FINDINGS of Coroner McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Dayle Patricia Weldon

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Dayle Patricia Weldon with an inquest, make the following findings.

Hearing Dates

1 and 2 November 2022 in Launceston and 22 November 2022 in Hobart, with written submissions received by 20 December 2022.

Representation

Counsel Assisting the Coroner: V Dawkins

Counsel for Regis Aged Care Pty Ltd ("Regis") and Kelly Binns: J Buxton

Counsel for Phaik Soh Vandenberg and Sharyn Bingley: R Phillips

Introduction and scope of inquest

1. This inquest involved an examination of circumstances surrounding the fatal fall of Mrs Dayle Weldon, an elderly resident of Regis Legana facility ("the facility") in Northern Tasmania. Mrs Weldon suffered dementia and was accommodated within the Allambi secure suite in the facility. Immediately before her fall, she had been very agitated and was unable to be effectively calmed by care staff. Her agitated behaviour included yelling and using her four-wheeled walker to bang on the exit door of the secure suite. Eventually, Mrs Weldon fell to the ground near the door and suffered a head injury. She died in hospital three days later as a result of that injury.

2. From the evidence in the coronial investigation, gathered over a number of years, there appeared to be questions concerning Mrs Weldon's care and supervision immediately before her death that could only be resolved by holding a public inquest and hearing from the staff members responsible for her care. Notably, there were inconsistencies in accounts between the relevant care staff, uncertainty about the circumstances of the fall and the response to Mrs Weldon's episode of agitation. Of particular relevance was the account of Sharyn Bingley, the Enrolled Nurse on duty, who stated that she had left Mrs Weldon in her state of high agitation for a short time before her fall to attend to dispensing Schedule 8 medications in another area of the facility. However, her account

in this regard was not apparently supported by the facility's Schedule 8 records gathered in the investigation. This issue on its own cast some doubt about the circumstances of Mrs Weldon's fall and the adequacy of her supervision.

3. In light of these matters, the scope of the inquest was as follows:

    a) Mrs Weldon's health in the week prior to her death, including any pain management provided to her.

    b) The sequence of events on 24 December 2018, including when, where and how Mrs Weldon fell.

    c) The supervision of Mrs Weldon on the evening of 24 December 2018.

    d) The actions of facility staff members Phaik Vandenberg (Registered Nurse), Sharyn Bingley (Enrolled Nurse) and Kelly Binns (carer) on 24 December 2018.

    e) The policies for the facility in December 2018 concerning the level of supervision of residents in the secure Allambi Suite and in the facility generally, including staff ratios.

    f) The options available to staff of the facility to manage agitated behaviour in residents.

Evidence in the investigation

4. In making my findings, I have had regard to the evidence gained in the comprehensive investigation into Mrs Dayle Weldon's death. The documentary evidence tendered at inquest comprised exhibits C1 to C31. The exhibit list is annexed to this finding.

5. At inquest the following witnesses gave oral testimony:

    - Kelly Binns, a carer at the facility;
    - Lee Robin Weldon, son of Mrs Weldon;
    - Phaik Soh Vandenberg, Registered Nurse ("RN") and nurse in charge at the facility at the relevant time;
    - Sharyn Bingley, Enrolled Nurse ("EN") at the facility; and
    - Filomena Ciavarella, the Executive General Manager of Strategy, Quality and Improvement for Regis.

Mrs Weldon's background and health

6. Mrs Weldon was born on 17 April 1925 in Launceston, Tasmania. At the time of her death she was aged 93 years of age. She was widowed, had three sons and was a retired nurse. She retired from nursing to care for her husband, who passed away in 1995 as a result of a stroke.

7. Mrs Weldon's son, Lee Weldon, gave evidence at the inquest and also provided a very detailed affidavit about his mother's life. At the inquest, he remembered his mother as active and *"full of beans",* and always involved in activities. He said that a *"lot of the life went out of her"* when her husband died and she continued to grieve for him after such a long marriage.

8. Mrs Weldon had been in good health, with no major medical conditions, until 2003. In that year, she suffered a severe stroke requiring a stenting procedure. In the years following, she was diagnosed with cerebrovascular disease, depression, Type 2 diabetes, reflux and arthritis.

9. In the several years before her death, Mrs Weldon was prone to falling. In November 2016 she suffered a significant fall hitting her head and requiring hospitalisation. It appears that following this fall, she suffered some functional decline.

10. Mrs Weldon had a number of witnessed and unwitnessed falls during 2017 and 2018. In early 2017 Mrs Weldon became a permanent resident of the facility. She required assistance to dress and shower. She used a four-wheeled walker for mobilising. A falls assessment was completed for Mrs Weldon on her admission to the facility, which identified that Mrs Weldon's falls in the past had been connected to leg collapses and that she suffered reduced limb strength in her left and right leg due to pain.

11. Whilst a resident of the facility, Mrs Weldon received regular visits and significant support from her sons and family members, who were loving and caring.

Circumstances surrounding death

12. In October 2018, Mrs Weldon moved to the Allambi Suite ("Allambi"), the only secure suite of the facility, due to her declining cognitive capacity. At that time, the Regis Legana facility had five accommodation suites, these being Cameron, Mountain View, Olivet, Gardam and Allambi.

13. Before being accommodated in Allambi, Mrs Weldon wandered out of the facility on several occasions, potentially placing herself in danger. She would express a wish to

leave the facility and also spoke of wanting to *"play chicken"* with cars on the road outside the facility.

14. In the weeks before Mrs Weldon's death, she regularly refused food and medication. From the beginning of December 2018 until her death, Mrs Weldon refused to take her medication on approximately twelve occasions. Notably, on the day of her fall, she refused lunch and dinner.

15. Kelly Binns was a member of the care staff of the facility who regularly looked after Mrs Weldon. Ms Binns described Mrs Weldon's behaviour in December 2018 as "*not much different than usual*". She said that she would display agitated behaviour and that "*she would walk around really fast, yell at people and state she wanted to get out of here*". She described occasions where Mrs Weldon had become upset or agitated and she (Ms Binns) had managed to calm her with a cup of tea or guiding her to her room.

16. Sharyn Bingley, EN, looked after Mrs Weldon regularly from the time she moved to Allambi. Ms Bingley gave evidence that Mrs Weldon was unsettled in Allambi and she did not consider that she had coped well with the move from Cameron. Ms Bingley gave evidence that she noticed a rapid deterioration in Mrs Weldon from when she saw her in Cameron to seeing her in Allambi.

17. In the days leading up to her death, Mrs Weldon showed distinct signs of physical and mental deterioration. She refused meals and medication and no longer enjoyed going outside. She exhibited signs of paranoid thinking, such as a belief that staff were poisoning her tea.

18. On 20 December 2018 staff of the facility, with agreement of Mrs Weldon's family, put in place arrangements to have a Norspan patch (transdermal opioid analgesic medication) prescribed and administered to her. Her general practitioner considered that this medication would be beneficial in managing Mrs Weldon's pain, paranoia and agitation. On the day of Mrs Weldon's fall, the Norspan patch had yet to be commenced.

19. I will now summarise the events leading to and surrounding Mrs Weldon's fatal fall as can be found upon the evidence. Further on in this finding, I set out and discuss the evidence given by the three witnesses who were staff members of the facility as there was focus upon the accuracy and credibility of that evidence and therefore any deficits in Mrs Weldon's care or supervision.

20. Following the conclusion of the evidence at inquest, the concerns regarding the witness evidence, particularly that of Ms Bingley, were resolved upon the production by Regis of records from the facility. This documentation partially, but importantly, corroborated the oral evidence regarding the circumstances of Mrs Weldon's fall and alleviated the concerns about whether Mrs Weldon's fall could have been reasonably prevented. Because I did not have that documentation prior to inquest, the investigation became prolonged and a public inquest was inevitable.

21. On 24 December 2018, Mrs Weldon had been outside in the secure courtyard and garden area attached to Allambi. When she returned inside, she sat on a lounge chair and put her head in her hands. She told carer Kelly Binns that she was experiencing a headache and was provided with medication which she initially refused. She then settled in her room until 5.00pm, had dinner and returned to her room.

22. By 8.00pm, Mrs Weldon was observed by staff to be pacing the suite and yelling. She also commenced to "ram" the exit door with her walker and to rattle the windows in an attempt to exit the facility, whilst yelling to get out. As she was not disturbing patients, she was permitted to continue her behaviour. At that time, Allambi had 16 residents of a maximum capacity of 18 residents.

23. By 9.00pm Mrs Weldon's behaviour was continuing. At that time Ms Bingley, the EN in Allambi, was asked by Ms Vandenberg (RN) to assist with Schedule 8 medication distribution in other areas of the facility. Schedule 8 medications must be administered by two personnel and are subject to strict requirements for documentation. Accordingly, Ms Bingley left Allambi to undertake this task in conjunction with Ms Vandenberg. There is no evidence that there was any other staff member apart from Ms Bingley readily available to perform this task.

24. The facility maintained a Schedule 8 medication register in Cameron which recorded medication administered to all suites in the facility, except Mountain View Lodge which is a separate building. Schedule 8 medications for the facility were also stored in Cameron before being taken to the residents in their suites.

25. By 9.15pm Ms Bingley completed the medication round with Ms Vandenberg. She immediately returned to Allambi and went to see Mrs Weldon, who responded angrily to her as she had not been allowed to leave. At this time, Mrs Weldon was yelling and ramming the exit door with her walker. The evidence in the investigation reveals that Ms Bingley and Ms Binns started to move away from her to provide her with space in the hope that she would become calmer. Mrs Weldon then suddenly jerked her

walker and fell backwards, hitting her head on the lower part of the exit door or, alternatively, the floor.

26. Ambulance Tasmania paramedics attended the facility and transported Mrs Weldon to the Launceston General Hospital. She was assessed as having a large subdural haemorrhage, with a very poor prognosis for survival. She was unsuitable for surgical intervention and was provided with comfort care until she passed away on 27 December 2018.

27. An autopsy was performed by pathologist, Dr Roseanne Devades. Dr Devades determined that Mrs Weldon suffered a catastrophic subdural haemorrhage as a result of her fall. I accept Dr Devades' opinion regarding the cause of Mrs Weldon's death.

Inquest scope issues

Management of Mrs Weldon prior to her death

28. I am satisfied that Mrs Weldon's care and management during her time in Allambi was of a good standard. Staff members did their best to manage her increasingly difficult behaviours and to have her accept her medication.

29. Mr Lee Weldon gave evidence at inquest that his impression of the care received by his mother at the facility seemed good and that he had no real complaints about it. He said that he was aware that she could be difficult at times but that staff handled her behaviours well. My general impression from the oral and documentary evidence is that Mrs Weldon received good care during her time in the facility.

30. One particular issue considered at inquest was that Mrs Weldon had still not received her Norspan patch, prescribed by her general practitioner, at the time of her fall. As noted above, the decision to introduce it had been made four days previously.

31. Ms Vandenberg was not aware of this prescription, but indicated that there is sometimes a delay between the general practitioner and pharmacy before medication is commenced. She noted that she would usually follow that up if it occurred.

32. A detailed affidavit was supplied by Filomena Ciavarella, Executive General Manager of Strategy, Quality and Improvement for Regis on 26 October 2022. In her affidavit and her court evidence she reviewed the notes and commented that the delay rested with the prescribing doctor. On 20 December 2022 the relevant note indicated that the patch was charted and a prescription was to go to the pharmacy. The note on 23 December 2018 at 10.30 am stated:

"…*will await Dr. to followup urgently her Norspan Patch from pharmacy as script was not written to dispense*…"

33. Thus, the delay in the Norspan patch being received at the facility was due to delay by the general practitioner in issuing the prescription and not any delay by staff of the facility. I am satisfied that the staff of the facility were actively following up the receipt of that medication for Mrs Weldon. It was desirable that she have the medication in a timely manner but there is no evidence that it was required as a matter of urgency.

34. Further, I am not able to say that Mrs Weldon would have been any less agitated on 24 December 2018 or that the fall would not have occurred if she had been using the Norspan patch at that time.

35. Ms Ciavarella noted that there was appropriate consideration by the staff of Mrs Weldon's pain levels. Specifically, on 24 December 2018 she was assessed as having nil pain, and she had been given about four doses of paracetamol. I am satisfied that Mrs Weldon did not suffer pain which lead to her agitation and fatal fall.

The sequence of events surrounding Mrs Weldon's fall on 24 December 2018

36. On 24 December 2018 in the afternoon shift, Ms Binns and Ms Bingley were working in Allambi. Ms Vandenberg was working as the RN in Cameron.

37. The evidence of these main witnesses were examined with a view to determining :

    a) The key factual circumstances surrounding the death;

    b) The records surrounding the schedule 8 drug that Ms Bingley stated she administered to explain her absence from Allambi; and

    c) The level of Mrs Weldon's agitation and the options available for the staff to manage her.

38. The sequence of events leading to the fall was described by Ms Binns as follows[1]:

    i. At the start of her shift, Mrs Weldon had been outside. She came in and sat in the lounge room, put her head in her hands and said she had a headache. Ms Binns told Mrs Weldon she would get the nurse and informed Ms Bingley. After this, she thought Mrs Weldon had her dinner and then went up to watch television in her room.

[1] The summaries of the evidence in this section are taken from Counsel Assisting's submissions and were not disputed by other counsel or interested parties.

ii. After dinner, Mrs Weldon came out of her room and was agitated, walking up the corridor and into people's rooms, yelling '*get me out of here*', and slamming her walker into walls. This went on for about half an hour. Ms Binns tried to talk to her, offered her a cup of tea, food, or to sit down.

iii. At around 9.00 pm Ms Bingley told her she was going to help with the Schedule 8 medication in Cameron with Ms Vandenberg. Ms Bingley was gone for around five minutes.

iv. Ms Bingley returned to Allambi two minutes before Mrs Weldon fell. During that time before the fall, Ms Binns and Ms Bingley discussed that they would leave Mrs Weldon for five minutes to see if she calmed down. She then turned to walk away.

v. When she turned to walk away, she noticed Ms Bingley was not coming, so she turned around and looked. She witnessed Mrs Weldon, with her four-wheeled walker starting to walk backwards, lose her balance and fall straight back. She was not sure if Mrs Weldon's head hit the entrance door or the floor, but she heard a "crack" noise. Neither she nor Ms Bingley were close enough to stop her from falling. Ms Bingley was about 2-3 metres away and she was further away towards the middle of Allambi.

vi. After the fall, Ms Binns sat with Mrs Weldon for 10-15 minutes. Lee Weldon was notified and attended. Ms Binns made him a cup of tea. She recalls Ms Bingley talking to Mr Weldon but did not hear that conversation.

39. The sequence of events leading to the fall was described by Ms Bingley as follows:

i. At 4.00 pm Ms Bingley saw Mrs Weldon with her head in her hands and Ms Binns informed her that Mrs Weldon had a headache. Ms Bingley went to ask her if she wanted some tablets for her headache. Mrs Weldon agreed to take some. She put her prescribed olanzapine and two Panadol tablets in Mrs Weldon's tea. It took some time for Mrs Weldon to drink the tea as she was suspicious about its contents. After Mrs Weldon took the olanzapine, she settled for a while.

ii. After this, Ms Bingley went about her usual routine with Ms Binns - caring for the Allambi residents and providing them with dinner.

iii. Sometime after dinner, Mrs Weldon became fixated with the exit door.

iv. At around 9.00 pm Ms Vandenberg rang her, stating words to the effect of *"when you're ready can you please come down and do the Schedule 8. I can see Dayle in the camera I didn't want to come up and upset her".* Ms Bingley replied *"yes, I'll be there".* When she left Allambi to assist with the Schedule 8 process, she thought that Mrs Weldon was in the vicinity of the exit door.

v. She went to Cameron and into the drug room, and met Ms Vandenberg there. They administered Targin, a Schedule 8 drug, to resident Thelma Lyons at around 9.00 pm. They had the drug chart and checked the drug order. Ms Vandenberg unlocked the safe and removed the Targin. They then checked it, wrote it in the register, signed it, and did the drug chart. They took all her other medications and went to her bedside and administered her tablets. This process took about five minutes.

vi. Whilst she was attending to the Schedule 8 process, she heard a *"wail or a wolf cry"* from Mrs Weldon emanating from Allambi.

vii. After the Schedule 8 process she went straight back to Allambi. She could see Mrs Weldon and Ms Binns on the other side of the door in the camera. She entered Allambi.

viii. When she walked through the door, Mrs Weldon was near the door. Ms Binns was talking to her trying to redirect her away, unsuccessfully. As she had walked through the door, Mrs Weldon had walked closer to the door, like she wanted to catch it before it closed. Once the door shut Mrs Weldon was angry and her behaviours escalated. Mrs Weldon rammed the exit door and was yelling something. They tried to coach her from the doorway. She rammed the door a couple of times with her walker.

ix. Ms Bingley said to Ms Binns '*We'll just leave her for a bit'*. Ms Bingley took a few steps. Ms Binns was ahead of her and went to walk off.

x. As they went to walk off, Mrs Weldon had a very tense fist on her walker and she made a sudden jerk or surge with it. Ms Bingley believed Mrs Weldon startled herself and then she saw her fall backwards and hit her head on the exit door. It was a very straight fall. She did not stagger back but she fell backwards onto the middle to lower part of the door.

xi. After Mrs Weldon fell, Ms Bingley called out and also called Ms Vandenberg on the telephone, requesting that she call an ambulance. They then commenced to monitor Mrs Weldon's vital signs.

xii. She telephoned Lee Weldon. She would have spoken to Mr Weldon but she did not apologise to him or say she had left Allambi *"to see someone"*.

40. Ms Vandenberg was the nurse in charge in Cameron on the date of the fall. On 24 December 2018 she recalled being called to Allambi by Ms Bingley in the evening, after tea time, because there had been a fall. She stopped what she was doing and went to Allambi. She saw Mrs Weldon on the floor, lying in the corridor between rooms 101 and 102 which is close to the entrance door to Allambi. Mrs Weldon was facing upwards with her feet pointing towards the dining room and her head towards the entrance door. Ms Bingley and Ms Binns were near Mrs Weldon. Ms Vandenberg could not recall seeing Mr Weldon or having a conversation with him.

41. Ms Vandenberg also did not recall administering Schedule 8 drugs with Ms Bingley generally or on that day. She could not remember hearing a wail or "wolf cry" or seeing Mrs Weldon on the camera screen outside Allambi. Ms Vandenberg stated she could not, in fact, ever remember hearing a resident's cry from Allambi when she was located in Cameron.

42. Mr Weldon gave evidence at inquest. He stated that he had seen his mother earlier that day. Her mood was good and they had talked and made arrangements for Christmas. He stated that he received a call from the facility at 10.00 pm. He could not remember the words but was told that his mother had had a fall and was unconscious. He went straight to the facility. He stated that he remembered someone apologising to him '*I'm sorry I should have been up here, I'd just gone down to see...*' and mentioned a name which he could not remember. He did not know who said that to him but he thought it was Ms Binns, who he had seen giving evidence at the inquest.

Schedule 8 administration and records

43. As stated above, Ms Bingley gave evidence that she administered a Schedule 8 medication, Targin, to Thelma Lyons, at around 9.00 pm on 24 December 2018.

44. In the facility notes, the entry made by Ms Bingley at 10.33pm on 24 December 2018 (after the fall) was "*with the RN in Cameron administering an S8 to another resident and the noise could be heard from another suite*".

45. As indicated above, Ms Vandenberg gave evidence that she had no specific memory of accessing and administering Schedule 8 medications on that day, but would assume she would have done them. Ms Vandenberg went through the records in some detail, explained the records and identified in the material that she was provided with and said that there was no entry which indicated a Schedule 8 administration by her and Ms Bingley on 24 December 2018.[2]

46. When she gave evidence on a second day, she said that Thelma Lyons was a resident in December 2018 and she was accommodated in room 217. She could not remember the medications prescribed for Ms Lyons but recalled that she took tablets. The description of the location of Ms Lyons' room is consistent with Ms Bingley's evidence.

47. The inquest was adjourned for further interrogation of Regis Tasmania records to identify whether any records were missing to corroborate Ms Bingley's account of being absent from Allambi for the specific purpose of administering Schedule 8 medications with Ms Vandenberg.

48. Prior to the commencement of the inquest, all relevant Schedule 8 records from the facility had been requested, and thought provided.

49. The affidavit of Sophie Andritsos, Senior Legal Counsel for Regis, was filed on 11 November 2022 after the evidence given by Ms Vandenberg, Ms Binns and Ms Bingley.

50. In her affidavit, Ms Andritsos deposed that Thelma Lyons was administered Targin at 9.00pm on 24 December 2018 as indicated on her personal drug chart signed by Ms Vandenberg. A copy of the personal drug chart was annexed to the affidavit. Ms Andritsos further deposed that the corresponding Schedule 8 drug register for that drug administration, which requires two signatures, was lost or missing. At that time, two signatures were not required on the personal drug chart and therefore Ms Bingley did not need to, and did not, sign it.

51. In May 2021, when further records were provided by the facility, upon request, for the Cameron and Mountain View Lodge Schedule 8 drug registers, the register relating to the Thelma Lyons entry was not included. The *Poisons Regulations* 2018[3] requires the facility to keep Schedule 8 records for at least two years from the creation of the record. It is unclear when this record was destroyed or misplaced. However, I do not consider that it was deliberately destroyed or withheld from the coronial investigation.

[2] She was provided with all the records the Coroner was provided with prior to inquest.
[3] Regulation 19.

52. I accept the submission of counsel for Regis that it was only at the commencement of the inquest in November 2022 that Regis was provided with the specific resident's name (Thelma Lyons) and dose of the relevant Schedule 8 drug (Targin) that Ms Bingley stated that she had administered at approximately 9.00pm on 24 December 2018. Therefore, it was only at that point that Regis became aware that the relevant Schedule 8 drug register was missing.

53. The importance of the Schedule 8 record to (a) corroborate Ms Bingley's evidence and (b) to make findings about Mrs Weldon's supervision at the time of her fall, was critical. It was most unfortunate that it could not be located. However, the personal drug record of Thelma Lyons ultimately provided by Regis was sufficient to corroborate Ms Bingley's account that there was an administration of Targin to that resident and that she (Ms Bingley) assisted in the process.

The supervision of Mrs Weldon on the evening of 24 December 2018

54. The evidence given by Ms Bingley and Ms Binns regarding the circumstances leading up to and surrounding Mrs Weldon's fall was consistent and was credible in its narrative. Both presented as caring and dedicated to their work. After hearing their evidence at inquest and resolving the issue associated with Ms Bingley's temporary absence from Allambi, the factual issues concerning possible inadequate supervision were resolved.

55. Ms Vandenberg's memory, both in her recorded statement with investigating officers and in her evidence in court, appeared to be poor in relation to that evening. For example, I would have expected that she would recall hearing a cry from Allambi or at least Ms Bingley talking to her about it. I accept Ms Bingley's evidence that this did occur. On several matters, Ms Vandenberg was of little assistance and this did not assist in resolving matters of fact.

56. In Allambi in the afternoon shift on 24 December 2018 there was one carer (Ms Binns) and one EN (Ms Bingley). Ms Vandenberg, RN, was the supervising nurse in Cameron.

57. When Ms Bingley left Allambi to administer the Schedule 8 medication, Mrs Weldon was supervised only by Ms Binns. It is the case, however that Ms Binns was supervising Mrs Weldon closely, talking to her in an effort to calm her and encourage her away from the exit door.

58. I am fully satisfied, after hearing the evidence at inquest, that Mrs Weldon was not left unsupervised or ineffectively supervised at any time during her period of agitation before her fall. It was not unreasonable in any way for Ms Bingley to leave Allambi for several

minutes to assist Ms Vandenberg with the important task of administering medication. Mrs Weldon had been agitated for a prolonged period and Ms Binns was confident in monitoring and supervising her.

59. At inquest, Ms Bingley suggested with some regret, that her act of leaving Allambi had the effect of escalating Mrs Weldon's behaviour at the exit door. That may have been the case but there was little that could have been done in that regard. It would have been unreasonable for Ms Bingley to withhold her assistance to Ms Vandenberg, even if she could have foreseen that it would cause an increase in Mrs Weldon's agitation.

60. I find that it was Ms Bingley (and not Ms Binns) who told Mr Weldon after Mrs Weldon's fall that she was sorry that she had left Allambi to go to another resident. I find that she was referring to leaving to administer Schedule 8 medication. Her apology was likely an expression of regret that she may have exacerbated the situation by leaving, rather than it being a statement that she was not there at the time of Mrs Weldon's fall.

General issues relating to Regis

61. None of the staff members of the facility who gave evidence considered lack of staffing to be an issue that led to Mrs Weldon's fall and death. Ms Binns stated that she did not think any amount of carers would have prevented what had happened and that if she had concerns about staffing she would have rung someone to come and help.

62. Ms Ciavarella noted that there were no vacant shifts on 24 December 2018 (afternoon). There was one carer and one nurse in Allambi, as scheduled. Ms Ciavarella said in her affidavit that there was also a flexible carer on that day who was working between Olivet and Allambi until 9.00pm. There was some general evidence from Ms Vandenberg, Ms Binns and Ms Bingley that there is now an additional carer on some shifts. This was confirmed by Ms Ciavarella's evidence.

63. Ms Ciavarella stated in her affidavit there are no staffing "ratios", as such, required in aged care, although the issue of required staffing in facilities is undergoing significant national reform.

64. Upon the evidence, I am satisfied that Allambi was fully and correctly staffed and that staffing issues did not contribute to Mrs Weldon's death.

65. Ms Ciavarella provided other comprehensive information in her affidavit relating to relevant policies, ongoing improvements made since the time of Mrs Weldon's death and regulatory monitoring. I accept the contents of the affidavits and, in particular note that there now exists a more comprehensive process for management and

documentation of Schedule 8 medications. I also accept that Regis had undertaken adequate falls risk assessments for Mrs Weldon and had in place appropriate prevention strategies at the time of her death. No more could have been reasonably done to prevent Mrs Weldon's fall.

The options available to staff to manage agitated behaviour in residents

66. It is plain upon the evidence that Mrs Weldon was very agitated prior to her fall and that this agitation caused the fall. Ms Binns gave evidence that it was not uncommon for residents to be in a state of agitation for an extended period requiring nursing and care staff to manage such episodes.

67. As a carer, Ms Binns described her options were '*try and comfort them, give them emotional support, offer them a drink or something to eat'*. If the behaviour escalated, she would inform the nurse or ring other carers. She said that sometimes not crowding the resident or leaving them would work.

68. Ms Bingley gave good evidence in this regard, confirming the approach used by Ms Binns and stating that she would initially use a diversional approach to focus a resident's attention on something else.

69. Ms Vandenberg said that when dealing with an agitated resident she would diffuse the situation in a calm manner by giving them space and making sure of her safety and the safety of other people around. She said that she may request the assistance of another nurse or carer.

70. Ms Ciavarella, in evidence at inquest, described her experience and involvement in investigating serious adverse events in the aged care and the health system. Her evidence was particularly helpful in assisting with the use of restrictive practices to manage a resident's behaviour. In very general terms, restrictive practices refer to the intentional restriction or control of a resident's movement or behaviour without their consent by use of physical force or chemical or environmental restraints.

71. She said in evidence that restrictive practices must be used as a last resort, must be for the benefit of the resident, and must be lawful with appropriate consent and appropriate medical review.[4] Further, they must be documented fully in the medical record and require evaluation.

[4] This process was also described by Ms Vandenberg in her evidence.

72. The *Behaviour and Restraint Management Policy* applicable for the facility at the time of Mrs Weldon's residency was annexed to Ms Ciavarella's affidavit. An example of the application of this policy occurred when Mrs Weldon was moved to Allambi. As her movements were restricted by being within a secure suite (and thus considered an environmental restraint), consultation with and the consent of relevant family members was obtained, as well as advice from a medical practitioner.

73. Ms Ciavarella stated that as Mrs Weldon was not subject to any other restrictive practices, the only options available to staff in managing her challenging behaviours were to work within her care and assessment plan. This was annexed to her affidavit, with the strategies contained in the plan, these being: (a) engaging her in useful activity, (b) calming the environment, (c) listening actively and acknowledging her feelings, (d) providing one-on-one emotional support from staff and family and (e) make a telephone call to her son and daughter-in-law.

74. She recognised that staff of the facility may have to respond, outside this plan but in a lawful manner, to behaviour of a resident which has the potential to harm the resident or others or to cause damage to property.

75. Ms Ciavarella noted that in response to Mrs Weldon's refusal to take medication there had been discussions with the family and her general practitioner and changes of medication were occurring. Further, she had been referred to the geriatrician on 27 November 2022 and it was not unusual that the appointment had not occurred within a month.[5] I accept that, at the time, these steps represented an appropriate escalation of Mrs Weldon's care and proper response to her difficult behaviour.

76. Ms Ciavarella further highlighted that on 23 December 2018 staff had discussed with Mrs Weldon's son whether she could be transferred to hospital in the event of an issue concerning her safety. That approval was granted by Mr Weldon. She noted that staff could also have called an ambulance or the police if the circumstances involved a sufficient level of risk or physical threat to others. I do not consider that these options were necessary or realistic at the time in question. There remained a reasonable chance that Mrs Weldon would imminently settle without instigating the significant step of calling police or ambulance. Staff members had been able to settle her in the past and, prior to her unexpected fall, it was reasonable for staff members to assess that she was not placing herself at significant physical risk.

[5] C30 - Referral for geriatric assessment.

77. Ms Ciavarella stated in her affidavit that *'staff adhered to the requirements set out in the BRM Policy (2018) in managing Mrs Weldon's behaviours through her documented behaviour assessment and care plans'.* I fully accept that this was the case.

Conclusion

78. In conclusion, I find that Mrs Weldon had undergone a rapid decline in her physical and mental condition in the weeks prior to her death, including an increase in her levels of agitation in the days before her death. She had been appropriately transferred to a secure suite of the facility. During her period in Allambi, she was provided with good care. As her condition noticeably deteriorated, steps were taken to provide her with additional medication and to have her assessed by a geriatrician. These matters were pending at the time of her death and there was no untoward delay associated with them.

79. In the hours before her death, where her agitation was increasing, the EN and carer took appropriate steps to attempt to calm her. At the time of her fall, she was under the supervision of both staff members who were dealing with the situation appropriately and lawfully. I make no criticism of the very short absence of the EN leaving Mrs Weldon for the purpose of assisting with Schedule 8 medications in another suite. Mrs Weldon's sudden movement with her walker causing her to fall backwards could not have been prevented and the strategy of the staff members in allowing her space for de-escalation of her behaviour was appropriate in the circumstances.

Formal findings required by section 28(1) of the *Coroners Act* 1995:

80. I find that:

    a) The identity of the deceased is Dayle Patricia Weldon, born 17 April 1925;

    b) Mrs Weldon died as a result of injuries sustained in a witnessed mechanical fall with head strike at Regis Legana;

    c) Mrs Weldon's cause of death was catastrophic subdural haemorrhage; and

    d) Mrs Weldon died on 27 December 2018 at the Launceston General Hospital in Tasmania.

81. The circumstances of Mrs Weldon's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

Acknowledgements

82. I am grateful to counsel assisting, Ms Dawkins, particularly for her very helpful closing submissions.

83. I acknowledge the co-operation provided by Regis in this inquest.

84. I convey my sincere condolences to the family and loved ones of Mrs Weldon.

Dated: 6 September 2023 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

LIST OF EXHIBITS

Record of investigation into the death of
WELDON, DAYLE

No.	TYPE OF EXHIBIT	NAME OF WITNESS	DATE TENDERED
C1	REPORT OF DEATH	CONSTABLE CURLEY	1.11.22
C2	DECLARATION OF LIFE EXTINCT	DR PETER RENSHAW	1.11.22
C3	AFFIDAVIT OF IDENTIFICATION	CONSTABLE DONALDSON	1.11.22
C4	POST-MORTEM	DR ROSA DEVADAS	1.11.22
C5	AMBULANCE TASMANIA RECORDS	AMBULANCE TASMANIA	1.11.22
C6	MEDICAL IMAGING REPORT	DEPARTMENT OF HEALTH AND HUMAN SERVICES	1.11.22
C7	NOTE REPORT AND INCIDENT FORMS	REGIS AGED CARE	1.11.22
C8	FALLS ASSESSMENT AND INCIDENT FORMS	REGIS AGED CARE	1.11.22
C9	MEDICATION DISPENSING RECORDS AND EMPLOYEE ROSTER	REGIS AGED CARE	1.11.22
C9.1	MEDICATION DISPENSING RECORD – CAMERON	REGIS AGED CARE	2.11.22
C10	MEDICATION DISPENSING RECORD 10.1 DAYLE WELDON 10.2 CAMERON 10.3 DOROTHY VELTMAN	REGIS AGED CARE	1.11.22
C11	REPRESENTATION	REGIS AGED CARE	1.11.22
C12	AFFIDAVIT	LEE ROBIN WELDON (SNOK)	1.11.22
C13	AFFIDAVIT	SHARYN BINGLEY	1.11.22
C14	STATUTORY DECLARATION	KELLY BINNS	1.11.22
C14a	DIAGRAM	KELLY BINNS	1.11.22

C15	**AFFIDAVIT**	**PHAIK SOH VANDENBERG**	**1.11.22**
C16	**AFFIDAVIT**	**CONSTABLE CURLEY**	**1.11.22**
C17	**AFFIDAVIT**	**CONSTABLE DONALDSON**	**1.11.22**
C18	**AFFIDAVIT**	**SENIOR CONSTABLE WALKER**	**1.11.22**
C19	**AFFIDAVIT AND INTERVIEW RECORDINGS**	**SERGEANT GENEVIEVE HICKMAN**	**1.11.22**
C20	**AFFIDAVIT**	**SERGEANT FORSYTH**	**1.11.22**
C21	**INTERVIEW (PENDRIVE)**	**BINGLEY; VANDENBERG AND SCENE**	**1.11.22**
C22	**GP RECORDS**	**EXETER MEDICAL CENTRE**	**1.11.22**
C23	**MEDICAL RECORDS**	**THS**	**1.11.22**
C24	**BEHAVIOUR AND RESTRAINT POLICY - 28.4.2017**	**REGIS AGED CARE**	**1.11.22**
C25	**STATEMENT FROM FILOMENA CIABARELLA**	**REGIS AGED CARE**	**1.11.22**
C26	**AGED CARE QUALITY AND SAFETY COMMISSION REPORT**	**REGIS AGED CARE**	**1.11.22**
C27	**SCHEDULE 8 CORRESPONDENCE**	**CORONERS OFFICE**	**2.11.22**
C28	**DIAGRAM OF REGIS AGED CARE LEGANA SUITES**	**REGIS AGED CARE**	**2.11.22**
C29	**DIAGRAM OF REGIS AGED CARE LEGANA SUITES – VANDENBERG**	**PHAIK VANDENBERG**	**2.11.22**
C30	**REFERRAL TO GERIATRICIAN – 27.11.18**	**LEGANA MEDICAL CENTRE**	**2.11.22**
C31	**STATEMENT OF SOPHIE ANDRITSOS**	**REGIS AGED CARE SENIOR LEGAL COUNSEL**	**22.11.22**