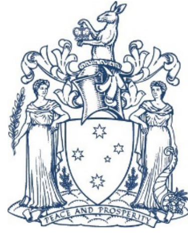

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 5809

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	PL[1]
Date of birth:	9 July 1929
Date of death:	30 October 2021
Cause of death:	1(a) Consequences of an assault
Place of death:	Yallambee Traralgon Village for the Aged, Matthews Crescent, Traralgon, Victoria, 3844

[1] At the direction of Coroner Katherine Lorenz, the name of the deceased has been replaced with a randomly generated two letter sequence as a pseudonym.

INTRODUCTION

1. On 30 October 2021, PL was 92 years old when she died at the Yallambee Traralgon Village for the Aged **(Yallambee)**. She had resided at this facility since August 2020. PL is survived by her two daughters.

2. PL was born in Poland and her primary language was Polish. She had a complex medical history including atrial fibrillation, hypertension, cervical spondylosis, and thoracic spondylosis amongst others. She also had difficulties with her mobility and required the use of a wheelchair for long distances and a four-wheel walking frame for short distances.

3. At a psychiatric review on 23 February 2021, Dr Ratnyake Athula opined that PL likely had Alzheimer's Disease, with behavioural and psychological symptoms of dementia. Her medication regime was modified as a result.

4. At Yallambee, PL's room was located within the Waratah Ward. This ward comprised of 18 residents suffering from dementia and mental health illnesses. It is a secure ward where residents are unable to leave unless staff use a swipe card to unlock the door. In addition, there is a nurses' station which can be locked by staff and cannot be accessed by residents.

THE CORONIAL INVESTIGATION

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

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

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

8. Victoria Police assigned Detective Senior Constable Luke Haxell (**DSC Haxell**) to be the Coroner's Investigator for the investigation into PL's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses such as treating clinicians, staff at Yallambee, investigating officers and the forensic pathologist- and submitted the materials to the Court.

9. This finding draws on the totality of the coronial investigation into the death of PL including evidence contained in the materials provided to the Court. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred:

10. On 3 September 2021, Waratah Ward resident John Kilgower **(Mr Kilgower)** was unsettled during the day and had refused to take his antipsychotic medication. Mr Kilgower had previously been diagnosed with frontotemporal dementia, Lewy Body Dementia and Alzheimer's Disease. He had resided at Yallambee since 2017.

11. Staff progress notes indicated that after lunch, Mr Kilgower *"started accusing other residents of stealing from him, getting into their personal space…staff intervened and diffused the situation."* He appeared to settle later in the day after speaking with his wife and being returned to his room.

12. At approximately 10.21 pm Personal Care Assistant Stephen Wilson (**PCA Wilson**) observed Mr Kilgower asleep in his room.

13. At approximately 12.45am on 4 September 2022, PCA Wilson and Registered Nurse Robyn Van Es (**RN Van Es**) were conducting a handover of the residents of the Waratah Ward in the nurses' station and heard a loud bang. They observed Mr Kilgower leaving another resident's room.

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

14. As PCA Wilson approached Mr Kilgower, he became aggressive and punched PCA Wilson in the head, before moving towards RN Van Es in a threatening manner. PCA Wilson and RN Van Es retreated to the nurses' station and locked the door. RN Van Es contacted emergency services, requesting police assistance. Mr Kilgower entered a number of other residents' rooms and assaulted them.

15. At one stage, PL walked out of her room and sat at a nearby table. A short time later, Mr Kilgower picked up PL's 4-wheel walker and threw it at the nurses' station. He subsequently assaulted PL and left her slumped on the ground.

16. Police members arrived thereafter and restrained Mr Kilgower. Ambulance Victoria paramedics also attended and triaged the 12 residents and one staff member that had been assaulted. PL was transported to the Latrobe Regional Hospital **(LRH)**, arriving at approximately 3.20am.

17. PL underwent a CT scan of her pelvis and head, revealing a shallow left supratentorial subdural bleed and a small depressed left nasal bone fracture. She had bruises to her upper back, arms and forehead, a lower jaw abrasion, skin tear to her chin/cheek, swelling to her right eye and pain in the right side of her hip.

18. On 5 September 2021, PL was discharged from the LRH and returned to Yallambee. However, she was withdrawn and refused nutrition. Her blood pressure was low on 7 September 2021, and she was reviewed the following day by a medical officer **(MO)**.

19. A rapid intervention review RN assessment was conducted on 9 September 2021 regarding PL's low blood pressure. The RN recommended that the blood pressure medication be withheld until further review by the MO the following week. Observations were also to be taken four times a day.

20. On 14 September 2021, the MO reviewed PL's medication as arranged, but no documentation related to the blood pressure medication was documented. PL's charting showed that vital signs and food and fluid charts were completed as directed. Neurological observations had not been completed.[3] Progress notes during the month of September reported on the emotional distress that PL experienced as a result of the incident.

[3] Aged Care Quality and Safety Commission **(ACQSC)** Investigation Report into Yallambee Traralgon Village for the Aged 8 September to 5 October 2021 at pg.33, provided as attachment YT05 to the Statement of Alison Snell,

21. On 25 October 2021, PL was palliated. She subsequently died on 30 October 2021 at 4.22pm.

Identity of the deceased

22. On 30 October 2021, PL, born 9 July 1929, was visually identified by her daughter.

23. Identity is not disputed and requires no further investigation.

Medical cause of death

24. Forensic Pathologist Dr Michael Burke (**Dr Burke**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 1 November 2021 and provided a written report of his findings dated 20 December 2021.

25. The post-mortem CT scan did not reveal any obvious facial fractures. There was an atrophic brain, no intra cranial haemorrhage, bilateral pleural effusions, calcified coronary arteries and aortic valve and possible non-displaced rib fractures on the left.

26. Dr Burke reviewed the medical records and x-rays and noted that PL had suffered an intra-articular olecranon fracture in the assault, presumably from falling backwards onto the ground. Dr Burke's initial opinion was that the medical cause of death was due to 1 (a) *Complications of a fall in a women with dementia.*

27. On 14 January 2022, one of PL's daughters contacted the Coroners Court and set out some concerns regarding the Medical Examiner's Report. Dr Burke subsequently reviewed his findings and provided a supplementary report dated 31 January 2022.

28. Dr Burke noted that the significant injury may well have occurred from the fall, but that it occurred in the setting of an incident with another resident at the aged care facility.

29. Dr Burke opined that it was more appropriate to formulate the cause of death as *1(a) Consequences of an assault*.

30. I accept Dr Burke's opinion.

YALLAMBEE'S CARE AND MANAGEMENT OF MR KILGOWER

Yallambee CEO. The ACQSC completed a fulsome investigation into the incident of 4 September 2021 which is discussed in detail later throughout this finding.

31. In July 2020, Mr Kilgower was admitted to the LRH where he presented with increasing aggression, attempting to hit staff, and non-compliance with care. He was diagnosed as suffering from psychosis and olfactory hallucinations, with ongoing risk of relapse and medication non-compliance.

32. Upon his return to Yallambee, his behaviour was monitored through ongoing behaviour report charting. The charting revealed that Mr Kilgower had increasing frequency of "*paranoid ideation that disturbs others and excessive suspiciousness from 19 June to 3 September 2021."*[4] Between 29 August to 3 September 2021, Mr Kilgower was recorded as having an increase in delusional thoughts.[5]

33. An investigation into the incident at Yallambee was completed by the Aged Care Quality and Safety Commission **(ACQSC)** following a Serious Incident Report Scheme notification by Yallambee. It was noted in the ACQSC report that charting intervention to manage Mr Kilgower's behaviours and notation regarding the success of management strategies had ceased on 14 June 2021.[6] It was noted in the report that staff confirmed that no changes had occurred regarding strategies or directions on how to care for Mr Kilgower despite his continued agitation, restlessness, and refusal to cooperate with care.[7] The charting had not been evaluated or used to initiate re-assessment or update care plans.

34. The ACQSC found that Mr Kilgower' s behaviour care plan was last updated on 23 July 2021, which recorded his verbal refusal of medication. It also indicated that he had demonstrated *"physical behaviour through constant physical agitation and manipulating nearby objects*."[8] The behaviour care plan did not address the issues of him hitting out at staff or physically threatening others through body posturing. The care plan also did not provide direction to staff in the management or refusal of his medications.[9]

35. Progress notes reported that Mr Kilgower had been refusing his antipsychotic medications from 13 July to 4 September 2021, with more frequent refusals during August and September. It was considered that his behaviour was triggered by confusion and frustration and no

[4] ACQSC Investigation Report into Yallambee Traralgon Village for the Aged 8 September to 5 October 2021 at pg.9, provided as attachment YT05 to the Statement of Alison Snell, Yallambee CEO.
[5] Ibid, pg.11.
[6] Ibid, pg.15.
[7] Ibid.
[8] Ibid.
[9] Ibid pg.16.

consideration of psychotic or delusional states as a potential trigger were identified. Mr Kilgower continued to display agitation, paranoia, and suspicion during August.

36. On 25 August 2021, Mr Kilgower was reviewed by the Aged Persons Mental Health Psychiatrist. His main issue was noted to be non-compliance with his medications. Progress notes from Yallambee did not document clinical staff follow up of this review.[10]

37. Between 31 August to 3 September 2021, Mr Kilgower continued to deteriorate. On 1 September 2021 he was documented as "*very twitchy and uneasy, walking around and unsettled for most of the shift."*[11] On the evening of 2 September 2021, he was reported to come in and out of his bedroom during the night. The ACQSC report noted that *"clinical management did not provide care staff with guidance or new strategies to implement when Mr Kilgower's agitation significantly escalated on 1 September 2021."*[12]

38. On 3 September 2021, there were increased signs of mental deterioration as Mr Kilgower accused other persons of stealing from him. He showed paranoid behaviour and became verbally aggressive. In the ACQSC report, it was noted that a few staff members had indicated they were *"careful and wary around Mr Kilgower as he became angry, and they were frightened of him."* [13] Whilst Mr Kilgower had not previously assaulted any resident at Yallambee, he had threatened staff in the prior 18 months.[14]

39. The ACQSC report noted that Mr Kilgower's medication refusals *"were not logged as incidents, investigated, and trended with appropriate action taken."*[15] Progress notes did not record staff contact with the medical officer or mental health services in relation to the changes in Mr Kilgower's presentation and thought processes. Behaviour assessments and care plans were not updated with additional strategies when current strategies were ineffective.

40. The ACQSC investigation concluded that Yallambee's assessment *"had not identified deficits in the care and management of Mr Kilgower prior to the incidents which may have contributed to the incident or if managed, prevented the incident."*[16]

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[10] Ibid pg.20.
[11] Ibid pg.18.
[12] Ibid pg. 24.
[13] Ibid pg,18.
[14] Statement of Stephen Wilson dated 5 September 2021.
[15] ACQSC Investigation Report into Yallambee Traralgon Village for the Aged 8 September to 5 October 2021, pg.24, provided as attachment YT05 to the Statement of Alison Snell, Yallambee CEO.
[16] Ibid, pg.7.

41. Further issues as identified by the ACQSC are discussed later in this finding.

POLICE INVESTIGATION:

42. On 4 September 2021, Mr Kilgower was transported to the LRH under section 351 of the *Mental Health Act 2014* (Vic). He advised LRH staff that he had assaulted the other residents as they were stealing his belongings and that he had "*unfinished business*"[17] back at the nursing home. He was medically examined, and it was noted that in addition to the injuries he received whilst assaulting other residents, he had a non-ST elevation myocardial infarction.

43. Mr Kilgower was admitted to the Macalister Aged Psychiatry Unit on 6 September 2021. LRH Consultant Psychiatrist Dr Anjith Divakaran diagnosed Mr Kilgower with *"late onset psychosis – Schizoaffective type, currently mixed episode with psychotic symptoms."* He noted that the collateral information and further assessment indicated that Mr Kilgower was "*generally not a violent person*"[18] and his treatment was focused on the behavioural and psychological symptoms of dementia.

44. Dr Divakaran indicated that Mr Kilgower would continue to be cared for at the Macalister Nursing home attached to the LRH. He stated, *"[t]his is to consolidate the gains from acute treatment and to ensure safety to himself and others prior to transition to a community nursing home."*[19]

45. The report of Dr Divakaran was considered by VIFM Senior Forensic Physician Dr Angela Williams. Dr Williams opined that that due to Mr Kilgower's dementia and the fact that he was being treated at a psychogeriatric nursing home facility, he was not fit for police interview. Dr Williams stated that "t*he only caveat on future interviewing would be if he began to improve significantly. This is unlikely as dementia is an irreversible and progressive disease."* She further noted that she could review her opinion if *"Mr Kilgower's circumstances/symptoms improved dramatically."*[20]

46. The Office of Public Prosecutions considered the available evidence regarding the incident at Yallambee. It was determined that it would not be in the public interest to lay charges in this

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[17] Medical Report for John Kilgower by Dr Anjith Divakaran dated 27 October 2021.
[18] Ibid.
[19] Ibid.
[20] VIFM Report of Dr Angela Williams dated 26 November 2021.

matter given Mr Kilgower' s progressive and irreversible dementia, and current treatment in a mental health facility.

FAMILY CONCERNS

47. On 25 October 2022, the Court received an email from PL's daughter querying the following;

    a) Why staff members did not attempt to restrain Mr Kilgower on the night given that other staff members came to assist those locked in the nurses' station.

    b) Why was PL left in the area on the night when two other residents had been removed by staff from the vicinity. PL's daughter stated she had been advised by Yallambee that Mr Kilgower was "*not considered a danger to other residents*" She stated that if this was the case, staff "*could have left both of the other residents in the area. Their actions imply that he was a danger, and I would like to know why mum was left vulnerable and unprotected.*"

    c) How would staff members prevent a similar type of situation in future?

48. On 1 December 2022, the Court received a statement from Yallambee CEO, Ms Alison Snell which addressed aspects of these queries. Ms Snell also advised that Yallambee had requested a review of the incident by Harcourt Aged Care Advisors. In addition, the ACQSC also completed a review into the incident. The relevant aspects of these investigations are summarised below.

49. It is important to note that resident to resident aggression (**RRA**) in a residential aged care service is defined as a '*negative, aggressive and intrusive verbal, physical, sexual and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.'*[21] A 2017 Australian study identified 28 deaths reported to the Coroner from 2000-2013, where the death was the result of RRA. Seven of these deaths occurred in Victoria.[22] However, the study noted that it is likely that RRA incidents are underreported for a number of reasons, including that incidents may occur without any credible witnesses present.[23]

[21] McDonald L, Hitzig SL, Pillemer KA, Lachs MS, Beaulieu M, Brownell P, et al. Developing a research agenda on resident-to-resident aggression: recommendations from a consensus conference. J Elder Abuse Negl. 2015; 27(2): 146-67.

[22] Briony Murphy et al, 'Deaths from Resident-to Resident Aggression in Australian Nursing Homes', *Journal of the American Geriatrics Society*, December 2017, Vol 65 No 12 p 2603.

[23] Ibid p2607.

Commonly, RRA occurs between one or more residents with dementia. These incidents can happen without warning and pose significant challenges for residential service providers to manage appropriately.

50. In considering the first two issues raised by PL's daughter, I note the evidence from the Yallambee staff members on the night. They indicated that they had initially approached Mr Kilgower in an attempt to calm him, but he had reacted aggressively and punched PCA Wilson. He then made a threatening remark towards RN Van Es. Both staff members feared for their staff and quickly entered the nurses' station as a result. At this time Mr Kilgower was "*smashing on the door with his hands"*[24] and PCA Wilson and RN Van Es contacted emergency services for assistance. PCA Wilson stated, *"[w]e were desperate for someone to arrive and restrain him. I don't believe Robyn and I alone could achieve this, and we're not allowed to use force on residents…He was like a wild man, and nothing was going to stop him."*[25]

51. PCA Wilson further stated that another resident came to the door of the nurses' station, and he swiped his card to usher her in. He indicated that he could see PL sitting down, but considered that due to her limited mobility, "*it would take too long to bring her into the nurses' station which would pose a risk once again to ourselves."*

52. Enrolled Nurse Sarah Eccles **(EN Eccles)** was working in the Acacia Ward on the night, which is housed separately to the Waratah Ward. The Acacia Ward and Waratah Ward are separated by a swipe card access door. At the time of the incident, PCA Wilson called EN Eccles to advise of the situation and that they had contacted police. He asked EN Eccles to attend the reception area to let police in when they arrived.

53. EN Eccles attended the garden area to be able to see inside Waratah Ward and observed Mr Kilgower going into the bedrooms on that side, appearing and disappearing as he made his way down the corridor. At this time, a female resident came out of her room and approached the main area. EN Eccles stated that Mr Kilgower had not noticed the resident at this time, and she took this opportunity to enter Waratah Ward to take the resident to safety. They entered through the swipe card door into the Acacia area.

54. EN Eccles then returned to the garden window outside Waratah Ward and contacted PCA Wilson again who stated that Mr Kilgower was *"still escalating."* EN Eccles banged on the

[24] Statement of Stephen Wilson dated 5 September 2021.
[25] Ibid.

window in an attempt to try and stop Mr Kilgower from attending the resident of Room 15. She stated, *"He looked straight at me, but I don't know if he saw me."*[26] She observed that Mr Kilgower continued to enter the other residents' rooms and also started to throw furniture around.

55. Upon the arrival of police, Mr Kilgower was restrained. PCA Wilson stated that upon seeing the other residents that had been affected, he was shocked by the extent of the incident. He stated,

> *"I had no idea John was doing this and didn't think he would go to that extreme. I saw tables and chairs overturned and furniture damaged…I have dealt with residents experiencing psychotic episodes but nothing like that."*[27]

56. On 13 September 2021, investigators from WorkSafe attended Yallambee. They noted that the following procedures were in place and had been communicated to employees;

    a) Resident Aggression Policy/Procedure

    b) Behavioural Policy/Procedure

    c) Occupational Violence Policy/Procedure

    d) Occupational Health and Safety Policy/Procedure

    e) Clinical Care Policy/Procedure

57. WorkSafe were advised that on the job training for behavioural management of identified residents has been carried out by all staff. However, no physical instruction or training for staff in regard to the de-escalation of occupational violence and aggression incidents (**OVA)** had been provided to employees working with these residents. WorkSafe considered that such instruction and training was necessary to enable employees to perform their work in a manner that is safe and without risks to health from OVA.

[26] Statement of Sarah Eccles dated 7 September 2021

[27] Statement of Stephen Wilson dated 5 September 2021.

58. As a result, WorkSafe issued an Improvement Notice on Yallambee on 15 September 2021 requiring that they provide *"such instruction and training as is necessary to enable employees to perform their work in a manner that is safe and without risk to health from OVA."*[28]

59. WorkSafe investigators again attended Yallambee on 16 March 2022 to follow up on the previously issued Improvement Notice. They were advised that 112 employees had completed training in Verbal Judo *"which teaches the art of persuasion to redirect other's negative behaviour to generate voluntary and peaceful resolution."* The remaining employees were scheduled for upcoming training with the last group to be completed on 21 April 2022. WorkSafe considered that the Improvement Notice had been complied with. [29]

60. On 4 January 2023, WorkSafe advised the Court that following their preliminary investigation into the matter, they would not be taking further action.

Review by Harcourt Aged Care Advisors

61. Yallambee arranged for an independent review of the incident by Harcourt Aged Care Advisors **(HACA)** to assist in identifying;

    a) The possible causes of the incident

    b) Harm caused by the incident

    c) Any operational issues that may have caused/contributed to the incident occurring and;

    d) Systemic issues that could benefit from further review and planned action around systems and processes.

62. HACA prepared an Investigation Report dated 21 September 2021 and a Final Report dated 24 January 2022. The Final Report included a recommended Plan for Continuous Improvement.

63. HACA's initial review noted that there were no specific incidents of physical aggression by Mr Kilgower that would have led staff to consider his health of such concern to lead to the incident on 4 September 2021. His ongoing refusal of medication was a challenge for staff,

[28] WorkSafe Improvement Notice issued to Yallambee Traralgon Village for the Aged Inc dated 15 September 2021 provided as attachment YT11 to the Statement of Alison Snell, Yallambee CEO.

[29] WorkSafe Inspection Report dated 16 March 2022 provided as attachment YT08 to the Statement of Alison Snell, Yallambee CEO.

and they had tried various strategies to encourage him to take his medications. The ongoing refusal had been happening for at least the past 12 months.[30]

64. The HACA initial review stated that Mr Kilgower did appear to exhibit *"acute deterioration that included auditory hallucinations and verbal aggression/behaviours in the preceding 24 hours to the incident."*[31] However, their report concluded that *"there does not appear to be any obvious gaps in the care provided that has caused the resident to act in the way he did or that that incident was foreseeable."*[32]

65. The HACA review further noted the following opportunities for improvement;

    a) Education for staff on Behavioural and Psychological Symptoms of Dementia, evidence-based assessment processes

    b) A review of current processes and procedures around escalation of behaviours of concern

    c) Education on identification and actions for mental and physical clinical deterioration

    d) Education around consumer-focused assessment and care planning.[33]

Review by the ACQSC

66. An investigation into the incident at Yallambee was commenced by the ACQSC on 8 September 2021. A comprehensive report was completed, and I only purport to reference the aspects which are directly relevant for my investigation into PL's death. This is in accordance with section 7 of the Act which outlines that a Coroner should liaise with other investigative authorities, official bodies, or statutory officers to avoid the unnecessary duplication of inquiries and investigations.

67. As outlined earlier, the ACQSC considered that pursuant to section 15LA(3)(a) of the Quality-of-Care Principles 2014 **(QCP)**, Yallambee's assessment *"had not identified the deficits in*

[30] HACA Report dated 21 September 2021 at pg.21, provided as attachment YT02 to the Statement of Alison Snell, Yallambee CEO.
[31] Ibid pg.23
[32] Ibid pg.24
[33] Ibid.

the care and management of Mr Kilgower prior to the incident which may have contributed to the incident or if managed, prevented the incident."[34]

68. The investigation also found;

a) That pursuant to sections 15LA(3)(c) of the QCP, Yallambee's assessment of the incident had *"not considered all aspects as to how the incident was managed and resolved in their final investigation."*[35]

b) Pursuant to sections 15LB(1)(a), 15LB(2)(a) and 15LB(2)(b) Yallambee had not used incident data to "*identify and address systemic issues or to improve the management and prevention of the incident."*[36] For example, staff did not use validated assessment tools and they did not consider how to improve management of similar incidents.

It was also noted that:

i. Despite recommendation, there were no effective strategies in place to reduce Mr Kilgower's resistance to ingesting regular medications to minimise the risk of uncontrolled agitation and psychosis.

ii. Yallambee did not have effective systems and processes in place to educate and guide staff in emergency and/or personal threat response or the management of deteriorating care recipients.

iii. They did not have effective processes to provide senior clinical guidance to staff in the management of complex cases, to prevent or reduce the risk of incidents.

iv. Despite Mr Kilgower's increasing agitation, aggression and paranoia, no assessment or review of his management occurred. There were no behavioural strategies trialled.

v. The deterioration of Mr Kilgower was not escalated as a clinical risk or discussed as a complex case.[37]

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[34] ACQSC Investigation Report into Yallambee Traralgon Village for the Aged 8 September to 5 October 2021 at pg.7 provided as attachment YT05 to the Statement of Alison Snell, Yallambee CEO.

[35] Ibid pg.8

[36] Ibid.

[37] ACQSC Incident Management Compliance Notice and Restrictive Practice Compliance Notice dated 12 November 2021 at pg.4-5 provided as attachment YT07 to the Statement of Alison Snell, Yallambee CEO.

c) Under section 15LB(1)(b) of the QCP, Yallambee did not *"demonstrate any feedback or training to staff as a result of the review and analysis of incident data. Including, no medication competency training following medication incidents in line with their policy."*[38]

69. The ACQSC also considered the assessment and monitoring of the affected residents following the incident. In respect of PL, the ACQSC considered her pain chart assessment and monitoring and found that "*a random sample of charts showed the experience of pain was not consistently responded to with an intervention and pain interventions were not consistently evaluated for effectiveness."*[39] It was also stated that PL's care plan *"was not dated and does not record changes in her care needs related to injuries from the incident on 4 September 2021…None of the care plans document pain as a care need or recognise PL's need for emotional support. The care plan does not guide staff in the management of changed needs."* [40]

70. On 12 November 2021, the ACQSC issued Yallambee with an *Incident Management Compliance and Restrictive Practice Compliance Notice*. Yallambee were required to comply with the actions outlined in this notice by 3 December 2021.

71. On 3 December 2021, Yallambee's then Interim CEO, Kate Keppitipola, provided a response to the ACQSC in regard to the notice. Notably, Ms Keppitipola acknowledged the concerns regarding the management of Mr Kilgower. She advised that Yallambee have *"taken significant steps to more appropriately review, interrogate and respond to clinical risk."* These included having several experienced senior clinical staff return to Yallambee, engaging external nurse advisors to assist with the process and guide the areas of action and focus, increasing the education team and developing a targeted education program to focus on high-risk areas. It was also noted that Yallambee reviewed and implemented changes to handover process and documentation to identify and act on clinical deterioration. [41]

72. It was also noted that a clinical risk meeting had been conducted fortnightly to review, understand and undertaken trend analysis to mitigate risk and implement strategies to prevent adverse outcomes for residents. Ms Keppitipola detailed that progress notes and incidents are

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[38] ACQSC Investigation Report into Yallambee Traralgon Village for the Aged 8 September to 5 October 2021 at pg.8 provided as attachment YT05 to the Statement of Alison Snell, Yallambee CEO.
[39] Ibid pg.31.
[40] Ibid pg. 32.
[41] Response of Interim CEO Kate Keppitipola to the ACQSC dated 3 December 2021 provided as attachment YT06 to the Statement of Alison Snell, Yallambee CEO.

monitored by the Director of Care, Clinical Care Coordinators and Registered Nurse in Charge, to ensure clinical deterioration is appropriately identified and trends assessed.

73. Ms Keppitipola also acknowledged;

    a) That Yallambee accepted that their staff required education on emergency situations and the use of validated assessment tools. They had commenced a number of strategies to address this, including the development and implementation of a comprehensive education planner, employment of an additional educator to support staff and engagement with a specialist de-escalation trainer to conduct training for all staff. She noted that staff had also completed the following education sessions;

        i. Restrictive Practices-new requirements

        ii. Minimising restrictive practices

        iii. Partnering to plan and deliver care

        iv. Management of unexpected deterioration

        v. Workplace aggression

        vi. De-escalation

    b) That Yallambee's previous assessment of the incident did not identify the deficits in the care of management of Mr Kilgower and that this assessment was not accurate.

    c) That Yallambee lacked sufficient monitoring and analysis of incident data and had taken immediate steps to address this immediately after the incident.

Statement of Yallambee CEO Alison Snell

74. On 1 December 2022, Yallambee's CEO Ms Snell advised the Court that the care home have taken a number of measures to prevent or mitigate the risk of any similar incidents in future. Ms Snell noted that Yallambee has undertaken to follow all recommendations identified by HACA review "*including substantial investment in further recommended training and employing an education/quality coordinator and filling roles for support staff and registered nurses.*" Yallambee also confirmed that all 180 staff have now completed the OVA training as recommended by WorkSafe.

75. Ms Snell also outlined that the following measures have been implemented at Yallambee;

a) Review and changes to staffing and clinical structure

b) New clinical working group to discuss incidents, incident trends and other identified clinical concerns for improvement

c) A new clinical incident and feedback report form

d) Monthly operational and clinical risk meetings with involvement to department managers

e) Regular meetings with the Board of Directors

f) Increased Clinical Governance and Risk subcommittee meetings and review

g) Education to staff regarding the Serious Incident Response Scheme and responsibilities

h) Review, assessment, and advice from specialist dementia consultants of whether locks on residents' doors are appropriate, purchasing additional keys and review of current security measures;

i) Implement actions and updating care plans following open disclosure meetings

j) Re-establishment of Australian Grief and Bereavement care support group

k) Review of laser alarms as part of IT review recommendations from August 2021

l) Updating incident management support including staffing by senior clinicians and printing hand over sheets with contacts and emergency procedures

m) Dementia Support Australia has facilitated referrals for all residents at Waratah House and assisted with engagement and specialist support

n) Care plans of residents in the wing have been reviewed to gauge risks of future incidents

o) A complete change of the executive management team.

76. Ms Snell also advised that Yallambee was recently accredited in August 2022 by the Aged Care Quality and Safety Department, having met 44 out of 44 criteria underpinned by the Aged Care Quality and Safety Standards. Ms Snell stated that this demonstrated that *"Yallambee has emerged from the September 2021 incident and has addressed any shortcomings that were identified following the incident."*

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was PL, born 9 July 1929;

    b) the death occurred on 30 October 2021 at the Yallambee Aged Care Facility, Matthews Crescent, Traralgon, Victoria, 3844, from *1(a) Consequences of an assault*; and

    c) the death occurred in the circumstances described above.

COMMENTS

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

78. Caring for persons affected by dementia is inherently difficult. It is a progressive and unpredictable disease that impacts individuals differently. Almost half a million Australians suffer from the disease, and it is the second leading cause of death. [42] Aggressive behaviour can be a feature for dementia patients and more than 68% of aged care residents have moderate to severe cognitive impairment.[43]

79. The events that transpired at Yallambee on the night of 4 September 2021 were undoubtedly traumatic and irrevocably affected the lives of all those involved. Incidents of RRA often occur very quickly and without warning, as they did on this night. I do not consider that the severity and magnitude of this incident could have been reasonably foreseen by staff members.

80. Yallambee's staff on the night attempted to respond to the situation in a manner that they considered most appropriate in the circumstances and with regards to both personal and external health and safety considerations. They contacted emergency services quickly and also contacted staff at the Acacia Ward for assistance. It is regrettable that at that stage, staff had not been provided with physical instruction or training on how to de-escalate incidents of

[42] Dementia Australia Statistics accessed 26 October 2023 at https://www.dementia.org.au/statistics
[43] Ibid.

OVA. If so, the situation may have been dealt with differently. Ms Snell has confirmed that all staff have since undertaken the OVA training.

81. The findings in the ACQSC report are comprehensive and outlined the difficulties and limitations of Yallambee's processes and procedures at the time of the incident. In addition, they highlighted the deficiencies in the understanding and management of Mr Kilgower's condition, given his ongoing refusal of medications and deteriorating symptoms. It is regrettable that these issues were not assessed or monitored appropriately, particularly for Mr Kilgower's own health and wellbeing.

82. I accept that Yallambee has undergone a significant restructure in respect of its executive management team and has implemented multiple significant changes as outlined above by Ms Snell. It is anticipated that these changes will provide appropriate support and guidance to staff in managing complex situations and residents' needs. It is also hoped that these changes will mitigate or prevent any similar issues in future.

83. Instances of RRA will continue to pose a challenge for residential aged care providers due to factors such as increased aging population, an increase in the number of vulnerable people entering care and the difficulties of administering care to a large group of patients with varying levels of needs and cognitive impairment. Proactive approaches by care providers to monitor and manage RRA risks are vital. It is also apparent that further research on how best to address, manage and prevent RRA is still required.

84. I convey my sincere condolences to the family of PL for their loss as well as to the other residents and staff members who were impacted by this tragic event.

85. I order that this finding be published on the Internet in accordance with section 73(1) Coroners Act and in accordance with the Rules.

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

PL's daughter, Senior Next of Kin

DSC Luke Haxell, Coroner's Investigator

Colin Biggers & Paisley Lawyers on behalf of Yallambee Traralgon Village for the Aged

The Aged Care Quality and Safety Commission

Signature:

Katherine Lorenz

Date: 29 February 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.