ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

SYDNEY HEARING

BUPA WILLOUGHBY CASE STUDY

SUBMISSIONS OF COUNSEL ASSISTING

Introduction

1. Mrs DE was born in 1947 and died on 15 August 2017 at 70 years of age.[1]

2. Between 6 July 2017 and 15 August 2017, Mrs DE was a resident of Bupa Aged Care Willoughby located at 71 Sydney Street, Willoughby New South Wales (**Bupa Willoughby**). This facility is, and was during the relevant period, operated by Bupa Aged Care Australia Pty Ltd (**Bupa**), an approved provider of residential aged care under the *Residential Aged Care Act 1997* (Cth).

3. Mrs DE had two daughters, Ms DI and DJ, who each gave evidence to the Commission to the effect that the standard of care provided to their mother fell below their expectations.[2]

4. Bupa provided documents concerning the period 1 July 2017 to 16 August 2017 (**relevant period**) relating to Ms DE's experience with Bupa Willoughby. Ms Maureen Berry, Executive Clinical Advisor at Bupa, made a statement in response to a notice from the Royal Commission.[3]

5. Ms Berry is an experienced registered nurse currently in her 46th year of practice.[4] During the relevant period Ms Berry was Chief Operating Officer of Bupa.[5] She was not involved in the direct care of Mrs DE, and she gave evidence based on a review of the relevant documents.[6]

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1 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, Death certificate, 15 August 2017, BPA.001.127.0191.

2 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001, 17 April 2019; Exhibit 3-36, Statement of DJ, 12 May 2019, WIT. 0190.0001.0001.

3 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [1] and [2]. A statement was also provided by Bupa employee which canvassed matters not relevant to this case study, Exhibit 3-37, Statement of Mr Timothy James Ross, 26 April 2019, WIT.0148.0001.0001.

4 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [7].

5 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [5].

6 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [9].

Background

6. In late 2016 Mrs DE was observed by her daughters to be experiencing some memory loss, forgetfulness and a small amount of confusion.[7]

7. In February 2017, Mrs DE had a fall at home and was taken to Royal North Shore Hospital where she was a patient for several weeks.[8]

8. Tests in hospital suggest that Mrs DE may have had a stroke or seizure.[9] Mrs DE had a history of cancer, having been diagnosed with lung cancer in 2002 and two brain tumours the following year.[10] While she had been in remission since 2004,[11] tests conducted during this hospital stay suggest that Mrs DE's cognitive and physical condition was deteriorating as a consequence of her previous medical treatment.[12]

9. Mrs DE was prescribed Epilim, an anti-seizure medication which was observed by Ms DI to improve her condition.[13]

10. Around mid-late February 2017, Mrs DE was assessed by an assessor from an Aged Care Assessment Team.[14] She was approved for a Home Care Package Level 4 package, Residential Respite - High Care and Residential Home Care.[15] The My Aged Care Client Record dated 3 March 2017 (**ACAT Assessment**) documents the care needs of Mrs DE, including that there must be an air mattress for pressure area care for Mrs DE.[16]

11. Around March 2017, Mrs DE's daughters started looking for a residential aged care facility.[17]

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7 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [9].

8 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [10]

9 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [12].

10 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [8].

11 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [8].

12 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [12]

13 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [12].

14 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [14].

15 Transcript, 13 May 2019, Berry, 1502.19-33; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 168, My Aged Care ACAT Assessment, 6 March 2017, BPA.036.002.9382 at .9383

16 Transcript, 13 May 2019, Berry, 1502.19-33; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 168, My Aged Care ACAT Assessment, 6 March 2017, BPA.036.002.9382 at .9383

17 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [20].

12. In May 2017 Mrs DE returns home from Royal North Shore Hospital. Upon her return arrangements were in place for Mrs DE to have assistance in her home with showering and shopping.[18]

26 May 2017 hospitalisation

13. On 26 May 2017, Mrs DE returns to Royal North Shore Hospital after suffering a second fall resulting in a right fractured humerus.[19] On this occasion she is admitted for a period of 41 days.[20]

14. At the time of admission, Mrs DE was experiencing other health problems including arthritis in her right knee, malnutrition, urinary retention and cognitive decline.[21]

15. As Mrs DE's cognitive condition declined, her ability to speak became limited.[22] A neurological assessment demonstrated a lack of capacity for decision making.[23]

16. Towards the end of her hospital admission Mrs DE was essentially bed or chair bound, requiring a significant level of care including full assistance and supervision in being mobile, activities of daily living and administering medication.[24] She had poor oral intake, and required lots of encouragement and supervision during meals.[25] Mrs DE was also at risk of developing pressure area injuries as she required assistance with most activities, including moving in bed.[26]

17. Mrs DE would often complain in hospital about pain or discomfort from her bed sores, fractured arm or arthritis.[27] Ms DJ observed that as Mrs DE lost her ability to speak it was more difficult to tell what was wrong, although there were times when she would moan,

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18 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [14].

19 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [16]

20 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Hospital Discharge Referral, 6 July 2017, BPA.001.127.0212.

21 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Hospital Discharge Referral, 6 July 2017, BPA.001.127.0212.

22 Transcript, DI, 1470.13-24.

23 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212 at .0213

24 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212; Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [22].

25 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212; Transcript 1470.26-38.

26 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [8]; Transcript, DI, 13 May 2019, 1471.1-2.

27 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [9]; Transcript, DI, 1471.7-16.

grimace and point to communicate that she was in pain.[28] Ms DI also observed that, while her mother could not necessarily tell her where the pain was or the extent of the pain, 'you could tell that something was really bothering her.'[29] Ms DI gave evidence that when Mrs DE needed to be turned because of her pressure sores '… it was really distressing. We would usually leave the room because she would be howling and moaning and she was very, very upset.'[30]

18. On 6 July 2017, DE was discharged from RNS Hospital and admitted to Bupa Willoughby on respite basis for two weeks.

Deficiencies in documentation

19. At paragraph 11 of her statement, Ms Berry made a number of observations based on her review of Ms DI's statement, medical records and other contemporaneous documents. These observations included:[31]

> "a. In relation to the clinical care provided to [Mrs DE] during the Relevant Period, and in particular, the management of [Mrs DE's] pain and discomfort while she was palliating, in my view [Mrs DE] was provided with clinical care that was appropriate to her particular needs and condition.[32]
>
> b. The documents maintained by the staff at Bupa Willoughby in relation to [Mrs DE's] care was not of a standard I would expect of staff in any Bupa home, and I do not consider it was prepared in a manner that is consistent with the policies, procedures and processes developed by Bupa..."[33]

20. Further, at paragraph 71 of her statement, Ms Berry states:

> On my review of the materials, I acknowledge that there were a number of departures from the expectations Bupa has of its employees, as outlined in the work instructions and policy documents listed [in the statement]. Those departures were related to communications with Mrs DE's family and the documentation managed by the Bupa Willoughby staff rather than the quality of care and safety provided Mrs DE.

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28 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [9].

29 Transcript, DI, 1471.11-14.

30 Transcript, DI 1471.7-11.

31 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [11].

32 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [11a].

33 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [11b].

Admission to Willoughby

21. During a telephone discussion on 2 June 2017, between a representative of Bupa Willoughby and Ms DJ, a general discussion took place regarding Mrs DE's care needs and the services that Bupa Willoughby could provide.[34] Ms DJ understood from this discussion that Bupa Willoughby would provide Mrs DE with the level of assistance that she needed.[35]

22. On 6 July 2017, Mrs DE was admitted to Bupa Willoughby on a respite basis although it was the expectation of her daughters that this would likely evolve into a permanent placement.[36] At the time of admission, Ms DJ had discussions with Bupa representatives during which Bupa were advised of a number of Mrs DE's health issues including her general physical incapacity, bed sores, arthritis, requirements for assistance with feeding, her cognitive incapacity, and her reliance on hearing aids and glasses.[37]

23. An agreement titled 'Bupa Willoughby Extra Services Resident and Accommodation Agreement – Respite' was entered into between Ms DJ on behalf of Mrs DE and Bupa. This document indicated that Ms DJ was Mrs DE's power of attorney, next of kin and primary contact, and that Ms DI was the alternative contact.[38]

24. On the date of admission a number of documents were created by Bupa staff, including an Interim Care Plan[39] and a Diet Analysis.[40]

25. On the date of her admission, staff of Bupa Willoughby were aware, or ought to have been aware, of the matters identified in the Royal North Shore Hospital Discharge Referral dated 6 July 2017 (**6 July Discharge Referral**).[41] These matters included:

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34 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [11].

35 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [11]; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 44, Aged Care Enquiry Form, 2 June 2017, BPA.001.153.0016.

36 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [12].

37 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [13].

38 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 51, Signed Respite Agreement, 6 July 2017, BPA.001.127.0150; Exhibit 3-34, Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 173, Enduring Power of Attorney, 13 March 2017, BPA.041.002.0329.

39 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 53, Interim Care Plan, 6 July 2017, BPA.001.127.0255.

40 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 171, Diet Analysis, 6 July 2017, BPA.041.002.0247.

41 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212; Transcript, Maureen Berry, 1503.17 – 1506.6.

a. Right humeral fracture, which was a communicated fracture of the head of the humerus which is a very serious fracture;[42]

b. 'Cognitive decline, cause unknown' and that the neuropsychological assessment demonstrated she had a lack of capacity for decision making;[43]

c. Malnutrition;[44]

d. That Mrs DE required "*lots of encouragement for oral intake and supervision during meals*";[45]

e. Urinary retention which was managed with an indwelling catheter;[46]

f. Risk of pressure areas; and[47]

g. The results of a blood test showed that Mrs DE had a high white cell count and high C-reactive protein, which together indicates that she had an infection.[48]

26. At the date of admission, Bupa Willoughby were also aware, or ought to have been aware, that Mrs DE did not have an advance care directive in place.[49]

The Interim Care Plan

27. It is the evidence of Ms Berry that it is not clear whether the 6 July Discharge Referral was available to Bupa Willoughby staff at the time of admission because the copy on the file did not have a date stamp indicating when it was received.[50] It was clear that the general practitioner who visited Mrs DE on the date of admission saw the 6 July discharge

42 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [21a].

43 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [21c].

44 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [21b].

45 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212 at .0214.

46 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212 at .0214.

47 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 50, Royal North Shore Discharge Referral, 6 July 2017, BPA.001.127.0212 at .0215.

48 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [21e].

49 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [18].

50 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [19]; Transcript, Maureen Berry, 1504.16.

summary.[51] Ms Berry agreed that, if Bupa Willoughby did not receive the 6 July Discharge Referral at the time of Mrs DE's admission, it was imperative for them to take steps to obtain it as soon as they could thereafter.[52] Any failure to obtain the document amounts to a breach of Bupa policy.[53]

28. The Interim Care Plan was prepared for Mrs DE by a Registered Nurse at Bupa Willoughby.[54] Relevant matters regarding the Interim Care Plan include that the document:

a. Does not mention Mrs DE's cognitive decline, which it should have;[55]

b. Specifies that glasses are worn at all times, but fails to specify that bilateral hearing aids were required;[56]

c. Identifies that Mrs DE had excoriation on her groin and required repositioning and pressure area care every four hours;[57]

d. Directs that Mrs DE required "full assistance" with meals and drinks. In this context full assist means that a staff member would need to be with a resident for their meals and to bring the food to their mouths (without forcing the resident to eat food) if the resident is unable to do so;[58]

e. Fails to specify that extra encouragement and supervision is required.[59]

29. There is no evidence to indicate that, with the exception of a hand written note regarding wound management on 13 August 2017, this plan was ever updated or replaced with a more comprehensive care plan during Mrs DE's time at Bupa Willoughby.[60]

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51 Transcript, Maureen Berry, 1504.22-46; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 160, Bupa Willoughby Nursing Progress Notes, 6 July 2017, record at 23:45; BPA.001.127.0295 at .0296.

52 Transcript, Maureen Berry, 1505.6-20.

53 Transcript, Maureen Berry, 1504.15 – 1505.6.

54 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 53, Interim Care Plan, 6 July 2019, BPA.001.127.0255.

55 Transcript, Maureen Berry, 1508.42 – 1509.3.

56 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [30j], [31d]; Transcript, Maureen Berry, 1509.42 – 1510.08.

57 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [30e]; Transcript, Maureen Berry, 1509.5-.20

58 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [30h].

59 Transcript, Maureen Berry, 1509.35-.40.

60 Transcript, Maureen Berry, 1508.16-.45.

Hospitalisation on 7 July 2017

30. On 7 July 2017, Mrs DE was transferred by ambulance to Royal North Shore Hospital.[61] At the time of admission at the hospital she presented pneumonia.[62]

31. Mrs DE had been found by paramedics with decreased consciousness, unchewed food and medications in mouth.[63]

32. As identified above, Bupa Willoughby had recorded in the Interim Care Plan that Mrs DE required full assist with eating. Mrs DE had also been assessed by a GP before her hospitalisation on 7 July 2017 and it had been identified that Mrs DE had "poor oral intake" and "poor swallow".[64] Bupa Willoughby were on notice that Mrs DE's care needs included close supervision during meals.

33. Ms Berry accepted in her oral evidence that the fact there was unchewed food and medicine in Mrs DE's mouth shows that the care provided to Mrs DE by Bupa Willoughby in relation to the clearing of her mouth was substandard. [65]

34. When put to Ms Berry that this oral evidence undermines the opinion expressed in paragraph 11(a) of her statement, identified at paragraph 19 above, Ms Berry stated that the opinion expressed in 11(a) was a reference to the management of her pain and discomfort and not a reference to the time she was transferred to hospital with unchewed food and medication in her mouth.[66]

35. In paragraph 73(c) of her statement, Ms Berry gives evidence that 'I would have expected that someone would have cleared [Mrs DE's mouth], provided she would allow it.' However, Mrs Berry's statement as a whole fails to make an appropriate concession about Bupa's substandard care of Mrs DE in this instance. In paragraph 71, Mrs Berry's statement expressed the opinion that Bupa's failures were limited to communication and documentation "rather than the quality of care and safety provided to [Mrs DE]." In oral evidence when Mrs Berry was taken to this paragraph (reproduced at paragraph 2 above),

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61 Transcript, DI, 1472.12-.20.

62 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 67, Royal North Shore Hospital Discharge Summary, 18 July 2017, BPA.001.127.0197 at .0197.

63 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 67, Royal North Shore Hospital Discharge Summary, 18 July 2017, BPA.001.127.0197 at .0197.

64 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 161, Doctor Notes, BPA.001.127.0220 at .0220.

65 Transcript, Maureen Berry, 1513.17-1514.1.

66 Transcript, Maureen Berry, 1514.25-.35.

and it was again put that this is an instance of substandard care, Ms Berry replied that 'it's an instance of failure to follow good safe practices'.[67]

36. After her re-admission on 7 July 2017, Mrs DE remained in hospital for 11 days.[68] At some stage during this hospital admission Ms DJ had a conference with a doctor, social worker and hospital registrar regarding palliative care.[69] The nature of this conversation was regarding the provision of counselling and support services that may be available, rather than any plans or direction about Mrs DE's final days.[70]

Return to Bupa Willoughby

37. On 18 July 2017, Mrs DE was again transferred back to Bupa Willoughby.[71]

38. On or about 20 July 2017, Ms DJ signed new accommodation agreement with Bupa, moving Mrs DE from a respite to permanent arrangement.[72] Again, Bupa were informed that Ms DJ was the power of attorney and primary contact for DE and Ms DI was the secondary contact.[73]

39. A Royal North Shore Hospital speech pathology discharge summary dated 18 July 2017 (**RNSH Speech Pathology Discharge**) gave details about Mrs DE's new diagnosis of dysphagia, further cognitive and functional decline, and detailed instructions about feeding based on speech pathology advice.[74]

40. The RNSH Speech Pathology Discharge was received by Bupa Willoughby on 18 July 2017. It was sent to Bupa Willoughby by facsimile on 18 July 2017,[75] and its receipt is evidenced in an entry in the Bupa Willoughby Nursing Progress Notes which states "*[r]eceived speech*

67 Transcript, Maureen Berry, 1515.7-.10.

68 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [14].

69 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [15].

70 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [15].

71 Statement of JD at [16].

72 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 62, Agreement between Bupa and DE, 20 July 2017, BPA.001.127.0109.

73 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [16].

74 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 59, Fax attaching discharge summary, 18 July 2017, BPA.001.153.0034 at .0036.

75 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 59, Fax attaching discharge summary, 18 July 2017, BPA.001.153.0034 at .0034.

pathology report from hospital (RNSH) Pt is on Dysphagic diet / mildly thickened fluid. CM will book speech path."[76]

41. The Royal North Shore Hospital discharge referral dated 18 July 2018 (**18 July Discharge Referral**), reflects the matters outlined in the RNSH Speech Pathology Discharge along with additional details about Mrs DE's cognitive and functional decline and a recommendation that Ms DE be referred to physiotherapy.[77]

42. The preferable view is that 18 July Discharge Referral was also received on or about 18 July 2018. Ms Berry gave evidence that the particular copy of 18 July Discharge Referral found on file was received by Bupa Willoughby on 25 July 2017 (a week after Mrs DE's readmission),[78] however it appears from the Medical and Allied Health Notes on 19 July 2018 that it had been received.[79]

43. The RNSH Speech Pathology Discharge and 18 July Discharge referral included identical instructions to '*monitor for signs of aspiration/penetration, coughing, wet gurgly voice with oral intake, reduced chest health*' (**RNSH Speech Pathology Directions**). Direction was also given for Mrs DE to be referred to a speech pathologist.[80]

44. At the time of her return to Bupa Willoughby, or in the few days following, the documents directing the care needs of Mrs DE should have been updated or replaced to reflect Mrs DE's care needs including the material deterioration in her health and the RNSH Speech Pathology Directions.

45. The Interim Care Plan was never updated to reflect the RNSH Speech Pathology Directions regarding Mrs DE's care needs to manage her dysphagia and risk of aspiration and

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76 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 160, Nursing Notes, 18 July 2017 at 9:20, BPA.001.127.0295 at .0296.

77 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 67, Discharge Referral, 18 July 2017, BPA.001.0127.0197 at .0201.

78 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [38].

79 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 161, Allied Health Notes, BPA.001.127.0220 at .0221.

80 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 59, Fax attaching discharge summary, 18 July 2017, BPA.001.153.0034; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 67, Royal North Shore Hospital Discharge Summary, 18 July 2017, BPA.001.127.0197.

choking.[81] This was a breach of Bupa's work instructions concerning care planning and dysphagia management.[82]

46. Ms Berry gave evidence that there is an expectation that the Bupa dysphagia management work instruction, which she described as being similar to the RNSH Speech Pathology Directions, would be followed by staff.[83] However, the expectation that staff will follow policy is no excuse for not including detailed instructions in assessment and care plans.[84]

47. On 18 July 2017 Bupa Willoughby staff completed a diet analysis and a nutrition and hydration assessment. The documents reflect in part the RNSH Speech Pathology Direction, however, both documents fail to reflect the level of care and supervision that was instructed particularly in relation to monitoring for aspiration risk.[85]

48. On 26 July 2017, Mrs DE was assessed by a speech pathologist.[86] The speech pathologist made recommendations, set out in the Bupa Willoughby Nursing Notes on a hand written note (**Speech Pathologist Recommendations**).[87] The Speech Pathologist Recommendations included that Mrs DE requires full assistance with oral intake and upright posture.

49. Bupa records show that a nutrition and hydration assessment reflective of the RNSH Speech Pathology Directions was completed on the date of Mrs DE's death.[88]

50. There is no evidence that the RNSH Speech Pathology Directions or the Speech Pathologist Recommendations were incorporated into a care plan (whether it be an update to the Interim Care Plan or the timely creation of a new care plan).[89] An update to the care plan documents to include these directions should have occurred within the first few days of Mrs DE's 18 July 2017 return to Bupa Willoughby. Failure to update or replace the Interim Care Plan had

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81 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [73a]

82 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 48, WI Res-03.2 Care Planning, 30 June 2017, BPA.046.016.6236; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 20, WI Res-4.3.5 Dysphagia Management, 1 September 2016, BPA.013.036.1010.

83 Transcript, Maureen Berry, 1519.14-23.

84 Transcript, Maureen Berry, 1519.25-30.

85 Transcript, Maureen Berry, 1518.18-1519.16.

86 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 160, Nursing Progress Notes, at 27 July 2017.

87 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 68, "Safe Swallowing Tips", BPA.036.002.5165.

88 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 80, Nutrition & Hydration Assessment, 15 August 2017, BPA.001.153.0023.

89 Transcript 1516.33-37.

material consequences for the standard of care provided to Mrs DE in that the physiotherapist failed to address Ms DE's respiratory status.[90]

51. On 26 July 2017, Mrs DE was assessed by a physiotherapist.[91] In breach of Bupa policy, this assessment was completed later than required and the physiotherapist failed to assess Mrs DE's respiratory status.[92] The failure to update the Interim Care Plan to adequately reflect the RNSH Speech Pathology Directions or the Speech Pathologist Recommendations led to this omission.[93] It follows that Ms DE lost the potential benefit of physiotherapy for respiratory issues.

52. Ms Berry gave evidence that she would expect the hand written note containing the Speech Pathologist Recommendations would be placed in Mrs DE's room.[94] In the absence of any direct supporting evidence from witnesses present at the time, it cannot safely be concluded that the handwritten instructions were so displayed, or (if they were displayed) for how long they were on display.

Care provided between 18 July and 14 August 2017

Assistance with feeding and adequate nutrition

53. During the relevant period, DE was unable to feed herself and was dependent on staff for assistance; she was bed bound and unable to move her limbs.[95]

54. Ms DI gave evidence that on most occasions when she visited Mrs DE, she found a tray of cold food next to her. The tray would be full of food and it appeared that she hadn't eaten any of her meal.[96] Ms DI described an occasion she observed in relation to Bupa's assistance feeding Ms DE as follows:

> On one occasion when we were visiting (and [DI's aunty] was visiting as well), a nurse came into the room and collected Mum's full tray of food. On this occasion [DI's aunty] asked "why

90 Transcript, Maureen Berry, 1516.1-37.

91 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 161, Allied Health Notes, BPA.001.127.0220 at .0223-5.

92 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 70, Physiotherapy Assessment, BPA.007.001.8399; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 2, FM Res 03.6 Physiotherapy Assessment, 2 September 2014, BPA.007.001.8399; Transcript, Maureen Berry, 1516.27-31; Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [73b].

93 Transcript, Maureen Berry, 1516.27-31.

94 Transcript, Maureen Berry, 13 May 2019, 1532.23-43.

95 Transcript, DI, 1473.14-26.

96 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [27].

> are you taking her tray when she hasn't eaten anything?" and the nurse said to us "She's not hungry. She doesn't eat. She's not hungry" and proceeded to scrape the entire contents of her meal into the bin and walk away. [DI's aunty] replied "Of course she isn't telling you this, she can't hear you, and she cannot speak/communicate." The nurse clearly shrugged off this comment and went about her business…"[97]

55. DI formed the impression from the conduct of the staff that they had made not made adequate attempts to feed Mrs DE.[98]

56. Around 2 August 2017 Ms DJ and DI requested a meeting with Bupa Willoughby staff to discuss their concerns regarding Mrs DE's care, including that she not being assisted with her eating.[99] This conference occurred on 10 August 2017.[100]

57. DI gave evidence that, on occasions where time was spent with Mrs DE to encourage her to eat, or food that Mrs DE enjoyed was provided to her, she could be encouraged to eat food.[101] Around 2 August 2017, Mrs DE's sister visited Mrs DE every day for a week, and during these visits assisted with feeding. Ms DI observed that Mrs DE 'really perked up over that week' and that she 'was looking more full in the face and alive and a lot healthier'.[102]

58. Following the conference, on 11, 12 and 13 August 2017, Daily Food Intake Records were completed detailing food and beverages consumed on these days.[103] There is an absence of such records for the balance of the days Mrs DE was a resident at Bupa Willoughby.

59. The Nursing Progress Notes contain a number of entries indicating instances where assistance was provided, or where food was consumed or refused.[104] These records do not cover each meal time during the relevant period, nor do they provide detail regarding the level of assistance provided.

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97 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [27].

98 Statement of DE at [28]; Transcript, DI, 1473.27-1474.30.

99 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [29].

100 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [18].

101 Transcript, DI, 1473.47-1474.1.

102 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [29]

103 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 166, Daily Food Intake Record, BPA.001.145.0003.

104 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 160, Nursing Progress Notes, BPA.001.127.0295. The relevant entries are identified in the Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [96].

60. It can be concluded from the evidence that, for the majority of her stay, Mrs DE did not receive adequate assistance from Bupa with feeding and drinking. It is unclear on the evidence what the cause of the inadequate assistance was.

61. Training of staff may have been a cause. When Ms Berry was asked during her oral evidence whether the staff at Bupa Willoughby at the time were adequately trained to properly assist people with cognitive issues with their feeding, she replied:

> I would expect so because this would not have been the only resident with a cognitive issue. However, Bupa Willoughby is not a home that has a specialist dementia unit such as, but there is training and instructions available, but I can't recall the last time staff were – had education on this – on this point of care.

62. The absence of a care plan reflecting the RNSH Speech Pathology Directions and/or the Speech Pathologist Recommendations may have contributed to Mrs DE not getting the optimal nutritional work intake she otherwise would have received.[105]

63. The failure to properly manage Mrs DE's hearing aids and glasses, discussed below, could also have been a contributing factor. In evidence, Ms Berry agreed that the absence of Mrs DE's hearing aids, including the omission of relevant instructions in this regard, could have had a real impact on the extent to which Mrs DE was able to take in food.[106]

Hearing aids and glasses

64. Bupa had been notified from the time of the initial assessment that Mrs DE had hearing and visual impairments requiring bilateral hearing aids and glasses.[107] Mrs DE was quite deaf and needed her glasses to see.[108]

65. Mrs DI gave evidence that Mrs DE's glasses and hearing aids would often go missing during her stay at Bupa Willoughby, and that her hearing aids were frequently flat or were not placed in Mrs DE's ears.[109]

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105 Transcript, Maureen Berry, 1519.30-36.

106 Transcript, Maureen Berry, 1519.38-44.

107 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 168, My Aged Care Client Record, 6 March 2017, BPA.036.002.9382 at .9384.

108 Transcript, Maureen Berry, 1475.43 – 1476.5.

109 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 [31] and [32]; Transcript, DI, 1475.41-1477.16.

66. This evidence shows a failure by Bupa to meet Mrs DE's care needs with regards to her hearing and vision, amounting to substandard care.

67. These aids were critical to her, particularly as someone with cognitive decline experiencing communication difficulties.

68. It is likely the omission of provision and use of her hearing aids and/or glasses meant Mrs DE was more likely to have felt bewildered, confused and distracted and less likely to be able to communicate and follow tasks. It may have increased her agitation.[110]

69. Ms Berry did not accept that the omission of the reference to the hearing aids in the Interim Care Plan was a gap in care. She described the omission as a material piece of information that would have directed care.[111]

70. The fact that the Interim Care Plan omitted reference to the hearing aid probably contributed to Mrs DE not having had the benefit of provision and use of her hearing aids.

Pressure sores

71. During the relevant period, Bupa Willoughby were also on notice in relation to shortcomings existing in its delivery of care regarding pressure sores as identified in an internal audit conducted in December 2016.[112] The audit report identified a number of shortcomings that had been observed at Bupa Willoughby around skin care.[113]

72. From the time of Mrs DE's initial admission, Bupa Willoughby had been aware of her risk of pressure sores and the ACAT assessment that there must be an air mattress for pressure area care for Mrs DE.[114]

73. The Interim Care Plan directed that repositioning would occur every four hours.[115]

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110 Transcript, Maureen Berry, 1510.1-44.

111 Transcript, Maureen Berry, 1510.41-44.

112 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 29, Bupa self-assessment report, 23 December 2016, BPA.001.033.2067.

113 Transcript, Maureen Berry, 1520.9-1521.37.

114 Transcript at 1502.35-38; Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [17]; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 34, Email attaching - My Aged Care - ACAT assessment, 6 March 2017, BPA.036.002.9381.

115 Transcript, Maureen Berry, 1522.4-9.

74. A Brayden Risk Assessment Scale Assessment was completed for Mrs DE.[116]

75. The purpose of the assessment is to determine the level of risk that a particular person has to developing pressure injuries. It is an important document as it determines how often interventions and what kinds of interventions will be indicated.[117]

76. The Brayden Risk Scale Assessment resulted in the categorisation of Mrs DE as "very high risk". The Brayden Risk Scale Assessment is undated, so it is unclear what date it occurred. However, a Skin Integrity Risk Assessment dated 22 July 2017 indicates that the Brayden Risk Assessment had been completed by this time. The document identifies that Mrs DE was a "high risk" requiring "reposition 1-2 hourly".[118]

77. In oral evidence, Ms Berry accepted that it was Bupa policy that for residents assessed as "high risk", Bupa policy was that there would be more frequent repositioning than four hours, being 'up to every two hours'.[119]

78. The Interim Care Plan was never updated to reflect the outcome of the Brayden Risk Scale Assessment. This constitutes a gap in care.[120]

79. There is nothing in Bupa's records to indicate that Mrs DE was provided with an air mattress. If an air mattress was provided it is expected this would be recorded in Bupa's records.[121]

80. On 13 August 2017 an open pressure wound was detected on Mrs DE's buttocks.[122]

81. A photograph produced by Bupa Willoughby shows a pressure wound approximately 4 cms long by 3 cms wide.[123] Contrary to Bupa policy, the photograph is not labelled and does not include a ruler next to the wound to properly record it.[124] It can be inferred that this is a

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116 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 155, Braden Risk Assessment Scale, undated, BPA.001.153.0026.

117 Transcript, Maureen Berry, 1522.16-27.

118 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 175, Skin Integrity Assessment, 22 July 2017.

119 Transcript, Maureen Berry, 1523.25-28.

120 Transcript, Maureen Berry, 1522.16-1523.36.

121 Transcript, Maureen Berry, 1502.34-43.

122 Transcript, Maureen Berry, 1502.45 – 1503.1; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 53, Interim Care Plan, 6 July 2017, BPA.001.127.0255, handwritten note on back of page.

123 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 172, Photograph – bed sore, undated ATU.0001.0001.0381_E.

124 Transcript, Maureen Berry, 1524.18-41.

photograph of Ms Berry taken on 13 August 2017.[125] The annotation on the reverse of the Interim Care Plan understates the size of the wound.[126]

82. In oral evidence, Ms Berry said that the photograph shows "evidence of healed pressure injuries", that the pressure area "would have been reddened for some time" and that "when staff were providing personal cares, such as washing her… they would have had an opportunity to view all of her skin and see what the condition was… and they would have noted that it was becoming red and should have raised the alarm to the registered nurse."[127]

83. Mrs Berry said further that:

> "[Mrs DE] already had a number of pressure area sores that were – that had occurred to her while she was in hospital. As they appeared to have healed, but this is very new skin and it's very easy for the new skin, with a minimum amount of pressure, to start to deteriorate again."[128]

84. In the Nursing Progress Notes there is an entry on 13 August 2017 which states '*Carer reported about the pressure sore on left buttocks, dressing applied, commenced on wound management and* [pressure area care].'[129]

85. There is no documented record of what, if any, pressure injury care Bupa was providing Mrs DE before this date. This entry suggests that there was not any wound management or pressure area care before this date.

Pain management

86. Mrs DE was a resident of Bupa for a period of four weeks before her death on the evening of 15 August 2017. During this time, Mrs DE had a number of painful conditions including arthritis, a recovering broken humerus and nascent pressure injury issues which presented as a wound on 13 August 2017.[130]

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125 Transcript, Maureen Berry, 1524.38-41.

126 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 53, Interim Care Plan, 6 July 2017, BPA.001.127.0255.

127 Transcript, Maureen Berry, 1524.25-1525.

128 Transcript, Maureen Berry, 1525.24-27.

129 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 160, Nursing Progress Notes, at 13:30 13 August 2017, BPA.001.127.0295 at .0302.

130 Transcript, Maureen Berry, 1529.41-44 and 1523.38-45.

87. The Nursing Progress Notes include a number of entries stating words to the effect that Ms DE was not experiencing pain. For example on 18 July 2017, the date of Mrs DE's return to Bupa Willoughby the note states as follows:

> Rt BIB Rt transport @930hrs Rt alert and confused @ times. ***Rt screaming ? reason. Nil c/o pain or discomfort when asked.*** Obs refused by Rt initially but allowed. BP – 130/86, T-36.9, SPO2 97%, RR -19, DR – 100bpm, NOK informed about Pt is with (BUPA) us now. Medication changes as per discharge summary. 1010hrs (emphasis added).

88. At this stage, Mrs DE was unable to communicate verbally and had experienced significant cognitive decline.

89. Mrs Berry agreed that during the second admission to Bupa Willoughby, Mrs DE was essentially unable to communicate verbally and was therefore indicated for the Abbey Pain Scale.[131] The Abbey Pain Scale is used to determine if someone is in pain when they are unable to verbally communicate.

90. An Abbey Pain Scale Management intervention was prepared by a Bupa Willoughby registered nurse, however it was only administered from 18 to 22 July 2017, and was then discontinued.[132] The

91. The Bupa nursing staff should have continued to administer the Abbey Pain Scale on at least a daily basis for Mrs DE.[133] In the absence of this being done it is impossible to form a reliable conclusion that Mrs DE was not in pain. This constitutes a serious failure of care.[134]

Communication with family and palliative care planning

92. On 20 July 2017, Ms DJ signed a permanent resident agreement which again specified that she was Mrs DE's Power of Attorney, next of kin and primary contact.[135]

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131 Transcript, Maureen Berry, 1530.9-13.

132 Bupa Tender Documents, tab 65, Abbey Pain Scale, 22 July 2017, BPA.007.001.8910.

133 Transcript, Maureen Berry, 1530.15-24.

134 Transcript, Maureen Berry, 12 May 2019, 1530.15-46.

135 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 [16]; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 62, Agreement between Bupa and DE, 20 July 2017, BPA.001.127.0109.

93. On 9 August 2017, a specialist palliative nurse from Greenwich Hospital attended Mrs DE without notice by Bupa Willoughby to Ms DI and Ms DJ.[136] DJ found out about the visit through a telephone call with her aunty, who was present at the appointment because she happened to be visiting Mrs DE at the time.[137] It is the evidence of Ms DJ that:

> 'If I had known [the appointment was happening], I would have wanted to be present so that I could have input into Mum's plan to make sure it was in line with what I thought Mum would have wanted. I would have also liked to be able to ask questions so that I could understand the state of mum's health at that time and what to expect in Mum's last days.'[138]

94. The palliative nurse recommended certain analgesics for Mrs DE, including a Norspan Patch and Endone PRN (as needed), and for end of life care medications for pain Morphine 2.5mg PRN, Midazolam 2.5mg PRN and a further item for nausea PRN.

95. On 11 August 2017 the palliative medications were prescribed and the Norspan patch was applied to Mrs DE.[139]

96. Ms DI and Ms DJ were dissatisfied with the level of information they were receiving from Bupa Willoughby, including a lack of information about visits by Bupa Willoughby's GP to Mrs DE.[140]

97. On 10 August 2017, a conference was held by Bupa Willoughby with the GP present, together with the daughters. During this meeting they were given a copy of the recommendations of the Greenwich Hospital nurse.[141] During the meeting the daughters were advised that it was not recommended they transfer Mrs DE to hospital due to her frailty.[142]

98. In her statement, Ms Berry correctly expresses the opinion that "[i]n my view, the staff in the Bupa home did not communicate effectively with DE's family about her health, ongoing

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136 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [17]; Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [37].

137 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [17].

138 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [17].

139 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 163, Medication Chart, BPA.001.127.0257 at .0265.

140 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [38].

141 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [18].

142 Exhibit 3-36, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at [18].

clinical and non-clinical care needs, and the family's expectations of DE's palliative care once she returned from the Royal North Shore Hospital on 18 July 2017."[143]

99. The failure by Bupa Willoughby to coordinate a meeting between the palliative care nurse and Ms DI and Ms DJ was correctly accepted by Ms Berry to be a shortcoming in communication and preparing for what was about to happen.[144]

100. Mr Berry correctly accepted in oral evidence that in the context of end of life care it is critical to include authorised representatives in the family in planning. It is critical because the accepted clinical approach to clinical care encompasses not only the person who's dying, but also their family.[145]

101. The importance of involving family members in the palliative care process through a family conference is a matter addressed in the National Health and Medical Research Council 'Guidelines for a Palliative Approach in residential Aged Care.'[146] The guidelines indicate that one feature of such conferences is that help should be provided to family members on what to expect.[147]

102. During the relevant period, Bupa's approach to communication with Ms DJ and Ms DI in relation to Mrs DE's ongoing care requirements was unacceptable. It fell below the level of communication to be expected from aged care providers. The lack of consultation regarding Mrs DE's ongoing health is of particular concern given the neurological assessment demonstrating that Mrs DE had a lack of capacity for decision making.[148]

103. During the relevant period, Bupa's approach to the involvement of Ms DJ and Ms DI in palliative care planning process were unacceptable. It fell below the standards expected of aged care providers in this regard, including a failure to meet the Palliative Approach in residential Aged Care Guidelines.

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143 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [11c].

144 Transcript, Maureen Berry, 1527.37-1528.8.

145 Transcript, Maureen Berry, 1526.17-32.

146 Exhibit 3-39 Guideline for a Palliative Approach in Residential Aged Care, approved by the National Health and Medical Research Council, May 2016, RCD.9999.0049.0016.

147 Transcript 1526.34-1527.9.

148 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 67, Discharge Referral, 18 July 2017, BPA.001.0127.0197.

Events of 15 August 2017

104. On the afternoon of 15 August 2017, Ms DI arrived at Bupa and found her Mum in a chair asleep and unattended. Ms DI noticed that her breathing was rapid and that her chest sounded rattly.[149] The nurse moved Mrs DE to her room and gave her oxygen.[150] Staff at Bupa told Ms DI that they would keep an eye on her and that 'she should be fine'.[151]

105. At about 6 pm that evening Ms DI received a call from a Bupa Willoughby nurse.[152] Ms DI struggled to understand what she was saying, it seemed to Ms DI that the nurse did not speak English very well.[153] Ms DI was asked whether she wanted Bupa Willoughby to call an ambulance.[154] Ms DI was confused and did not know what was going on and did not feel capable of making a decision with the lack of information.[155] When she asked for an update on Mrs DE's condition, the nurse replied 'could be pneumonia. I don't know'.[156] The Bupa nurse did not give Ms DI 'any idea of [Mrs DE's] condition, symptoms or whether she had declined, her level of consciousness etc'.[157]

106. Ms DI and DJ arrived at Bupa later that night and found their mother breathing loudly and with difficulty. The following evidence of Ms DI regarding the events of that evening should be accepted:

> 20. [DI] and I drove to Bupa Willoughby together. When I arrived, I could hear Mum's breathing 20 meters down the corridor, it was so loud. When I got into the room I could see that her breathing was very laboured, and she looked uncomfortable. There was no one around to help my Mum. I felt quite panicked at this stage, my sister and I were taking turns running around looking for someone and staying with Mum. This went on for at least 30 minutes before we could find someone to help us.
>
> 21. Even when we were able to find people, we felt they did not know how to handle the situation. I recall that there was a male nurse [DN] and a female [DO] staff member on duty that night. They did not speak very good English and it was difficult to communicate with them, in particular [DO]. When we asked for help the female nurse told me 'we're busy, we'll

149 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [41].

150 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [41].

151 Transcript, DI, 1479.40.

152 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [42].

153 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [42].

154 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [42].

155 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [42].

156 Transcript, DI, 1480.18-19.

157 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [42].

> get there when we can.' When the staff members came to Mum's room they did not do much. They would adjust the oxygen tank and then disappear for another 30 minutes.
>
> 22. We had a print out of the palliative care nurse's medication plan. We got out that piece of paper and showed it to one of the nurses. If felt like we were begging them to give Mum the medication listed on that plan. Eventually they did give Mum something, although it seemed to me that they had not even considered giving her drugs before we asked.
>
> 23. Over the course of the night we attempted to call the palliative care nurse directly at Greenwich Hospital. She found Mum's file and spent a lot of time talking to us. She was he only person that night that spoke to us about what was happening and what to expect.

107. At about 9.30pm that evening, the afterhours GP attended Ms DE. The attendance of the visit was described by Ms DI in the following evidence, which should be accepted:

> At about 9:30 pm the GP arrived to come and see Mum (this was not the regular GP that saw Mum as part of Bupa Willoughby – from what we could gather he was from an out of hours doctors service). He looked at Mum, checked a few things as far as her breathing and chest, then said something under his breath to the nurse and then walked out. He was in the room for all of about 90 seconds. [Ms DJ] called the DP back and said "Hold on, can you please tell us what is going on?" He replied "This is not my area of expertise". He gave us no other indication as to Mum's condition, what was happening, if or how she was declining, what to expect. We were completely in the dark. Once he'd left the room [DJ] and I looked at each other in disbelieve and felt helpless.

108. On 15 August 2017 Mrs DE was administered 2.5 milligrams of morphine sulfate at 17:45 and 18:80 and 19:30, Robunul (which had been prescribed by the afterhours GP) at 20:40 and midazolam at 21:45.[158]

109. Mrs DE passed away at 11pm.

110. Ms Berry gave evidence that the clinical care provided on that day was adequate.[159] No such finding should be made. It is unclear on the evidence whether the clinical care provided to Mrs DE on this evening was appropriate.

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158 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [101].

159 Exhibit 3-38, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [103].

111. The evidence of Ms DI and Ms DJ regarding their interactions with Bupa staff as set out in paragraphs 108 and 109 above should be accepted. The frequency, duration and nature of these interactions was unacceptable.

112. The cause of these substandard interactions is unclear. Mrs Berry gave evidence that the level of staff working during the relevant time on 15 August 2017 was consistent with Bupa Rostering principles.[160] The evidence of Ms DI and Ms DJ however suggests that the rostering principles do not provide for adequate staffing levels.

Complaint to the Aged Care Complaints Commissioner

113. On 21 September 2017 Ms DJ reported her concerns regarding Bupa Willoughby to the Aged Care Complaints Commissioner (**Complaints Commissioner**).[161]

114. This complaint led to an investigation into the matter by the Complaints Commissioner and a number of interim findings being made against Bupa Willoughby in relation to the care of Mrs DE.

115. In the course of the investigation by the Complaints Commissioner, Bupa wrote a letter to the Complaints Commissioner dated 4 May 2018 attaching a table which included responses to concerns raised by the Complaints Commissioner.[162]

116. The 4 May 2018 letter states "*As a matter of transparency, we note that unfortunately this review did not include interviews with the employees who provided direct care to* [Mrs DE] *as they are no longer employed by Bupa*."[163]

160 Transcript, Maureen Berry, 1533.46-1537.19.

161 Exhibit 3-35, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at [57].

162 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 118, Bupa response to Complaints Commissioner, 4 May 2018, CTH.4001.1001.2866; Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 116, Response to Complaints Commissioner Notice of Intention to Issue Directions Willoughby, BPA.007.001.8782.

163 Exhibit 3-34, Bupa Willoughby Case Study Tender Bundle, tab 118, Bupa response to Complaints Commissioner, 4 May 2018, CTH.4001.1001.2866 at .2866.

117. The evidence shows that this statement is incorrect, as there were four registered nurses directly involved in the care of Mrs DE during the relevant period and who remained employees of Bupa Willoughby as at 9 April 2019.[164]

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31 May 2019

[164] Transcript, Maureen Berry, 1493.19-1496.32.