Coroner

having investigated the death of:

Details of deceased:

Surname: NEFF
First name: CLAUS
Address: 7/64 Stud Road, Dandenong South, Victoria 3175

AND having held an inquest in relation to this death on 17th June, 2010 and 25th June, 2010 at Melbourne
find that the identity of the deceased was CLAUS J NEFF, born on 28th February, 1932 and death occurred on 26th June, 2008

on the Dandenong bound train track between Webster Street and Dandenong Train Station

from
1a. MULTIPLE INJURIES IN A TRAIN INCIDENT

in the following circumstances:

Background

1. Mr Neff was a 76-year-old male who suffered from advanced dementia. He had lived with his wife Miriam at an address in Dandenong South over the last 24 years, and I note here that they had been happily married for a total of some 44 years at the time of his death.

2. Approximately 10 years ago, Mr Neff began to show signs of the onset of dementia and commenced treatment for that condition under the care of his Consultant Psychiatrist, Dr Hillol Das. Over this period, his dementia progressed to the point where Mrs Neff could no longer take care of him at home.[1]

3. During this time, it is also relevant that Mr Neff did not display any signs of self-harm and was described by his wife as being a gentle and loving man.

[1] See medical report at Exhibit 1, dated 6th March 2007 and evidence of Dr Das from transcript page 2.

4. It was in these circumstances that Mr Neff was admitted to the Cardinal Knox Retirement Village Closed Care Facility, on the afternoon of the 26th of June 2008. The facility housed some 52 residents and was fully occupied at the relevant time.

5. On the same evening, Mr Neff was discovered missing from the facility and at approximately 1900 hours, when his whereabouts could not be established, he was reported missing to Police.

6. After leaving the facility it is now known that Mr Neff attempted to return to his home by walking along the railway track in the direction of Dandenong station.

7. At approximately 1930 hours, an oncoming train operator observed Mr Neff seated on the Dandenong bound centre rail track. The operator immediately applied emergency braking while Mr Neff (on seeing the oncoming train), also endeavoured to move from its path. Both of these attempts were unsuccessful and the train struck Mr Neff which impact resulted in the infliction of severe injury and Mr Neff's immediate death.[2]

The Admission of Mr Neff to the Cardinal Knox Village facility

Mrs Miriam Neff

8. As indicated above Mrs Neff reluctantly agreed to admit him to the care of the Cardinal Knox Facility, which is situated at 69 Langhorne Street Dandenong, this occurring on the early afternoon of the 26th of June 2008.[3]

9. On arrival, they were admitted through the front door, which required an attendant to come and enter a code on a nearby key pad.

10. At the time, Mr and Mrs Neff were met by Administration Coordinator, Sylvia Nelson, and shown to room 45. Thereafter they waited for approximately half an hour before RN-in-Charge Natalie Jean-Francois, came. RNC Jean-Francois explained that she was very busy and had to deal with a patient suffering from diabetes. On her return following a further half hour absence, she took Mr Neff's blood pressure and weighed him.

11. I note here that, according to Mrs Neff, no other processing was carried out at this time, all of this having earlier been completed by 'Aged Care.'[4] Her additional evidence was that she

[2] I note here that Counsel for Southern Cross Care Victoria, the owners of the Cardinal Knox Village facility, accepted responsibility for his clients failure to supervise Mr Neff, 'which led to Mr Neff exiting without detection and which led to his death'.
See transcript page 2.

[3] Mrs Neff had previously visited the Centre on the 19th of June with a 'Glenora,' from 'Aged Care', who assessed Mr Neff. On this occasion, Mrs Neff saw General Manager, Nina Kraskov, who also filled out various forms and determined to admit him to the Centre. On the 26th she called the Centre and was told to bring Mr Neff in after lunch, which she did, arriving with him by taxi at around 12.30 pm. See also the statement of Administrative Assistant Kellie Sprie at Exhibit 4.

[4] See transcript at Page 16 to17.
'They had all (of) those assessment(s), his date of birth, his sickness; everything was assessed before he went there.'
See also Brief at page 190 to 200, where Aged Care Assessments are set out.

did not get a further opportunity to discuss her husband with staff, other than to say that he liked ice cream.

12. After this, Mrs Neff said good-bye and with the assistance of the staff then congregated at the front desk, she was able to exit the facility.[5]

13. According to Mrs Neff, at this time her husband was not aware that he was going to be left at the Centre and was generally restless, stating that he wanted to go home. On her way out, she recalled that she especially requested a female attendant at the front desk,

> *"to keep an eye on Claus as he was alone and confused... I felt so bad leaving him there, we had never been apart all those years".* [6]

14. It is relevant to record here that Mrs Neff's evidence as to these matters was not challenged by Counsel representing either the Cardinal Knox Village Care Facility, or RN Jean-Francois.

Administrative Coordinator Sylvia Nelson

15. Ms Nelson testified that late in the week ending the 20th of June she learnt from the Director of Nursing (Julie Milne) that Mr Neff would be admitted on the 26th. She prepared a folder for his admission. She believed she completed and returned same by Tuesday the 24th. It held all relevant documents plus blank forms for,

> *"the various assessments, progress notes and his Aged Care Assessments".*

16. Ms Nelson further testified that she sat at the front reception desk and admitted the Neff's into the building on their arrival on the 26th. She then went to the Nurse's office and informed RN Jean-Francois of the Neff arrival. With the RN's approval, she took them to Mr Neff's allocated room. She bought his luggage to the room and engaged with Mrs Neff who told her, out of Mr Neff's earshot, that she was concerned about getting away from Mr Neff, 'and was afraid that he would follow her.'[7]

17. She later observed that she was not able to converse with Mr Neff and that he did not appear to have a clear idea about what was going on.[8]

18. Her further evidence was that she was requested to call a taxi for Mrs Neff at around 1.59 pm and believes that Mrs Neff left at 2.15. She did not see Mr Neff in the foyer during this time. Later she observed him walking around the facility and appearing to engage with other residents.

[5] See transcript page 21.
[6] See Mrs Neff's statement at Exhibit 2 and further at Transcript page 19 where she details an earlier attempt to have him admitted, which ultimately she could not bring herself to complete.
[7] See discussion at Transcript page 32.
[8] See transcript at page 56.

19. At approximately 4.30pm, Ms Nelson took a telephone call from Mrs Neff who was in tears and was anxious about her husband. Ms Nelson informed her that he appeared to be doing well and told Mrs Neff that she could call at any time.[9]

20. In evidence, Ms Nelson provided an organizational chart and confirmed which staff were working on the 26th. She further testified about the position and manner of operation of the doors at the centre. I note here that the front entrance door had a key pad to use for both entry and exiting the premises.[10]

21. She did not recall witnessing a conversation between the RN and the Life Style Coordinator, Sara Cummins, in relation to the possibility that Mr Neff was a 'wanderer.'

22. Ms Nelson further testified that she was normally at the front reception desk during the hours between 9 and 5 and sometimes later, except when she took a break. She was unable to recall when she left on the day of the 26th.

23. Ms Nelson was also questioned about the kitchen door which was an alternate entry and its possible use by Mr Neff as the means of his exit.[11] Her testimony was that its use was discouraged. See also the evidence of the afternoon shift kitchen staff, Elizabeth Batshon,[12] as to its (lack of) potential for use by Mr Neff to exit the premises, on the evening of the 26th.

24. Additional evidence was given concerning the use of anti-wandering alarms and their use to warn nursing staff and personal care staff, via a DECT phone alarm, of when an 'at-risk' resident has walked to a position which is proximate to an exit door. Ms Nelson was broadly aware of their use within the facility but was unable to testify specifically concerning their availability on the 26th.

Administrative Assistant Kellie Sprie

25. Administrative Assistant Kellie Sprie further testified concerning her observations during this period.[13] Her testimony was that Mr Neff was confused and unsettled and that staff were generally aware that he was a new arrival with that matter certainly a likely issue for discussion at the 3.00pm nursing handover. [14]

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9 See Ms Nelson's statement at Exhibit 3 page 2 and 3. See evidence of Mr Neff's appearing to converse with residents in the communal lounge from Transcript page 31.

10 See chart Exhibit 3(a) and photographs at Exhibit 3(b) and transcript from page 28 concerning exiting arrangements and her evidence from Transcript page 34 about the green button for entry through the main door, during office hours, the disabling of the keypad system and use of the DECT phone by staff to assist (authorized) entry into the premises outside office hours, from transcript page 44.

11 See transcript from page 39.

12 See Elizabeth Batshon from transcript page 251 and Exhibit 15 her statement, and 15(a), her diagram of the kitchen dining room area. From all of the evidence I am satisfied that there is no reasonable likelihood that Mr Neff exited the building via the kitchen.

13 See Exhibit 4 at page 2, where Ms Sprie details Mr Neff's confusion about why he had been left at the premises and her intentionally misleading response that she, Mrs Neff, would be back, and also transcript from page 59.

14 See discussion at Footnote 34 below.

26. Ms Sprie's additional evidence was that at one point she saw him outside in a secure area, fidgeting with the gate, (seemingly trying to open it). This observation was not passed on to nursing or personal care staff. [15]

Life Style Coordinator Sarah Cummins

27. At 2.30pm, following the residents meeting, Ms Cummins, together with Ms Sprie, introduced herself to Mr Neff. Mr Neff was confused and asked about Mrs Neff. Later at around 4.00pm, (like Ms Sprie), Ms Cummins also noticed Mr Neff outside touching the gate. She went out to him and was able to persuade him to return to the communal lounge. Ms Cummins also noticed Mr Neff talking to staff and asking about the whereabouts of his wife and at approximately 4.45pm, she observed him ask a fellow resident about where the door was. She noticed this resident, a Mr Clappers, point Mr Neff in the direction of the front door.

28. Concerned about what she had seen, Ms Cummins went to see RN Jean-Francois about Mr Neff.

> *"I told her about the incident in the court yard, (the apparent attempt by Mr Neff, to open the gate); I told her that I believed Mr Neff was a wanderer and that he should have an alarm. She replied sarcastically words to the effect,*
>
> *And we don't know that?*
>
> *as if to suggest that was already known and I was stating the obvious. I told her that I was finishing in five minutes and I would not be in tomorrow."*[16]

29. Ms Cummins further testified that on the following Monday (after Mr Neff's death), she returned to the facility and wrote up her note of her observations of Mr Neff and her following confrontation with RN Jean-Francois, in the progress notes.

30. It is relevant to note here that this record was not found in the Court Brief, but had been obtained by Counsel, Mr Murdoch, who then made it available to the Court.[17]

General Manager Nina Kraskov

31. RN Nina Kraskov was the manager of the Cardinal Knox Village facility and met Mr and Mrs Neff on the 19th. She arranged for his admission on the 26th. Ms Kraskov chose this date although she knew that neither she nor Director of Nursing Julie Milne would be at the facility on the 26th.

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[15] See transcript page 65.
[16] See Exhibit 5 at page 2. Her further evidence was that she was also concerned that Mr Neff might be a risk of being subject to 'Sundowners Syndrome' (and as such be more prone to wandering in the early evening). See also the discussion at transcript page 70.
According to Ms Cummins, it was a matter for either the RN or personal carers to make a decision concerning the deployment of an alarm device.
[17] See Exhibit 5(a) at page 1, together with the discussion at transcript page 73 and 74. See also Exhibit 5(b) the Resident History Index.

32. Neither witness saw their absence on this day as a particular issue.

Director of Nursing Julie Milne

33. Nurse Julie Milne was the Director of Nursing at the time under examination.[18] On the 19th of June, Nina Kraskov informed her that Mr Neff would be admitted to the facility on the 26th of June and would take up residence in room 45.

34. Ms Milne or Ms Nelson prepared forms for the nurse who was to be on duty that day, as she knew she would be attending a conference on the 26th with Nina Kraskov, and would be unable to perform these duties herself.[19]

35. At 7.55 pm, on the 26th, she was informed of Mr Neff's disappearance and was told by PCA Autard-Barry, that she had not been able to contact Nina Kraskov. She also advised that RN Jean-Francois had left the building 'in a hurry', after the police had gone and, further, that she believed that Mr Neff had been let out of the facility by a visitor.[20]

36. Later she received a second call from PCA Autard-Barry informing that the police had advised that Mr Neff had been in an accident and was deceased. This information was then passed on to General Manager of Residential Services, Denise Bolmait, who with the CEO Jan Horsnell, immediately drove to the facility, to offer support to staff.

37. Julie Milne further testified to later reviewing the Neff file and discovering that, in her opinion, the admitting RN had not properly dealt with certain matters pertaining to admission.[21]

38. Notable among these was the failure of the RN to deal with the risk that Mr Neff may seek to abscond although this risk was identified and referred to in the falls risk assessment, which was a separate document.[22]

39. According to Julie Milne if the interim care plan had been properly completed with the need for intervention appropriately recorded, the plan should have been for Mr Neff to immediately commence to use a wanderer's alarm and for a sighting chart system, to be implemented.

40. Julie Milne's further testimony was that RN Jean-Francois had carried out this sort of admission work in the past and that it was part of her job description to fulfil this function. Her further observation was that her documentation had previously been lacking and that she had been counselled about this matter.[23]

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18 Prior to this appointment, she had held the post of nurse-in-charge of the facility.
19 Julie Milne gave the admission pack to the RN on the 24/6 at the same time informing her that she would be responsible for the admission.
20 See Exhibit 13 pages 1-2.
21 Ibid pages 6-9.
22 See full Progress Notes which includes the later added comments of Sara Cummins at Exhibit 5(a) and the notes written up by RN Jean-Francois also at Exhibit 5(a), where the need for Mr Neff to wear an alarm was also noted.
23 Ibid page 7-8.

41. Julie Milne also criticized RN Jean-Francois for attending to a 'power of attorney matter', which occupied her between 11.30am and 1.30pm, observing that priority should have been given to the admission of Mr Neff. [24]

42. Ms Milne was then referred to the Interim Care Plan drawn up by RN Jean-Francois[25] and to the Aged Care Assessment of Mr Neff, which was given to RN Jean-Francois prior to the arrival of Mr Neff.[26]

43. By March 2008, Julie Milne testified that she had been setting up admissions or doing them herself for a period of some three months, with the other RN's not called upon as they worked night or weekend shifts only.[27]

44. To assist RN Jean-Francois on this occasion, Ms Milne stated that she had prepared a checklist for her to complete.

45. Ms Milne further stated that in the previous three months, Jean-Francois may have done one admission only but would as a Div 1, have done them in the past.[28] They had not discussed the new admission procedure, but she was satisfied that as a Div 1 nurse Jean-Francois had the requisite skill.

> *"Oh the fact that she was a registered Div 1... She had a duty of care; she'd been working at the facility for quite a while."*[29]

46. Ms Milne's further observation was that had Mr Neff been on a sighting chart with sightings required at a particular interval that this may well have contributed to his early rescue.[30] She also observed that the falls risk assessment was incorrect because it omitted to assess his depression.[31]

RN Jean-Francois

47. RN Jean-Francois testified that she was the In-Charge RN on the 26th of June. She was initially delayed but attended to the Neffs in Room 45 from 12.30pm, in accordance with the plan previously laid out by Julie Milne. According to Jean-Francois, Mrs Neff informed her at this time that Mr Neff tended to wander.

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24 Ibid page 8, where she also makes further criticisms concerning the prioritizing and timing of RN Jean-Francois' provision of insulin to other residents during the period Mr Neff was waiting for the admission process to be completed.
25 See Exhibit 18(a) at Brief page 183 where it is noted that Mr Neff is assessed as minimal comprehension and impaired hearing and Exhibit 13 (b). See discussion at transcript page 165.
26 See Exhibit 2(b)
27 See discussion at transcript page 169-170.
28 Ms Milne again acknowledged that RN Jean-Francois had a history of documentation error.
29 See transcript page 175.
30 See transcript at page 191-92.
31 See transcript at page 193 and Exhibit 13(d). I note here the observation made by RN Jean-Francois that Mr Neff tends to abscond and the need to keep him in a secure environment, is again referred to in this assessment.

48. Mr Neff was neatly dressed in a brown suit and was wearing a white shirt. After some difficulty, she was able to finally take his blood pressure and weigh him. She further recorded that he tends to abscond and will need the doors locked at all times.[32]

49. According to Jean-Francois, she had made a decision that Mr Neff needed a wandering alarm.[33]

50. After completing the interview, but not the paperwork, Mrs Neff departed. Thereafter, Jean-Francois had to attend to various other administrative duties until at around 3.00pm she attended the handover and, according to her initial version, referred the PCA's to Mr Neff's wandering, and the care plan.[34]

51. When examined about the transcript of that meeting, however, Jean-Francois admitted that she simply informed the PCA's that the admission papers had not yet been completed and confirmed that she hadn't mentioned to them the fact that no working personal alarm was available.[35] She further stated that she hadn't informed Julie Milne that she couldn't locate an alarm because she was too stressed and had too much to deal with.[36]

52. Her further testimony was that she did not feel competent to do admissions.

> *"I was able but I did not do enough admissions at Cardinal Knox to be competent in doing them."*[37]

Mr Neff's Departure

53. An elderly man was seen outside of the facility at approximately 6.10pm by eyewitness Kathleen Herraman who considered that this person must have been a visitor, based on the quality of his clothing.[38]

54. There are signs on the front entrance advising visitors to not let the residents leave the facility. The front entrance doors also have a delay before they close, to allow elderly and infirm people sufficient time to enter or exit. Based on the door delays and lack of any adjoining

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32 See statement at exhibit 16, page 3 and transcript at page 363, where she testified that Mrs Neff stated that her husband likes to wander.

33 See Jean-Francois' statement at Exhibit 18 at page 3, and at transcript 372-73, and at page 400, where she states that she recorded this only after Mr Neff was discovered missing. See also her examination at page 408 where she agreed with Mr Murdoch for the Home, that she told an earlier inquiry that she did not think Mr Neff needed an alarm at that time.

34 See ibid page 4. See however the tape and transcript of the handover at Ex 7 (d) and 7(e), where the (handover meeting) transcript establishes that this exchange did not occur and that the need for a warning alarm (or its unavailability), was not referred to at the handover meeting.

35 See transcript page 398

36 See transcript at page 373.

37 See transcript page 393.

38 Numerous statements noted how Mr Neff was very well dressed on the day of his admission, and this may have influenced his ability to leave the facility as another visitor exited through the main front doors. See also Exhibit 6 at page 1. There was no record kept of the CCTV monitoring of the front entrance area which would otherwise have further assisted this line of inquiry.

antechamber, I am satisfied that it is also possible that Mr Neff exited the facility without attracting the attention of an exiting visitor.

55. Elizabeth Batshon (Food Services Assistant) stated that she allowed "Alex, the Pharmacist" to enter through the kitchen at 6.00pm (pg 95). Rumali Madawala (PCA) estimated that the pharmacist attended the premises at 6.20pm and only stayed for approximately 5 minutes (pg 57), leaving via the front door.

56. In the period immediately prior to absconding, Mr Neff was placed in the lounge area while the PCAs prepared the other residents for bed. According to the facility map contained in the brief, this lounge area has a line-of-site to the front entrance doors.

57. From his statement, pharmacist Alex Tranh Lac Trang had no recollection of attending the facility on that particular evening and, thus, no recollection of contact with any staff or residents. He had signed a drug order from the facility on that date, so does not dispute that he was there that evening, but in oral testimony as well, did not demonstrate any recall of any detail and had no particular recollection of Mr Neff.

Finding

I direct myself as to in what circumstances reliance may be placed on circumstantial evidence. Having so directed myself I find that,

1) I have reviewed again the evidence of all witnesses and Counsel's submissions.[39] I am satisfied that it is more probable than not that Mr Neff left the Cardinal Knox Village facility via the front door some time shortly after 6.00pm on the evening of June 26th and was later observed outside by Kathleen Heeraman. He had evidently become aware of its use from his own observations and from information provided by a resident, Mr Clappers. Further, I note here that there is no evidence that he was ever seen near the kitchen door or other evidence which supports the suggestion that he may have exited via the kitchen door. Rather, Mr Neff, dressed in his arrival suit and intending to return home (while believing that he was not doing anything other than acting appropriately), left through the front door with the unwitting assistance of either Mr Tang or another unknown visitor. At the time, he was confused and troubled about his situation and had not been informed that he had been brought to the Centre as part of a plan under which he would henceforward reside there permanently.

2) Given his confusion and the failure of staff to inform him of the permanent nature of his new situation, I further find that the early implementation of a care plan which involved frequent observations, and an ongoing management of his movement around the facility, was imperative.

[39] See transcript page 532 and in particular the exchange between Counsel and the Court at 549-550, which I have again considered.

3) As indicated above, RN Jean-Francois did not record his risk of wandering in his interim care plan, but rather in his falls risk assessment only. It is also the case that the handover meeting transcript (discussed above), makes no mention that RN Jean-Francois spoke to staff of his wandering risk and the procedures needed to be taken to address this risk.[40] From this evidence, together with the rest of the evidence, I find that while some of the PCA'S may have privately alerted themselves to the problems of Mr Neff, no specific information had been provided to them about this matter prior to his departure from the facility.

4) I also find that RN Jean-Francois had not, at least by the time of the handover, commenced to put strategies in place to meet Mr Neff's presentation.

5) One option available for incorporation within such a plan was the use of a personal alarm to be attached to Mr Neff's clothing, which would have informed staff whenever he approached the main entrance.[41] RN Jean-Francois testified that she would have employed such an alarm had one been made available to her. Against this, Julie Milne and Nina Kraskov testified that alarms were available and were found in the appropriate place in the nursing station on the morning of the 27th.[42] In this regard, I have again reviewed the various notes made by Jean-Francois on the 26th and the transcript of the handover meeting. From such review, I find myself satisfied that, during the course of the afternoon her state of mind concerning Mr Neff and a care plan was that the admission process was not complete and required a contribution from others, (including the facilities contracted GP), before such a plan was implemented, in part or in full. I am also satisfied that if she had in fact determined to employ an alarm for Mr Neff but was unable to find one, she would have sought outside assistance or, at the very least, have recorded the fact that a significant systems failure (beyond her control) had occurred.[43] I expect that in such circumstances, she would also have raised this at the handover meeting and or with other on site staff, including Sarah Cummins, who had felt so strongly that she had confronted her over the very same issue.

Having so reviewed all of the evidence together with the notes made by RN Jean-Francois at the time, I find myself satisfied that in fact RN Jean-Francois did not address the availability of a warning device for use by Mr Neff at the time of his admission or at any time prior to his departure that afternoon and it follows that I disbelieve her evidence to the contrary.

6) I further find that on the afternoon of his admission RN Jean-Francois did not complete the care plan or fully comprehend the urgency of the threat posed by Mr Neff's

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[40] Page 202.

[41] I note that had a personal alarm been affixed to Mr Neff's clothing following his arrival it is likely that he would have unintentionally caused it to be activated as he slowly became accustomed to its operation. It is also the case that its activation would have caused him further alarm and confusion.

[42] I further find that the rest of the evidence does not support the possibility that the warning devices were deliberately hidden from her, or equally surreptitiously, were replaced after June 26th, and I dismiss this as a possibility.

[43] See discussion at transcript 381.

presentation and for that reason failed to respond appropriately, this despite the cautionary exchange, which occurred between herself and Sarah Cummins.

7) Moving to the role played by senior staff at the facility, I find that the decision made by Ms Kraskov to allow the Claus Neff admission to occur in the absence of either herself or Julie Milne was ill-judged and, at the least, that the matter should have been revisited before his arrival.[44]

Both Ms Kraskov and Ms Milne, were aware of documentation difficulties, which had been evident in previous work tasks undertaken by Ms Jean-Francois. They were also aware that check list apart, no particular instruction had been given to Ms Jean-Francois concerning Ms Milne's approach to admissions which process she was overseeing at the time. I further find myself satisfied that by the 24th of June when the admission package was given to RN Jean-Francois, that she had had little or no recent experience in regard to admissions.[45]

8) In these circumstances, I consider that further direction and supervision was called for and I find that the failure to address this issue was sub-optimal.

Conclusion

I find that the failure to sufficiently up-train and supervise the work of RN Jean-Francois in regard to the admission process and related matters, contributed to her failure to comprehend the dangers presented by Mr Neff's behaviour and presentation, and to her failure to adequately respond to that danger.

Each of these failures contributed to Mr Neff's ability to leave the facility without interruption and to the tragedy which then occurred.

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

Wandering/absconding procedures and policies

Procedures for the identification and management of residents at-risk of wandering at Cardinal Knox Village are detailed by the *RS Missing Resident Procedure* document.[46] According to the RS Missing Resident Procedure, residents considered at-risk of wandering should have:

a. The risk of wandering recorded on their Care Plan and resident's medical record;

[44] See transcript at page 267.
[45] See evidence of RN Jean-Francois, from page 356-61 as to her lack of familiarity with the forms and admission process.
[46] See exhibit 13 page 7 and Exhibit 21 page 38.

b. A "Danger to Self and Others Care Plan" and "Problem Wandering/Intrusive Behaviour Care Plan" are completed and all staff are made aware of the potential risk;

c. A Resident Identification Form is required to be completed, including a recent photograph of the resident, to be provided to police in the event that the resident goes missing;

d. A wandering alarm device is to be affixed;

e. An identification device with the name of the resident, facility address and telephone number, such as identity bracelets or name tags placed on clothes; and

f. A clothing record filled out each day with a description of the resident's clothes.

In her statement, Ms Milne did not mention the RS Missing Resident Procedure, but noted that residents at-risk of wandering should have:

a. A wandering alarm device affixed;

b. An hourly sighting chart;

c. A Resident Identification Form completed; and

d. A clothing record filled out.

None of these procedures were undertaken in the case of Mr Neff.

1. In these circumstances I recommend that all staff at Cardinal Knox Village continue to undertake initial training in regard to dementia policies before their commencement of duty and, further, that each undertake a full retraining in regard to same not less than once every 12 months.[47]

2. Having regard to my discussion with Mrs Bolmait, I further recommend that the interim care admission form be amended to include a mandatory dropdown field in reference to strategies to be adopted to protect the applicant. This box would then need to be completed with details of the strategy adopted and implemented, before the remainder of the form becomes active.

Signature:

Peter White
Coroner
Date: 21st October, 2011

[47] Mr B. Gatehouse has testified as to his availability to provide a suitable instruction in this matter and this is one possibility the Cardinal Knox Village might usefully consider. Such instruction should also include advice as to how the security system operates, as per the testimoney of Mr I. Birkenhead.