Current key issues and the impact of the Quakers Hill Coronial Inquest Findings

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Overview

- Nursing home fire – 5am, 18 November 2011
- 81 residents residing at home at time
- 14 deaths
- Roger Dean, Registered Nurse, deliberately lit fires in two areas of the nursing home

Coronial Inquests

- Not criminal or civil trials – not about guilt
- Dean pleaded guilty and was convicted of 11 counts of murder and 8 counts of recklessly causing grievous bodily harm
- Sentenced to life without parole
- Key question – How did Dean get in the position to light the fires?

Dean's employment at Quakers Hill

- Applied for a nightshift part-time RN role (unsupervised) on 6 September 2011 (started 13 Sept 2011) – fire 17 November 2011 (interrupted 3 month probation period)
- Facility desperately needed an RN who could cover nightshift
- Dean provided his resume, RN registration and some written references
- A police check was performed

Resume

- August 2007 to 'current' – Cheese Cake Shop
- Limited aged care experience (2002-2004)
- Last RN experience – ended July 2007 (St George public hospital)
- Referees – Cheese Cake Shop owner (also live-in partner) & Mr Bernardi of St Vincent's Hospital (worked there in 1997 for 3 months)

No reference checks

- St George Hospital (May 1997) – damaged car and splashed paint on supervisors car after argument

- St John of God Hospital (2011) – found drug affected at work (slurred speech, white froth around mouth, uncoordinated, unable to administer medication or read medication charts) – moved to dayshift from nightshift - told management he was bipolar and depressed

Coroner found:

- Resume was misleading
- References were out of date and timeworn
- No reference, referee or former employer checks
- No medical check – despite policy requiring same
- Employed after an interview of less than 1 hour

Events of 16 & 17 November 2011

- Dean spending large amounts of time alone in treatment room (about 2 hours per shift, 36 occasions per shift) with door closed and locked (S8 cupboard in treatment room)
- Sticky tape wrapped around blister packs
- 8.30pm on 17 November 2011 – management identified that 237 Endone (narcotic opioid analgesic) tablets were missing

Two suspects

- Afternoon shift RN & Dean
- Afternoon shift RN ruled out
- Dean – only RN to have administered Endone in the last 2 weeks
- Called police (10.10pm) re "stolen medication" – before Dean came to work – but did not advise police they suspected Dean

Police

- Dean starts work at 10.30pm – given key for S8 cabinet
- Police arrive 12.04am – let in by Dean
- Police ask to see S8 cupboard – see no signs of forced entry
- After 17 minutes police called away to a more urgent matter and determine they will follow-up in the morning
- Dean starts lighting fires at 4.53am in an attempt to destroy evidence

Coroner's overall findings

- Should have conducted (proper) reference and referee checks – as opposed to none at all
- Failure to immediately suspend Dean – lame and risky – danger to other staff and residents
- No basis to give S8 keys or leave alone in-charge on nightshift – very lax management – query if RNs should have "permission" to have S8 keys on nightshift when alone

Coroner's overall findings

- Should have foreseen Dean may seek to destroy evidence in the circumstances, or intimidate witnesses
- *Poisons and Therapeutic Goods Act 1996* (and Regulations 2008) rely upon sound management practices – not in place here
- St John of God Hospital – failure to follow mandatory reporting of health professional affected by drugs or alcohol at work (*Health Practitioner Regulation National Law (NSW) 2009*)

How does this fit with the Fair Work Commission?

George Camille v Berala on the Park [2015] FWC 2264

unfair dismissal

Camille v Berala

- Employed 1989 – PT EN
- Incident in July 2014 – inappropriate touching of female resident's genitals, seen by daughter. Daughter later withdrew complaint as requested by management to put in writing – Applicant given final warning and put on morning shift (never made it to morning shift)
- Incident 25 August 2014 - inappropriate touching of female resident's genitals, seen by daughter (different resident/daughter). Daughter provided statement. Camille suspended on pay – terminated 3 Sept 2014

Camille v Berala

- Police called – arrested Applicant and took to station for questioning; 2 provisional AVOs are issued
- Department notified – mandatory reporting
- Nursing and Midwifery Council of NSW notified – imposed restrictions
- Health Care Complaints Commission notified – began investigation
- Australian Health Practitioner Regulation Agency notified – began investigation

Camille v Berala – FWC findings

- Final warning in relation to 1st incident harsh
- Evidence of resident's daughter (in 2nd incident) not accepted
- Applicant did not treat resident with dignity and respect
- Valid reason for dismissal and procedural fairness accorded but decision to dismiss was "harsh" in circumstances – Applicant awarded 13 week's pay

George Camille v Berala on the Park [2015] FWC 6938

re costs

Applicant offered 26 weeks pay before evidence was prepared!