IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 002604

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: Carl Robert Adler

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	23 November 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	23 November 2022
Counsel assisting the Coroner:	Ann Kho, Coroner's Solicitor
Catchwords	Disability services, in care

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I, AUDREY JAMIESON, Coroner,

having investigated the death of CARL ROBERT ADLER

and having held an inquest in relation to this death on 23 November 2022

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

find that the identity of the deceased was CARL ROBERT ADLER

born on 26 October 1971

and the death occurred between 2 and 3 June 2018

at 115 Learmonth Street, Alfredton, Victoria 3350

from:

1 (a) COLD ENVIRONMENTAL EXPOSURE IN A MAN WITH CARDIOMEGALY

in the following summary of circumstances:

1. Carl Robert Adler was 46 years of age at the time of his death. He was the middle child of three children, and is survived by his two sisters, Karen, and Julia Adler.

2. Mr Adler had a longstanding diagnosis of treatment resistant schizophrenia (1990). He was subsequently diagnosed with intellectual disability in 2014, and autism in 2015. He commenced receiving state funded disability services under the National Disability Insurance Scheme (**NDIS**) after having been diagnosed with autism[1].

3. Mr Adler had been a long-term patient of Sovereign House Secure Extended Care Unit[2] (**SECU**) at Ballarat Health Services since 2002, where he received compulsory in-patient treatment under the *Mental Health Act 2014* (Vic).

[1] This was after the rollout of the National Disability Insurance Scheme (**NDIS**) in July 2016.
[2] Secure Extended Care Units (**SECU**) are sub-acute services that are intended to provide a more settled environment within which individuals with enduring mental illness are provided with treatment and support that is aimed at developing skills for living in the community.

4. Mr Adler had no documented significant physical health concerns. He received monthly medical reviews and blood testing as a requirement to monitor his Clozapine prescription.[3]

5. In August 2017, Mr Adler commenced a gradual transition to living in a community care accommodation, a group home located at 16 Leopold Street, Alfredton (herein referred to as the "Leopold Street complex") operated by McCallum Disability Services Inc. (herein referred to as "McCallum").

6. Following Mr Adler's discharge from Sovereign House SECU and the completion of his transition to McCallum, his mental health treatment was varied to a community treatment order (**CTO**).[4] His latest CTO expired in March 2018.

7. While residing at the Leopold Street complex, Mr Adler exhibited behaviours of wandering off or leaving the premises without staff supervision or staff consent. Staff reportedly stated that he usually returned to his unit on his own shortly after leaving.[5]

8. On the evening of 2 June 2018, Mr Adler left the Leopold Street premises and was unable to be found in the nearby vicinity. He was eventually located deceased by a member of the public on the morning of 3 June 2018.

9. At the time of Mr Adler's residency at McCallum, the Department of Health and Human Services[6] (**DHHS**) was responsible for funding the majority of the disability services and functions[7] at McCallum.

THE CORONIAL INVESTIGATION

Jurisdiction

10. Mr Adler's death was a reportable death under section 4 of the *Coroners Act 2008* (Vic) ("the Act") because it occurred in Victoria and appeared to be unexpected and unnatural. His

[3] Coronial Brief of Evidence (**CB**), Police Summary, page (i).
[4] Which allowed Mr Adler to maintain mental health support and treatment on a compulsory basis from his treating team.
[5] Court File (**CF**), Disability Services Commissioner Investigation Report (DSC Investigation Report) dated 23 September 2020.
[6] Currently the Department of Families, Fairness and Housing (**DFFH**).
[7] Including the operation of the Vacancy Management Unit by assisting McCallum in assessing individuals in need of supported accommodations.

death also meets the reportability criteria of a person "in care" as defined in section 3 of the Act because the level of care Mr Adler required from McCallum was analogous to a person in care.[8]

11. Pursuant to section 52(1) of the Act, Coroners have absolute discretion as to whether to hold an Inquest. However, a Coroner must hold an Inquest if a person was a person *who immediately before death* was in the care of the State.

12. Pursuant to section 52(3A) of the Act, an Inquest is not mandatory as part of the coronial investigation into the death of a person in care, if the Coroner considers the death of a person in care was due to natural causes. As opposed to section 52(3A), although Mr Adler's death appeared to be of natural causes, the circumstances surrounding his death were unnatural.[9]

13. An investigation into Mr Adler's death was also conducted under the auspices of the *Disability Services Act 2006* (Vic) by the Disability Services Commissioner (**DSC**) who has a different scope to that of a coronial investigation, although it can sometimes overlap. The jurisdiction of the DSC is an important oversight of a particularly vulnerable group of persons in the care of disability services. The DSC's jurisdiction expands to the services provided to the deceased during their lifetime, whether those services are connected with the death.[10]

14. Pursuant to section 7(a) of the Act, a Coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite the investigation. I have therefore conducted my investigation in a restorative and preventative lens, without mirroring the DSC's investigation.[11]

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[8] But for the transition of disability services funding to the NDIS Mr Adler would still be considered a person who immediately before death was in the care of the State. Consequently, I determined that the quality of Mr Adler's care should be subjected to the same level of coronial scrutiny as a person in care.
[9] See paragraph 66.
[10] As opposed to a coroner's jurisdiction where a coronial investigation is limited to surrounding circumstances of death, which are limited to events that are sufficiently proximate and causally related to the death.
[11] See paragraphs 16 and 67.

Purpose of a coronial investigation

15. The purpose of a coronial investigation of a reportable death[12] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[13] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[14]

16. The broader purpose of any coronial investigation 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.[15] Coroners are empowered to report to the Attorney-General in relation to 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.[16] These are effectively the vehicles by which the coroner's prevention role can be advanced.[17]

17. The Coroners Court of Victoria is an inquisitorial jurisdiction.[18] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a

[12] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria, a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Unless otherwise stipulated, all references to the legislation that follow are to provisions of the Act.
[13] Section 67(1), of the Act.
[14] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[15] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".
[16] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[17] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(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.
[18] Section 89(4) of the Act.

reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[19]

18. 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.

Sources of evidence

19. This Finding is based on the totality of the material produced by the coronial investigation into the death of Carl Robert Adler. That is, the Court File, Coronial Brief of evidence compiled by Leading Senior Constable Tracey Atkins and the *Investigation Report into disability services provided by McCallum Disability Services to Mr Adler* ("Investigation Report") issued on 23 September 2020 by the DSC.

20. The brief and the Investigation Report will remain on the coronial file, together with the Inquest transcript.[20] In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Standard of proof

21. 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

[19] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.
[20] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

to the principles enunciated in *Briginshaw v Briginshaw*[21]. 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
- 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.

BACKGROUND CIRCUMSTANCES[22]

22. At a young age, Mr Adler exhibited challenging behaviours, described by his parents as *"impulsive and aggressive"*.[23] As he grew older, his "behavioural issues" worsened and progressively, his risk-taking behaviour increased.[24] Schooling also became challenging for him from about the age of 16 years.

23. Mr Adler had been living in psychiatric care facilities for most his adulthood for his safety and given his level of vulnerability. Multiple trials for him to live in less restrictive environments were not successful.

24. The "*Risk Profile"* included within Mr Adler's Clinical Risk Management Plan at the Ballarat Mental Health Services, dated 27 August 2017, assessed his risks as follows:

- accidental self-harm – Moderate
- vulnerability – High
- absconding – Low (Supervised and escorted leave only)
- deliberate self-harm – Low
- compliance – Moderate
- protective factors – Moderate

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[21] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

[22] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.

[23] CB, Police Summary.

[24] Ibid.

25. Additionally, Mr Adler's latest SECU report prepared for the Mental Health Tribunal indicates that less restrictive treatment was not an option due to his deteriorating mental state and intellectual disability. The report cautioned that *"if [he] were to be discharged into the community without proper planning, given his intensive support requirements, his mental state would likely deteriorate significantly putting himself at risk"*.

Transition to McCallum

26. In October 2015, Julia expressed concerns about the suitability of Mr Adler's living environment in the SECU, due to the changing nature of the client base.[25] She believed there seemed to be more patients with drug or substance-related disorders admitted to the unit, which she felt would leave her brother more vulnerable to bullying.[26]

27. Plans and arrangements were subsequently made to transition Mr Adler to McCallum which he was allocated under his NDIS funding.

28. On 6 September 2017, Mr Adler commenced his first sleepover at McCallum until he transitioned to living full time at the Leopold Street complex. The transition took approximately six months.[27]

29. Mr Adler's transition to living in McCallum included a gradual increase in overnight leave from SECU, with progression tailored to his choices and preferences about which nights he would like to stay over. There was feedback from staff to assess how he was coping with the changes.[28]

30. Furthermore, as a safety net, Mr Adler's bed was held at the SECU for three months after he fully transitioned, so that he could be readmitted directly to SECU if required.

[25] CF, DSC Investigation Report.
[26] Ibid.
[27] CF, DSC Investigation Report.
[28] Ibid.

Leopold Street complex layout and support model

31. The complex comprises eight residential units with one-bedroom, two-bedroom and three-bedroom units. The complex has minimal environmental restrictions, with some fencing in the backyards.[29] The grounds are open plan with no boundary fences or gates.[30]

32. Five of the eight units were classified as independent living units and the rest were supported accommodation units.[31] The support model for these units was a "sleepover model" with active night shifts to care for unwell residents.[32]

33. Mr Adler resided in a two-bedroom, supported accommodation unit with another resident, Neil Heaton. There was an infrared alarm on the entry door[33] of Mr Adler's unit, but not on other entry or exit doors.

34. While residing in the Leopold Street premises, Mr Adler was provided with the opportunity to participate in outdoor activities. He was allowed to go on walks or outings in a supported and flexible manner. He also had a night walking routine on a set route incorporated into his usual routine.[34]

35. Mr Adler was ordinarily accompanied by staff if he wished to leave the Leopold Street premises. Several strategies were also developed to assist Mr Adler in remembering to call for staff assistance when he wanted to leave.[35]

36. For instance, a *"STOP"* sign was placed on the front door as a visual trigger. Staff reported that it had been an effective strategy as they observed Mr Adler would pause upon observing this sign at the door and then ring the doorbell as a way of alerting staff that he wished to leave and explore.[36]

37. Staff were also made aware of signs that suggested Mr Adler was eager to leave and explore. The signs included agitation, restlessness, pacing in the living room and ringing the doorbell.

[29] CB, Statement of Janet Wrait.
[30] Ibid.
[31] Ibid.
[32] Ibid.
[33] CF, DSC Investigation Report. Primarily because Mr Heaton was at risk of wandering because of his medical condition.
[34] CF, DSC Investigation Report.
[35] Ibid.
[36] CB, Statement of Noelene Collins.

On observing of these signs, staff would either arrange to walk with Mr Adler or redirect his attention and inform him that they would walk at a more suitable time.

Ms Julia Adler's concerns

38. Mr Adler's sister, Julia, declined to provide a statement to the Court but provided extensive details to the coroner's investigator and to the DSC investigation concerning her brother's previous living arrangements and his transition to McCallum.

39. When Julia recounted her brother's lengthy admission to the locked unit, she said her brother needed to be in a secure environment, primarily, because of the risk of him running or wandering off.[37] She also stated that he can be a danger to himself due to the risk of misadventure.

40. After visiting the Leopold Street complex, Julia became concerned about how open the environment was, in contrast to what Mr Adler was used to. She felt that Mr Adler needed a facility with high fences to "keep him in".[38]

41. Despite that, Julia eventually approved her brother's move to the Leopold Street complex with the understanding that her brother would have 24-hour supervision and all the buildings' access points were equipped with infrared triggered alarms.[39] Another reason was also because she felt that overall, her brother was provided with a happier living environment.[40]

IMMEDIATE SURROUNDING CIRCUMSTANCES

42. According to the Manager of Accommodation Services at McCallum, Janet Wraith, two support workers were rostered throughout the day on the weekends. One support worker typically finishes at 7.30pm and another at 10.00pm. The support worker that finishes at 10.00pm will commence a sleepover shift.

[37] CF, DSC Investigation Report.
[38] Ibid.
[39] CF, DSC Investigation Report.
[40] Ibid.

43. On Saturday evening, 2 June 2018, Mr Adler had showered and ate his supper. On-duty disability support worker, Neil Henderson recounted Mr Adler appeared *"pretty calm"* as he was *"usually pacing and couldn't sit still"*.[41] He was dressed in his blue and white striped pyjamas, grey coloured hat and black runners.[42]

44. While Mr Adler got ready to watch football with Mr Heaton on the television in the living room, Mr Henderson left the living room briefly to make himself a coffee.[43]

45. Upon returning to the living room to check on them, Mr Henderson noticed Mr Adler was not in the room. He searched everywhere in the unit and nearby areas, including Leopold Street but could not locate Mr Adler.[44]

46. At approximately 7.35pm, Mr Adler was sighted by a road user, Matthew Harding, who was driving his vehicle along Winter Street.[45] Mr Harding recounted Mr Adler "*seemed to be walking and then running"* on the footpath.

47. Mr Harding then contacted the Ballarat Police Station to report his sighting as he was concerned for Mr Adler's welfare because of his minimal clothing and his *"almost frightened or confused"* demeanour.

48. At approximately 7.45pm, Mr Henderson contacted McCallum's on-call service and reported that Mr Adler had left his unit and was missing. Julia was informed of her brother's disappearance.

49. Victoria Police and State Emergency services immediately searched the surrounding areas. Mr Henderson also continuing to search locations that Mr Adler had known to have wandered to, but all efforts were to no avail.

50. There were no further sightings by other members of the public and the details of Mr Adler's movements after Mr Harding's sighting and his death overnight remains unknown.

[41] CB, Statement of Neil Henderson.
[42] Ibid.
[43] Ibid.
[44] CB, Statement of Neil Henderson.
[45] CB, Statement of Matthew Harding.

51. On 3 June 2018, at approximately 11.05am, while doing a "U-turn" at a driveway at a local shop located at 115 Learmonth Street, Joshua Reynolds sighted Mr Adler lying face down in the drain outside the premises.[46]

52. Mr Reynolds alerted police officers who happened to be patrolling in the area. Resuscitation efforts were not attempted as Mr Adler was cold to touch and appeared deceased.[47] Ambulance paramedics attended shortly after and formally pronounced Mr Adler deceased.

53. Police commenced an investigation around the scene and found no suspicious circumstances.

INVESTIGATION PRECEDING THE INQUEST

Identification

54. On 3 June 2018, Carl Robert Adler, born 26 October 1971, was visually identified by his sister, Julia Evelyn Adler.

55. The identity of Carl Robert Adler is not in dispute and required no further investigation.

Medical cause of death

56. On 5 June 2018, Senior Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Carl Robert Adler. In preparing her report, Dr Archer reviewed the preliminary examination report and a post-mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83), VFIM contact log and medical records from Alfredton Medical Centre. Dr Archer provided a written report of her findings dated 17 September 2018.

<u>Post-mortem examination</u>

57. Dr Archer reported that the autopsy findings included:

- Cardiomegaly (enlarged heart)
- Multiple abrasions and bruising

[46] CB, Statement of Joshua Reynolds.
[47] CB, Statement of Acting Sergeant Anthony Creanor.

- Fractured right central upper incisor
- Focal pancreatic head haemorrhage
- Duplex left ureter
- Right lobe of liver haemangioma.

58. Dr Archer noted the heart weighed at 560 grams and was greater than the 95th percentile for a man of his body weight and height.

59. In addition to reporting the autopsy findings above, Dr Archer noted Mr Adler was outdoors with light clothing on a winter night. According to the records of Ballarat Aerodrome Bureau of Meteorology, the temperature for the night dropped to a low of 1.6°C.

60. Dr Archer commented that prolonged exposure to low environmental temperature can result in hypothermia, which is a reduction of core body temperature below 35°C. A drop in core body temperature below 32°C is potentially fatal as hypothermia results in confusion, biochemical derangement, and organ dysfunction.

61. Dr Archer also commented that hypothermia is commonly associated with falls and collisions with solid objects. She posited the superficial injuries sustained by Mr Adler was likely to account from falls and collisions that may have occurred.

62. In considering the possible mechanism of death, Dr Archer explained that cardiomegaly is associated with sudden cardiac death due to lethal arrhythmia. This risk may be potentiated by physiological stress, such as hypothermia.

63. Dr Archer eliminated the possibility of Mr Adler sustaining a head injury when he fell into a concrete drain as there was no evidence of head injury at autopsy or on the post-mortem CT scan that may have caused or contributed to his death.

Toxicology

64. Toxicology analysis of post-mortem samples revealed the presence of clozapine[48], chlorpromazine[49], carbamazepine[50] and benztropine[51] in blood and urine samples, and atropine in the urine sample. Ethanol (alcohol) was not detected.

65. Vitreous humour biochemistry showed elevation of sodium (>200 mmol/l) and chloride (>150 mmol/l), which indicated the possibility of antemortem dehydration. Levels of potassium, glucose, urea and creatinine were within normal post-mortem limits.

Forensic pathology opinion

66. Dr Archer concluded that Mr Adler's death was due to natural causes and ascribed the medical cause of death to: "1 (a) cold environmental exposure in a man with cardiomegaly".

DSC INVESTIGATION AND FINDINGS

67. On 5 June 2018, the DSC commenced its investigation[52] into disability services provided by McCallum to Mr Adler. The scope of the investigation related to provision of disability services delivered in context of the circumstances of Mr Adler's death.

68. The purpose of the DSC's investigation was to identify issues in the services being investigated and to consider any action that the service provider should take in response to those issues or to otherwise improve the services being investigated.

69. The DSC considered documents relating to Mr Adler's care, as well as McCallum responses to DSC questions relating to its service provision.

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[48] Clozapine is a second-generation (atypical) antipsychotic drug effective for treating the positive and negative symptoms of schizophrenia, although clinically it is restricted to schizophrenic patients who do not respond to first-line antipsychotics.

[49] Chlorpromazine is a phenothiazine derivative used as a first-generation antipsychotic and antiemetic. It acts by a competitive antagonism of dopamine D2 receptors in the mesolimbic/mesocortical pathways and the chemoreceptor trigger zone.

[50] Carbamazepine is an antiepileptic drug that mediates its pharmacological effects by a use-dependent block of Na+ channels to inhibit action potential initiation and propagation. Clinical indications include partial and tonic-clonic seizures, neuropathic pain and bipolar disorder.

[51] Benztropine is a centrally acting muscarinic antagonist (probably M1 receptors) used as an antiparkinsonian agent and to control extrapyramidal disorders due to neuroleptic drugs.

[52] Pursuant to section 128I of the *Disability Act 2006* (Vic).

70. The investigation found that *"insufficient attention was directed to the fact that Mr Adler had spent many years in a secure environment and detained in the capacity of an 'involuntary patient'"*. [53]

71. It was also highlighted that Mr Adler's transition *"to a minimally restrictive living environment such as Leopold Street [complex], removed the protective or mitigating factors pertaining to his risk of absconding"* and yet this risk was not formally re-assessed as part of the transition plan.

The DSC's Findings

72. The DSC summarised its investigation in the following Findings[54]:

Finding 1: McCallum did not adequately assess the risks associated with Mr Adler's likelihood to wander or abscond from Leopold Street as part of his transition to living in a less restrictive environment.

Finding 2: Following repeated incidents where Mr Adler left the residence without permission, McCallum did not review strategies to better manage his behaviour and the need to balance safety, risk and choice.

Finding 3: After Mr Adler went missing on 2 June 2018, McCallum failed to notify his next-of-kin in a timely manner.

73. A draft Investigation Report of the DSC investigation, including a draft of the proposed *Notice to Take Action*, was provided to McCallum to enable an opportunity to respond.[55]

74. On 13 September 2019, McCallum provided its response to the draft Investigation Report. McCallum highlighted that *"the focus of the support model at the Leopold Street complex was designed and created for people with a disability who have the capacity to live in a less structured environment than a traditional Group home"*.[56]

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[53] CF, DSC Investigation Report.
[54] CF, DSC Investigation Report.
[55] Section 132ZF of the *Disability Act 2006* (Vic) requires that if a DSC Investigation Report makes an adverse comment on or gives an adverse opinion of an individual or a service provider, at least 14 days before giving the report, the DSC must give a copy of the relevant part of the report to the individual or service provider and give a reasonable opportunity to comment on the adverse comment or opinion.
[56] CF, DSC Investigation Report.

75. McCallum also responded contrary to Julia's understanding it made no representation that there were infrared triggered alarms installed within the Leopold Street complex and 24 hours supervision at its facility.[57]

76. Regarding its selection role within the DHHS' Vacancy Management Unit[58] (**VMU**), McCallum advised that it was not the decision maker, but it played a role in the selection of new residents for appropriate accommodation.

77. McCallum stated further it was felt the draft investigation report did not sufficiently acknowledge the process for matching applicants for disability housing to vacancies, specifically the role of VMU and input from other health specialists involved. However, McCallum considered this information is important in the context of DSC's finding that it did not adequately assess the risk of Mr Adler wandering from the group home.

78. According to DHHS VMU's advice to the DSC, at the time of Mr Adler's relocation to the Leopold Street group home, an agency or a service provider was required to agree to the selection or placement of a resident to a group home. If concerns relating to an identified risk were raised, the agency or service provider was requested to consider whether risk mitigation strategies could be safely implemented with the support of the relevant Departmental programs.

79. The VMU selection panel only make recommendation of the most suitable applicant for a vacancy and the Vacancy Selection plan does provide jurisdiction for the VMU to ensure that strategies were in place within a service. Moreover, supports identified by the VMU selection panel would be of consideration to service providers.

Were the strategies adequate?

80. Regarding Finding 2, McCallum advised that it disagreed those strategies were lacking but stated that overall, it could have done more to improve its risk management process.

[57] CF, DSC Investigation Report.
[58] The VMU is responsible for assessing individuals in need of supported accommodation, such as Mr Adler, and determined their eligibility for funded support accommodation (such as the type offered at Leopold Street complex). The VMU is the body with the authority to approve a resident for any particular residential vacancy that became available within the public or private housing sector.

81. McCallum advised that there was a document entitled *"Strategies for Carl Adler when he decides to go for a walk or go on an outing"* ("the document") to manage Mr Adler's wandering risk in conjunction with using least restrictive practices and measures that aimed at providing Mr Adler with opportunities to enjoy the outdoors activities such as going on walks or outings in a supported and flexible manner.

82. While it was outlined that there were strategies in place for Mr Adler when he indicated he wanted to go for a walk, the DSC did not identify strategies to address the situation when he left the premises unexpectedly. There was also no indication whether Mr Adler had previously left the complex without permission and whether he may do it again.

83. Additionally, while McCallum advised that the ongoing review of this document addressed Mr Adler's behaviour, the investigation revealed that the document was not dated and to indicate when strategies were developed, revised or implemented. Therefore, any changes that may have occurred to Mr Adler's risk management resulting from staff discussions or reviews about his behaviour were unclear from the available evidence.

Notice to Take Action

84. On 23 September 2020, the final *Notice to Take Action*[59] was formally issued to McCallum. The areas and issues identified for improvement in the notice are as follows[60]:

    i. McCallum to implement a comprehensive risk assessment process for clients entering their service, to identify and assess individual client support needs and mitigate any risks to client safety. This process must include involvement of family members/guardians where possible.

    ii. McCallum to implement a process which ensures that emerging risks or behavioural concerns for any resident are clearly documented, assessed and evaluated in a structured manner and updated as changes to the risk or behaviour occurs, and appropriate management strategies developed. The process must include evidence of communication with family members/guardians who should be involved with the

[59] Pursuant to section 128M of the *Disability Act 2006* (Vic) and pursuant to section 128P of the same Act, a service provider who has been given a Notice To Take Action must report to the Commissioner in writing about the action taken to comply with the Notice.
[60] CF, DSC Investigation Report.

development of management strategies and provided with regular updates where possible.

iii. McCallum to develop a process to ensure that in the event of a resident having been confirmed missing, that their family or guardian is informed at the earliest time practicable and that a plan is developed to keep them updated of changing circumstances.

FURTHER INVESTIGATION

85. Following the completion of the DSC's investigation, I considered the issues related to the DSC's Finding 1 and 3 had been addressed in the *Notice* (to McCallum) *to Take Action and* did not necessitate me to explore them further.

86. However, I determined that some outstanding issues fell under the restorative and preventative jurisdiction of the Coroners Court. I sought further information from McCallum in relation to strategies and staff training employed by McCallum in managing residents at risk of wandering; and the restorative and preventative measures taken since Mr Adler's death. These included:

(a) Knowledge of Mr Adler's risk of wandering when he first visited the Leopold Street complex and when he commenced living in his unit since 6 September 2017;
(b) What actions or responses McCallum has taken to manage this risk, having known that there were at least six incidents of wandering or attempts to wander by Mr Adler;
(c) Information about whether staff were adequately equipped to deal with the risks of wandering, in particular, Mr Adler; and
(d) Information about what McCallum has done since Mr Adler's death to improve the management of its residents' wandering risk.

87. By email dated 4 March 2022, the Court received a statement from Noelene Collins, Executive Manager of Accommodation Services at McCallum, detailing McCallum's response to the outstanding issues.

88. When asked about the knowledge of Mr Adler's wandering risk when he first visited the premises and commenced his sleepover in September 2017, Ms Collins stated that there was

no indication Mr Adler was at risk of leaving supervision. Neither was this risk identified and indicated when Mr Adler's application was presented in the VMU selection process.

What were the strategies in place to manage Mr Adler's wandering risk?

89. In respect of Mr Adler's first incident of leaving or wandering in February 2018, Ms Collins stated that staff responded appropriately by preparing an incident report and discussed the incident at a staff meeting.[61]

90. Ms Collins stated further that staff considered the nature of Mr Adler's wandering behaviour was not *"sinister"* and did not arise from *"a desire to leave [the] Leopold Street"* premises. Instead, they considered Mr Adler was "familiarising" himself in a new environment.

91. Ms Collins also advised that a functional assessment underwent by Mr Adler on 9 May 2018 found no evidence of him wandering at night, but there was a risk of him wandering at other times.

92. Ms Collins stated that staff did not perceive the recurrence of wandering at that time suggested the strategies were failing or ineffective. She further highlighted that the process of working with Mr Adler to manage his wandering risk was gradual and that it would not have been possible or reasonable for these strategies to immediately prevent his behaviour.

What were the training provided to staff in managing its clients?

93. Ms Collins advised that McCallum does not provide specific training in relation to managing its clients' risk of actively leaving supervision. She explained that McCallum provides disability services to different clients, which subjected its staff to a range of risks that are highly varied and contextual from client to client. Instead, McCallum relies upon a thorough understanding of the Positive Behaviour Support[62] approach to managing a range of different behavioural issues of its clients.

[61] CB, Statement of Noelene Collins.
[62] Positive Behaviour Support (**PBS**) is an evidence-based approach aimed at increasing a person's quality of life and decreasing the frequency and severity of difficult behaviours (or "behaviours of concern") by teaching them new skills and adjusting their environment to promote positive behaviour changes.

94. Ms Collins advised that such staff trainings were provided by an external training consultant and commenced around September 2017 and were extensively rolled out in 2018.

Subsequent actions/responses

95. Ms Collins advised that while McCallum had not conducted an internal investigation into Mr Adler's incident, it had actively participated in the DSC investigation.

96. Since Mr Adler's death and also in response to the DSC's *Notice to Take Action*, McCallum has undertaken the following changes[63]:

- In late 2019, McCallum conducted a formal review to develop a new risk assessment system to ensure future risk assessments focus on a known range of risks within disability support settings in order to achieve a comprehensive assessment of holistic risks.[64]
- In July 2020, McCallum updated its *Customer Support Planning Procedure,* and along with this procedure, it implemented a new risk assessment tool. The new risk assessment tool specifically provides *"wandering and actively leaving premises"* as a risk to be assessed. It requires each risk to be categorised on a scale of no risk, low risk, medium risk and high risk. Additionally, risks that were assessed as medium or high will warrant documentations of a mitigating control.
- In October 2020, McCallum updated its *Customer Support Planning Procedure* to include guidance to staff about when risk assessments should be performed.
- In September 2018, McCallum revised its *Positive Behaviour and Restrictive Interventions Procedure.* The Procedure was subsequently reviewed in February 2020, which provides for a flow chart that assists staff in responding and considering the seriousness behaviours of concern.

97. Ms Collins advised that regarding when risk assessments should be performed, the *Customer Support Planning Procedure* provides risk assessments are to be conducted in the following manner:

[63] CB, Statement of Noelene Collins.

[64] Ms Collins explained that the specific change to the new risk assessment tool, was implemented as a result of Mr Adler's incident. It was also implemented in conjunction with quality improvement changes under the National Disability Insurance Agency's quality standards.

- An initial risk assessment should be performed before a customer starts with McCallum;
- A risk assessment should be performed within the first 30 to 60 days as part of the first support plan development;
- Risk assessments should form part of annual support planning processes;
- Risk assessments should also be performed whenever there are significant changes to risk factors, which may trigger changes to a resident's support plan; and
- Risk assessments should also be conducted as part of incident reviews and it may be required, for instance, due to the seriousness of an incident or frequency of incidents.

THE INQUEST

98. The actions McCallum took to address the issues about Mr Adler's service provision were consistent with the Findings in the Investigation Report and the DSC's *Notice to Take Action.* I determined that McCallum had made appropriate concessions and provided adequate response in addressing the outstanding issues, obviating any need to hear witness evidence.

99. I determined further that this matter would be appropriately finalised by way of a Form 37 *Finding into Death with Inquest* and to hand down my Findings at the conclusion of a Summary Inquest.

100. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 23 November 2022.

COMMENTS

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

101. Other than her concern about her brother's ability to leave his unit without supervision, Julia spoke highly of the delivery of services to Mr Adler at McCallum. She believed the new living environment "made a big difference" to her brother's mental health and wellbeing. She said that he had "blossomed" in his new home.

102. I acknowledge that Julia was optimistic about the change in her brother's living arrangements and was supportive of transitioning him to a less restrictive accommodation. I also acknowledge that Mr Adler's treating clinicians and support coordinator were of the view that the Leopold Street complex was "ideal" for his transition back into a community care life.[65]

103. The available evidence indicates that Mr Adler was a challenging resident to manage in a less strictive setting, given his deteriorating intellectual disability and his extensive past history of involuntary hospitalisation. These issues were recognised in his SECU report and Clinical Risk Management Plan at the Ballarat Mental Health Services, and although some strategies were put in place by McCallum there is no indication that his overall risk had been reviewed.

104. It appears that McCallum did not appreciate the information contained in the Clinical Risk Management Plan[66], in particular, Mr Adler's low "absconding"[67] risk was assessed in an environment that was very different to McCallum's.

105. The available evidence also indicates that McCallum did not initially consider Mr Adler's risk of wandering until he commenced his residency at McCallum. There were six incidents where he left or attempted to leave the Leopold Street premises or displayed behaviours of concern. Furthermore, there were two occasions where he chose not to comply with requests from staff asking him not to leave the premises.

106. The DSC noted that staff did not strictly adhere to the relevant procedure in the documentation and reporting of incidents. In so finding, it is apparent staff only documented Mr Adler's behaviours in the context of recording what he had done but without noting specific strategies that were used on each incident or strategies that were developed, revised, or implemented following each incident. As mentioned, there was only one reported incident that led to a staff meeting to address the issues proactively.

[65] CB, SECU Report.
[66] See paragraph 24.
[67] The wording absconding instead of wandering was used in the plan because Mr Adler was still a SECU inpatient living in a restricted environment.

107. The subsequent actions that McCallum have since undertaken are consistent with the recommendations provided by the DSC in its Investigation Report. I am also satisfied from my coronial perspective that they are restorative and preventative.

108. Consequently, I have determined that it is not necessary for me to make any recommendations for the implementation of preventative measures related to managing clients who pose a wandering risk. However, I do consider the circumstances surrounding Mr Adler's death may provide opportunities for relevant Victorian governmental entities and NDIS funded facilities to consider how best they might approach persons in Mr Adler's situation to ensure involuntary patients are discharged to appropriate supported accommodations.

FINDINGS/ CONCLUSIONS

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Carl Robert Adler, born 26 October 1971, died between 2 and 3 June 2018 at 115 Learmonth Street, Alfredton, Victoria.

2. I find that there is clear and cogent evidence that the death of Carl Robert Adler was preventable. His overall risk was never reviewed prior to his transition to Leopold Street complex. This was a missed opportunity.

3. I do however acknowledge and I find that appropriate restorative and preventative measures have been implemented by McCallum Disability Services in response of Carl Robert Adler's death.

4. AND save from the Comments made above, I make no adverse Findings against McCallum Disability Services Inc.

5. I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Carl Robert Adler, a man with pre-existing medical condition of cardiomegaly, died from the exposure to the cold.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by a coroner, the Findings, Comments and Recommendations made following an inquest must be published on the Internet in accordance with the rules, and I make no such order.

DISTRIBUTION OF FINDING

I direct that a copy of this finding be provided:

Julia Adler

Karen Liu, K&L Gates, Lawyers for McCallum Disability Services Inc.

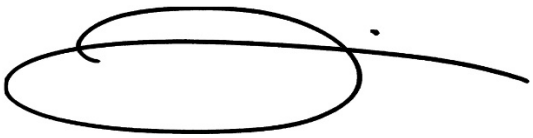
Leading Senior Constable Tracey Atkins, Coroner's Investigator, Victoria Police

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Kathleen Alonso, Acting Regulatory Officer, South Division, Department of Families, Fairness and Housing

National Disability Insurance Agency

Signature:



AUDREY JAMIESON
CORONER

Date: 23 November 2022

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 inquest. 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.