JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	2 OCTOBER 2023
DELIVERED	**:**	11 OCTOBER 2023
FILE NO/S	**:**	CORC 435 of 2020
DECEASED	**:**	PAPANASTASIOU, KATHRYN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S. Markham appeared to assist the coroner.

Ms R. Panetta and Ms P. Campbell (Panetta McGrath) appeared for Brightwater Care Group.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Kathryn PAPANASTASIOU*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 2 October 2023, find that the identity of the deceased person was* ***Kathryn PAPANASTASIOU*** *and that death occurred on 15 March 2020 at Sir Charles Gairdner Hospital, Hospital Avenue, Nedlands, from fractures of the legs, with terminal palliative care, in an elderly lady with multiple co-morbidities in the following circumstances:*

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INTRODUCTION

1. Ms Kathryn Papanastasiou (Ms Papanastasiou) died at Sir Charles Gairdner Hospital (SCGH) on 15 March 2020 from fractures of the legs, with terminal palliative care, in an elderly lady with multiple co-morbidities. She was 74 years of age.[1,2,3,4,5,6]

2. At the relevant time, Ms Papanastasiou was a resident at an aged care facility and was confined to a wheelchair. On 4 March 2020, she and several other aged care residents were being taken to an event at Optus Stadium in a bus. On the way to the event, the driver of the bus braked suddenly, causing Ms Papanastasiou to fall out of her wheelchair onto the bus floor.

3. Ms Papanastasiou sustained serious injuries and she was taken to SCGH by ambulance. Scans confirmed she had fractured bones in both of her legs, and after discussions between her family and her treating team, it was decided Ms Papanastasiou was not a suitable candidate for surgery. Instead she was treated palliatively, and kept comfortable until she died.

4. On 2 October 2023 in at Perth, I held an inquest into the circumstances of Ms Papanastasiou's death.

5. The documentary evidence adduced at the inquest comprised one volume, and the following witnesses gave evidence:

a. Ms Wendy Delahoy-Bianchi (Bus driver); and

b. Ms Andrea King (Allied Health Manager, Brightwater Care Group).

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (29.05.22)
[2] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22)
[3] Exhibit 1, Vol. 1, Tab 2.2, Memorandum - Sen. Const. N Arnold (15.03.20)
[4] Exhibit 1, Vol. 1, Tab 13.1, SCGH Discharge summary (15.03.20)
[5] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of Deceased: Visual Means (15.03.20)
[6] Exhibit 1, Vol. 1, Tab 4.2, Supplementary Post Mortem Report (16.06.20)

MS PAPANASTASIOU

Background[7,8]

6. Ms Papanastasiou was born on 25 February 1946. She had two children from a previous marriage, and at the time of her death, she was a resident of Brightwater Onslow Gardens (Onslow), an aged care facility in Subiaco run by the Brightwater Care Group (Brightwater).

Medical history[9,10,11]

7. Ms Papanastasiou's medical history included congestive heart failure, cognitive impairment, type-2 diabetes with neuropathy, obstructive sleep apnoea, high blood pressure, obesity, and multiple system atrophy. Ms Papanastasiou also had a history of falls, and as a consequence of her restricted mobility, she was confined to a wheelchair. A falls assessment document from Onslow states: "*Resident is immobile and does not attempt to move*".[12]

8. Ms Papanastasiou required assistance with all aspects of daily living and an Onslow assessment form states that she needed help from two carers to transfer from bed to chair and/or to reposition in a bed or chair. The assessment form also notes that Ms Papanastasiou "*is not to ambulate any distance*", and that she used a bed with rails.[13,14]

9. On 2 March 2020, Brightwater sent an email to Ms Papanastasiou's daughter requesting that a "*restraint form*" be updated. The email noted that the tray table attached to the Wheelchair was required "*for upper limb/body positioning*" because of Ms Papanastasiou's "*reduced postural control*". The email also said that the tray table was used for "*functional purposes*" and Ms Papanastasiou "*can request to remove it*", but that "*As it is considered a restrictive practice we need the NOK to give consent for it*".[15]

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[7] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death Report (29.05.22)
[8] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22), p3
[9] Exhibit 1, Vol. 1, Tab 11.1, Resident details - Brightwater Onslow Gardens
[10] Exhibit 1, Vol. 1, Tab 13.1, SCGH Discharge summary (15.03.20), p3
[11] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22), p6
[12] Exhibit 1, Vol. 1, Tab 11.6, Brightwater Falls assessment form
[13] Exhibit 1, Vol. 1, Tab 11.6, Brightwater Falls assessment form
[14] See also: Exhibit 1, Vol. 1, Tab 11.4, Brightwater Summary Care Plan
[15] Exhibit 1, Vol. 1, Tab 18.AK16, Email - Brightwater to Ms Papanastasiou's daughter (02.03.20)

EVENTS LEADING TO DEATH[16,17,18,19,20,21]

Ms Papanastasiou is loaded in the bus[22]

10. On 4 March 2020, Ms Papanastasiou and five other Onslow residents were being taken to an event at the Optus Stadium in two small buses. Ms Papanastasiou, who was sitting in the Wheelchair, was loaded onto one of the buses (the Bus) by Ms Delahoy-Bianchi, who was the driver of the Bus. At the time, Ms Delahoy-Bianchi was Brightwater's volunteer coordinator, a role she had held for about five years, having previously been employed by Brightwater as a therapy assistant for about 10 years.[23]

11. Although Ms Delahoy-Bianchi's duties as volunteer coordinator did not normally include loading and driving Brightwater's buses, she had undergone training in this regard, including refresher training on 20 November 2017.[24,25] However, Ms Delahoy-Bianchi last drove a Brightwater bus in November 2019, and had not been required to secure a wheelchair occupant in one since December 2018.[26]

12. In her statement, Ms Delahoy-Bianchi had this to say about her ability to transport Brightwater residents in buses:

> I was attending the event as Volunteer Co-ordinator but had agreed to drive one of the buses. I was competent in driving buses and securing wheelchairs but I did not do it regularly.[27]

13. At the inquest, Ms Delahoy-Bianchi produced a document entitled "*Event Time Line*" in which she had set out her plan for the day. According to the time line, the plan was for Onslow residents to be collected at 8.45 am on 4 March 2020, and arrive at Optus Stadium at 10.00 am.[28]

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[16] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22), pp3-6
[17] Exhibit 1, Vol. 1, Tab 12, Report - Panetta McGrath Lawyers (26.03.20)
[18] Exhibit 1, Vol. 1, Tab 17.1, Statement - Ms W Delahoy-Bianchi (07.08.23) and ts 02.10.23 (Delahoy-Bianchi), pp6-37
[19] Exhibit 1, Vol. 1, Tab 17.2, Record of Meeting - Ms W Delahoy-Bianchi (11.03.20)
[20] Exhibit 1, Vol. 1, Tab 17.3, Record of Meeting - Ms W Delahoy-Bianchi (06.03.20)
[21] Exhibit 1, Vol. 1, Tab 7.1 - 7.3, WAPOL Incident Report & Running Sheets (15.03.20)
[22] ts 02.10.23 (Delahoy-Bianchi), pp20-30
[23] ts 02.10.23 (Delahoy-Bianchi), pp7-8
[24] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), para 21
[25] Exhibit 1, Vol. 1, Tab 18.AK4, Brightwater Driving Training Assessment Sign Off Page (20.11.17)
[26] Exhibit 1, Vol. 1, Tab 12, Report - Panetta McGrath Lawyers (26.03.20), p 9 and ts 02.10.23 (Delahoy-Bianchi), p11
[27] Exhibit 1, Vol. 1, Tab 17.1, Statement - Ms W Delahoy-Bianchi (07.08.23), para 6 and ts 02.10.23 (Delahoy-Bianchi), pp11-13
[28] Exhibit 1, Vol. 1, Tab 17.4, Event Time Line - Getaway for a day to Optus Stadium and ts 02.10.23 (Delahoy-Bianchi), pp17-18

14. In any case, as Ms Delahoy-Bianchi was busy loading Ms Papanastasiou onto the Bus, she was approached by a visitor to Onslow. The visitor became verbally abusive as he demanded the Bus be moved because it was blocking his exit on Onslow's semicircular driveway. At the inquest, Ms Delahoy-Bianchi said that she suggested to the visitor that he reverse out of the driveway, but he refused to do so. Quite understandably, as Ms Delahoy-Bianchi was busy loading residents onto the Bus, she declined to move it.[29]

15. Ms Papanastasiou was sitting in the Wheelchair and she was loaded onto the Bus using a rear hoist. Ms Delahoy-Bianchi had removed the tray table attached to the Wheelchair in accordance with Brightwater's policy, and at the inquest, she said she could not recall being told the tray table assisted Ms Papanastasiou with her postural instability.[30,31]

16. Once the Wheelchair had been loaded onto the Bus, Ms Delahoy-Bianchi secured it in place using straps attached to "*carriages*" in metal tracks bolted to the Bus floor. Ms Delahoy-Bianchi tightened the two carriages at the front of the Wheelchair, and two at the rear thus ensuring the Wheelchair could not move during transit.[32]

17. The two rear carriages were also designed to take straps that could be passed under the arms of the wheelchair being secured, and fastened "*low across the hips of the resident*" by means of buckles.[33] At the inquest, Ms Delahoy-Bianchi confirmed that she obtained the straps she needed to secure Ms Papanastasiou in the Wheelchair from an "equipment bin" (which was actually a black canvas bag) secured to the wall at the rear of the Bus on the driver's side.[34]

18. The equipment bin was used to store lap-sash and shoulder straps, and Ms Delahoy-Bianchi confirmed she sourced what she thought was an appropriate set of lap-sash straps from the equipment bin.

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[29] ts 02.10.23 (Delahoy-Bianchi), pp17-18
[30] Exhibit 1, Vol. 1, Tab 18.AK8, Wheelchair transport policy and guidelines, p2
[31] ts 02.10.23 (Delahoy-Bianchi), pp14-15
[32] ts 02.10.23 (Delahoy-Bianchi), pp20-24
[33] Exhibit 1, Vol. 1, Tab 9.2, Q'Straint - QRT 1, 3 & 5 Information certificate (28.04.16)
[34] ts 02.10.23 (Delahoy-Bianchi), pp23-26 and ts 02.10.23 (King), p43

19. However, as I have noted Ms Delahoy-Bianchi was being verbally abused by a visitor to Onslow, and in her haste to complete the loading process as quickly as possible, she inadvertently grabbed two straps from the equipment bin which both had "*male*" connectors and therefore could not be connected together.[35]

20. Ms Delahoy-Bianchi realised her mistake as she tried to connect the straps, and although she went back to the equipment bin to find a lap-sash strap with a "*female*" connector, she was unable to do so. Ms Delahoy-Bianchi asked the driver of the other bus if he had an appropriate lap-sash strap, but the one he provided was the wrong size and was therefore unusable. In the absence of a lap-sash strap, Ms Delahoy-Bianchi decided to secure Ms Papanastasiou into the Wheelchair using a shoulder strap which she attached to a carriage on the Bus wall.[36]

21. It was later discovered that at the relevant time, the equipment bin did in fact contain a complete set of lap-sash straps. However, the straps had been placed in a black bag at the bottom of the black canvas equipment bin and had been overlooked.[37]

22. At the inquest, Ms Delahoy-Bianchi confirmed that when she had obtained the first lot of lap-sash straps, they were lying loose in the bottom of the equipment bin. However, when she returned to the equipment bin to try to find a lap-sash strap with a female connector, she was unable to do so because she had assumed that the black bag containing the straps was the base of the equipment bin.[38]

23. In a meeting Ms Delahoy-Bianchi attended on 6 March 2020,[39] she relevantly noted that: "*There were no instructions available and no information that each set of straps had its own bag*". As to her decision to use a shoulder strap to secure Ms Papanastasiou in the Wheelchair, Ms Delahoy-Bianchi stated:

[35] ts 02.10.23 (Delahoy-Bianchi), pp27
[36] ts 02.10.23 (Delahoy-Bianchi), pp26-28
[37] Exhibit 1, Vol. 1, Tab 17.1, Statement - Ms W Delahoy-Bianchi (07.08.23), paras 44-45
[38] ts 02.10.23 (Delahoy-Bianchi), pp27-28
[39] At the inquest, Ms Delahoy-Bianchi confirmed that the record of this meeting was accurate

> I think at that point, I should have taken (Ms Papanastasiou) off the bus. However, I thought that I could secure her with the shoulder strap and I made the decision to keep (Ms Papanastasiou) on the bus and take her with us.[40]

24. Ms Delahoy-Bianchi outlined the pressures she was experiencing at the time she was loading Ms Papanastasiou into the Bus in the following terms:

> I guess it was time pressure. We had to be at Optus (Stadium) by a certain time. (Ms Papanastasiou) would have missed the excursion. Had to be there by 10.15 am but we had arranged to meet others at 10 am. Also, when boarding (Ms Papanastasiou) a man came out and had a go at me for blocking the driveway and said he couldn't get out. He asked me to move the bus. I said I couldn't as we were onboarding. He was quite irritated and aggressive, saying I was making him go the wrong way to get out. **This may have also made me do things quickly**.[41,42,43] [Emphasis added]

Ms Papanastasiou is injured[44]

25. Once all of the Onslow residents had been loaded, the buses set off for Optus Stadium at about 9.30 am. The Bus was in the lead, and at about 9.45 am, Ms Delahoy-Bianchi was driving northeast along Thomas Street in Subiaco. When the Bus was in the vicinity of Wellington Street, Ms Delahoy-Bianchi glanced down at a maps application on her mobile phone. Although the mobile phone was secured in a cradle next to the steering wheel, it was below the level of the windscreen.

26. When Ms Delahoy-Bianchi looked up a few moments later, she realised that the traffic in front of the Bus had stopped and she applied the brakes. The force of this sudden and heavy braking event caused Ms Papanastasiou to fall out of the Wheelchair and land on the Bus floor.

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[40] Exhibit 1, Vol. 1, Tab 17.3, Record of Meeting - Ms W Delahoy-Bianchi (06.03.20), pp2-3
[41] Exhibit 1, Vol. 1, Tab 17.3, Record of Meeting - Ms W Delahoy-Bianchi (06.03.20)
[42] See also: ts 02.10.23 (Delahoy-Bianchi), pp16-18
[43] Exhibit 1, Vol. 1, Tab 17.4, Event Time Line - Optus Stadium outing and ts 02.10.23 (Delahoy-Bianchi), pp17-18
[44] ts 02.10.23 (Delahoy-Bianchi), pp30-34 & 36

27. Ms Delahoy-Bianchi says after the braking event, she heard a noise and then one of the residents say that Ms Papanastasiou had fallen from the Wheelchair. Ms Delahoy-Bianchi got out of the Bus and when she opened the side door, she found Ms Papanastasiou lying face up on the Bus floor. Ms Papanastasiou had landed with her head on top of the Wheelchair's foot plates. Her left leg was bent, and her right leg was under the wheelchair of another resident.

28. Ms Delahoy-Bianchi and the driver of the other bus moved their vehicles into Subiaco Road because they were blocking traffic, and then attended to Ms Papanastasiou. The driver of the other bus released the front and rear carriages from the now empty Wheelchair, and as Ms Delahoy-Bianchi gently lifted Ms Papanastasiou's head off the Wheelchair's footplates, the other driver removed the Wheelchair from the Bus.

29. At all relevant times, Ms Papanastasiou was conscious and able to speak, and she complained of pain in her legs. Ms Delahoy-Bianchi called emergency services at 9.57 am and the driver of the other bus called Onslow to advise them of the incident. An ambulance arrived at the scene at 10.24 am and Ms Papanastasiou was taken to SCGH. Meanwhile, the other residents went on to Optus Stadium.[45]

30. Neither Ms Delahoy-Bianchi nor the other bus driver recall releasing the buckle on the shoulder strap as the Wheelchair was being removed. None of the other occupants of the Bus were able to assist with this issue either. This leaves open a number of possibilities including that Ms Papanastasiou may have fallen from the Wheelchair despite the shoulder strap being in place; that the shoulder strap was not properly connected in the first place; or that the shoulder strap had somehow become disconnected before the accident.

31. In his report, the Coronial Investigation Squad (CIS) officer investigating Ms Papanastasiou's death made the following observation about the evidence relating to the shoulder strap:

[45] Exhibit 1, Vol. 1, Tab 6, SJA Patient care record (04.03.20)

> It cannot be determined if the deceased's over shoulder restraint remained in place at the time of her fall, or if she may have undone it during transport. The other occupants of the bus at the time the deceased fell have no recollection of the status of the deceased's restraints.[46]

32. After Ms Papanastasiou had been taken to SCGH, Ms Delahoy-Bianchi lodged an online crash report.[47] Brightwater reported the incident to WorkSafe WA on 5 March 2020, but were advised that a report was unnecessary because the accident "*did not meet the prescribed circumstances*".[48]

33. After the incident, the Bus (including the carriages) was examined and found to have no defects which would have caused or contributed to the accident. At the conclusion of their investigation, police concluded there was no evidence of criminality in relation to Ms Papanastasiou's death.[49,50]

34. Section 27(5)(a) of the *Coroners Act 1996* (WA) provides that a coroner may report to the Director of Public Prosecutions if they believe that an indictable offence has been committed "*in connection with a death which the coroner has investigated*". A report may also be made to the Commissioner of Police in respect of a simple offence. Having carefully examined the available evidence, I have determined there is no proper basis for me to make a report to either the Director of Public Prosecutions, or the Commissioner of Police and I decline to do so.

35. I also note that at the relevant time, it was "*a matter of general practice*" for a Brightwater staff member to travel in the rear of vehicles during outings. However, at the time of the accident, this general practice was "*not mandatory*" and as I noted at the inquest, each of the buses departing from Onslow on 4 March 2020 only had one Brightwater staff member onboard, namely the driver.[51,52]

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[46] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22)
[47] Exhibit 1, Vol. 1, Tab 10, Online crash report form, Receipt No. 3889851689 (06.03.20)
[48] Exhibit 1, Vol. 1, Tab 12, Report - Panetta McGrath Lawyers (26.03.20), p7
[49] Exhibit 1, Vol. 1, Tab 9.1, Vehicle Assessment Report (26.03.20)
[50] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22), p6
[51] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 84-85 and ts 02.10.23 (King), pp56-57 & 67
[52] See also: ts 02.10.23 (Delahoy-Bianchi), p9

36. I note with approval that at the inquest, Ms King confirmed that Brightwater now requires that in addition to the driver, a second therapy assistant must now travel in the rear of the vehicle to monitor and assist residents. Whilst the second therapy assistant is not necessarily a substitute driver, they will have completed Brightwater's driver training and are therefore familiar with the procedure for loading and unloading residents, including those in wheelchairs.[53]

Hospital treatment and death[54,55]

37. At SCGH, scans showed that Ms Papanastasiou had sustained fractures to her right and left femurs, and her right tibia and fibula. She was also diagnosed with respiratory acidosis, anaemia (secondary to bleeding), low blood pressure (secondary to bleeding and acidosis), and an acute kidney injury causing high potassium levels (hyperkalaemia).

38. Ms Papanastasiou was reviewed by an orthopaedic surgeon and an anaesthetist and assessed as a "*high anaesthetic risk*". This was because of the severity of her injuries, her low blood pressure with acidosis, and her significant pre-existing medical conditions.

39. Ms Papanastasiou's treating team discussed the available management options and the risks of each option with her family. Following this discussion, it was decided to treat Ms Papanastasiou's injuries conservatively using splints and analgesia.

40. Over the next few days, Ms Papanastasiou's condition slowly deteriorated, and on 11 March 2020 she was transitioned to palliative care. Ms Papanastasiou was kept comfortable until she died at about 8.15 am on 15 March 2020.[56,57]

[53] ts 02.10.23 (King), pp56-57
[54] Exhibit 1, Vol. 1, Tab 13.1, SCGH Discharge summary (15.03.20)
[55] Exhibit 1, Vol. 1, Tab 16, SCGH Emergency Department and Inpatient Notes (15.03.20)
[56] Exhibit 1, Vol. 1, Tab 13.1, SCGH Discharge summary (15.03.20)
[57] Exhibit 1, Vol. 1, Tab 7.1, WAPOL Incident Report (15.03.20)

CAUSE AND MANNER OF DEATH[58,59,60]

41. A forensic pathologist (Dr Clive Cooke) conducted an external post mortem examination and reviewed CT scans. Dr Cooke noted Ms Papanastasiou had sustained fractures to "*the lower parts of both thigh bones and the upper part of the right shin bone*".

42. During his examination, Dr Cooke also noted bruising to Ms Papanastasiou's lower legs and the front of her left shoulder, as well as changes related to her recent medical care.

43. Toxicological analysis found medications in Ms Papanastasiou's system that were consistent with her medical care. A small amount of acetone was also detected, and Dr Cooke noted that this: "*may occur with terminal illness*".[61,62,63]

44. At the conclusion of his external post mortem examination, Dr Cooke expressed the opinion that the cause of Ms Papanastasiou's death was "*Fractures of the legs, with terminal palliative care, in an elderly lady with multiple co-morbidities*".[64]

45. I respectfully accept and adopt Dr Cooke's conclusion as my finding in relation to the cause of Ms Papanastasiou's death.

46. Further, in view of the circumstances, I find that Ms Papanastasiou's death occurred by way of accident.

[58] Exhibit 1, Vol. 1, Tab 4.1, Post Mortem Report (20.03.20)
[59] Exhibit 1, Vol. 1, Tab 4.2, Supplementary Post Mortem Report (16.06.20)
[60] Exhibit 1, Vol. 1, Tab 5.3, Letter - Dr C Cooke (20.03.20)
[61] Exhibit 1, Vol. 1, Tab 5.1, Urgent Interim Toxicology Report (24.03.20)
[62] Exhibit 1, Vol. 1, Tab 5.2, Final Toxicology Report (14.05.20)
[63] Exhibit 1, Vol. 1, Tab 4.2, Supplementary Post Mortem Report (16.06.20)
[64] Exhibit 1, Vol. 1, Tab 4.1, Post Mortem Report (20.03.20)

WAS MS PAPANASTASIOU PROPERLY SECURED?

Wheelchair brakes[65,66]

47. As I have explained, Ms Papanastasiou's wheelchair was secured in the Bus by means of straps attached to four carriages bolted to the Bus floor. The available evidence establishes that after it had been secured, the Wheelchair did not move during the accident. In fact, the driver of the other bus had to untighten the carriages securing the Wheelchair before it could be removed from the Bus after the accident.[67]

48. For the sake of completeness, I note that on 2 March 2020, (that is, two days before the accident) Ms Papanastasiou's daughter contacted Onslow to raise concerns about the Wheelchair's brakes. An occupational therapist investigated the issue and in a report dated 3 March 2020, she stated:

> *Reason for consultation:* NOK Nicola (would) like Kathy's wheelchair checked. She said that when she took her out the brakes were not working.
>
> *Interventions, comments, follow up required:* Spoke with Nicola (NOK) about interest in ordering a new tray table. Brakes appear in working order. Advised care staff to revert if further issues. Will review tyre pressure and recheck brakes. OT to follow up.[68]

49. In his report, the investigating CIS officer noted:

> CIS officers inspected the deceased's wheelchair (at Onslow) on 15 March 2020 and found no issues with the brakes. During and after the deceased's fall the wheelchair remained securely fastened to the tracking in the floor of the vehicle and had not moved as a result of the stop. **Due to the four-point system for securing the wheelchair into the floor tracks the wheelchair's brakes were not required to be used during transport and was not a contributing factor to the incident.**[69] [Emphasis added]

[65] Exhibit 1, Vol. 1, Tab 7.1, WAPOL Incident Report (15.03.20)
[66] Exhibit 1, Vol. 1, Tab 14, Various photographs of Ms Papanastasiou's wheelchair
[67] Exhibit 1, Vol. 1, Tab 12, Report - Panetta McGrath Lawyers (26.03.20), p8
[68] Exhibit 1, Vol. 1, Tab 8, Assessment for Ms Papanastasiou (03 Mar 20, 1.30 pm)
[69] Exhibit 1, Vol. 1, Tab 2.1, Report - Sen. Const. D Sheahan (29.05.22), pp7-8

Shoulder strap

50. At the relevant time, Brightwater's policy relating to the transport of residents in wheelchairs required that the resident be restrained with an "*occupant restraint system that complies with the relevant Australian Standard*". The relevant Australian Standard[70] provided that the approved restraints are either a pelvic lap-sash (two-point restraint) or a shoulder restraint connected to a pelvic lap-sash (three-point restraint), and that the minimum recommended restraint for securing a wheelchair occupant was a pelvic lap-sash.[71]

51. At the relevant time, Brightwater's policy provided that "*both pelvic and shoulder restraints should be used where practicable*", with the pelvic belt positioned "*low across the front of the pelvis so as to bear upon the bony structure of the body*" and passing "*from the upper thighs at approximately 45°*". The policy also provided that where it was not possible to restrain a resident in this way, a risk assessment must be undertaken to "*determine safety measures to manage risks*".[72,73]

52. Consistent with its policy at the time, Brightwater's training and assessment for drivers loading and securing residents into buses, covered the use of two-point restraints and three-point restraints.[74] In this case, it does not appear that an appropriate risk assessment was conducted after Ms Delahoy-Bianchi was unable to locate a pelvic lap sash. Instead, at a meeting she attended after the accident, Ms Delahoy-Bianchi said:

> I think at that point, I should have taken her off the bus. However, I thought that I could secure her with the shoulder strap and I made the decision to keep (Ms Papanastasiou) on the bus and take her with us.[75]

53. With respect, I do not consider this constitutes an appropriate risk assessment. Further, restraining Ms Papanastasiou using only a shoulder strap was contrary to the requirements of the relevant Australian Standard, and for that reason, to Brightwater's policy at the time.

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[70] AS/NZS 3696.19:2009, Wheeled mobility devices for use as seats in motor vehicles (ISO7176-19:2008, MOD)
[71] Exhibit 1, Vol. 1, Tab 15, WA Travel Safe Interagency Group Transporting people with disabilities - Securing the occupant
[72] Exhibit 1, Vol. 1, Tab 12, Report - Panetta McGrath Lawyers (26.03.20), p9
[73] Exhibit 1, Vol. 1, Tab 18, Statement – Ms A King (20.09.23), paras 41(e)-(g)
[74] Exhibit 1, Vol. 1, Tab 12, Report - Panetta McGrath Lawyers (26.03.20), p10
[75] Exhibit 1, Vol. 1, Tab 17.3, Record of Meeting - Ms W Delahoy-Bianchi (06.03.20)

CHANGES SINCE MS PAPANASTASIOU'S DEATH

Policy and training changes[76]

54. Ms Andrea King outlined the changes to Brightwater's driver training regime and its policies relating to the transport of its residents, since Ms Papanastasiou's death. Those changes include:

a. *Community Access Program Standard Operating Procedure*: this document supports Brightwater's community access program (CAP) and provides that therapy assistants dedicated to the CAP program will ensure the Brightwater aged care bus is in working order on the day, and will have undergone "*initial and regular competency training and assessment around driving and using Brightwater buses*".[77,78]

b. *Transporting Clients in Wheelchairs in Brightwater Specialised Vehicles Procedure*: this document sets out Brightwater's policy for managing the risks associated with transporting residents in wheelchairs. Where it is not possible for a resident to be transferred to a seat in the vehicle, the occupant restraint system used "*should be in accordance with the manufacturer's instructions and the relevant Australian Standards*". The document also provides that "***both pelvic and shoulder restraints should be used where practicable***"[79,80] [Emphasis added]; and

c. *Community Access Program (Bus Outings) Procedure*: this document provides that an occupational therapist assess each resident participating in the CAP program and that all staff attending CAP outings will be trained in loading/unloading and securing wheelchairs.

Further, a minimum of one onsite therapy assistant (who knows the residents) is to attend CAP outings and a staff member must "*be seated in the back of the bus with passengers to monitor and support as needed during the trip*".

[76] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 45-76
[77] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 50-53
[78] Exhibit 1, Vol. 1, Tab 18.AK9, Community Access program Residential Aged Care - Standard Operating Procedure
[79] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 54-56
[80] Exhibit 1, Vol. 1, Tab 18.AK10, Transporting Clients in Wheelchairs in Brightwater Specialised Vehicles Procedure

> The document also requires the therapy assistant to check that all wheelchairs are in "*good working order*" and "*suitable for transport*" and that all wheelchairs are secured properly and "*all passengers are securely restrained by seatbelts*".[81,82]

55. In addition to these new policies Brightwater has created three positions for therapy assistants "*who are dedicated to supporting the Brightwater Community Access Program, including driving clients in Brightwater community vehicles*". These therapy assistants are the only staff authorised to drive Brightwater's aged care passenger vehicles. Brightwater has also introduced an outings consent form, and a risk assessment checklist for wheelchair transportation (the Checklist).[83,84,85]

56. The Checklist is completed by an occupational therapist, and when it has been determined that a wheelchair user cannot safely transfer to a vehicle seat, that client's wheelchair is assessed for suitability. The Checklist also requires an assessment of whether the client's wheelchair can be safely accommodated in Brightwater's vehicles, and whether the wheelchair tie down and occupant restraint systems are adequate.[86]

57. In October 2021, Brightwater also updated its driver training course. The training now consists of an on-line theory component which trainees must successfully complete before attending a practical training session. The practical component of the driver training course covers loading, unloading, positioning, and securing wheelchairs; passenger safety; bus familiarisation; and accident/incident procedures.[87]

58. All residential aged care therapy assistants are required to pass all components of the driver training course except the driver skills assessment. As there must now be a therapy assistant travelling with passengers in the bus, this means that these staff can assist the driver with loading and unloading of clients, including those in wheelchairs.[88]

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[81] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 57-58
[82] Exhibit 1, Vol. 1, Tab 18.AK11, Community Access Program (Bus Outings)
[83] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 48, 59-76 & 77-82
[84] Exhibit 1, Vol. 1, Tab 18.AK12, Outings Consent form
[85] Exhibit 1, Vol. 1, Tab 18.AK13, Risk Assessment Checklist for Wheelchair Transportation
[86] Exhibit 1, Vol. 1, Tab 18.AK13, Risk Assessment Checklist for Wheelchair Transportation and ts 02.10.23 (King), pp55-56
[87] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 87-89
[88] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 87-89

59. At the inquest, I noted a discrepancy between Brightwater's policy and its training regime documents on the minimum standard for restraining wheelchair occupant. As noted, Brightwater's policy now requires that the restraint system: "*Should be in accordance with the manufacturer's instructions and the relevant Australian Standards*", and that "*both pelvic and shoulder restraints* ***should be used where practicable***"[89] [Emphasis added].

60. Notwithstanding the vague and discretionary language of the policy, Brightwater's training documentation makes it clear that one of the driver's key responsibilities when loading a client is to: "*Check that the resident's lap-sash or seat-belt is secured and meets the manufacturer's requirements and Australian Standards*".[90]

61. Given this discrepancy, at the inquest I indicated I was considering making a recommendation that Brightwater further amend its policy documentation to make it clear that when a resident is being transported in a wheelchair, a three point restraint system consisting of a pelvic lap sash and a shoulder strap must be used to secure the resident.

62. I note with approval that in relation to the suggested policy amendment, Ms King stated at the inquest: "*I think that's something we need to do".*[91]

63. As to refresher training for Brightwater drivers, in her statement Ms King noted:

> As I have oversight of currency of practice in relation to the Community Access Program, I ensure that all new staff are trained. If a staff person has not used a Brightwater vehicle for a long period of time, such as 12 to 18 months, the staff person will be asked to undertake training again by myself.[92]

[89] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 55(b)-(c)
[90] Exhibit 1, Vol. 1, Tab 18.AK15, Brightwater Driver Training
[91] ts 02.10.23 (King), p52
[92] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), para 94

64. At the inquest, I also indicated I was concerned about the potentially discretionary nature of this approach to refresher training. Pleasingly, Ms King advised that she intended to amend Brightwater's policy documentation to make it clear that annual mandatory refresher training would be required for all staff responsible for driving vehicles used to transport residents.[93]

Vehicle upgrades

65. In her statement, Ms King noted that during the COVID-19 furlough, Brightwater's fleet of residential aged care community access vehicles were retrofitted with navigational aids, including a reversing camera and a multimedia device which includes satellite navigation, and software which connects to Brightwater's mobile devices.[94]

66. As to the use of mobile phones by Brightwater drivers, in her statement Ms King noted:

> Brightwater drivers are directed not to use mobile devices as navigational aids unless the mobile device is in a hands-free holder and the destination is pre-set before the driver starts their journey.[95]

67. As mentioned, when Ms Delahoy-Bianchi used the navigation app on her mobile phone she had to glance down, because the cradle holding her mobile phone was below the level of the dashboard in the Bus.[96]

68. At the inquest, Ms King advised that in the Brightwater buses used for the transport of aged care residents, cradles to hold driver's mobile phones have been installed on the right hand side above the level of the vehicle's dashboard.[97] This means that a driver glancing at a navigation app on their mobile phone in one of these new cradles would not have to take their eyes off the road. Ms King also noted that the multimedia systems in Brightwater's buses now give verbal navigation instructions, thereby reducing the need for drivers to actually look at the screen.[98]

[93] ts 02.10.22 (King), pp66-67
[94] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), paras 96-97
[95] Exhibit 1, Vol. 1, Tab 18, Statement - Ms A King (20.09.23), para 92(e)
[96] ts 02.10.22 (Delahoy-Bianchi), pp30-31 and ts 02.10.22 (King), pp64-65
[97] ts 02.10.22 (King), pp64-66
[98] ts 02.10.22 (King), pp65-66

Applicable legislation

69. For the sake of completeness, I note that the Department of Transport (DoT) advised the Court that although the *Road Traffic Vehicles Regulations 2014* (RTVR) require vehicles to comply with the Australian Design Rules (ADR):

> The ADR do not provide standards for wheelchair accessible vehicles nor for occupant restraint/s in such vehicles.[99]

70. The Department of Transport advised that regulation 235(2) of the RTVR provides that a person may not make modifications to a vehicle without the approval of the DoT Chief Executive Officer (CEO), and when approval is given, the CEO must issue a modification permit.[100]

71. In this case, a business called Omnibus Services was granted a "type approval" on 30 March 2015, to modify Toyota HiAce vehicles by installing additional seating, a rear hydraulic wheelchair hoist, and tracking to secure three wheelchairs.[101] Relevantly, a Motor Vehicle Modification Approval certificate dated 24 June 2015, was issued in relation to the Bus following the installation of rear seating, tracks for three wheel chairs, and a rear hoist.[102]

72. In relation to the applicability of passenger services legislation to the Bus, I note that DoT advised the Court that:

> The motor vehicle in question here (the Bus) is not, and has never been, authorised as a passenger transport vehicle to be used in providing a passenger transport service (for hire or reward).[103]

73. DoT advised the Court that as a consequence, the requirements of the *Transport (Road Passenger Services) Act 2018* (WA) and the *Transport (Road Passenger Services) Regulations 2020*, which provide for standards in relation to passenger vehicles used as wheelchair accessible vehicles, were inapplicable, and therefore did not apply to the Bus.[104]

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[99] Exhibit 1, Vol. 1, Tab 19.1, Letter Department of Transport to the Court (21.09.23), p1
[100] Exhibit 1, Vol. 1, Tab 19.1, Letter Department of Transport to the Court (21.09.23), p1
[101] Exhibit 1, Vol. 1, Tab 19.3, Type Approval Toyota HiAce (30.03.15)
[102] Exhibit 1, Vol. 1, Tab 19.5, Motor Vehicle Modification Approval Certificate (24.06.15)
[103] Exhibit 1, Vol. 1, Tab 19.1, Letter Department of Transport to the Court (21.09.23), p2
[104] Exhibit 1, Vol. 1, Tab 19.1, Letter Department of Transport to the Court (21.09.23), p2

RECOMMENDATIONS

74. In light of the observations I have made in this finding, I make the following recommendations:

Recommendation 1

I recommend that Brightwater Care Group amend its policy documentation to make it clear that when a resident is being transported in a wheelchair, a three point restraint system (consisting of a pelvic lap sash and a shoulder strap) is to be used to secure the resident in their wheelchair.

Recommendation 2

In order to ensure that the straps used to secure residents being transported in wheelchairs are serviceable and available to all users, I recommend Brightwater Care Group consider:

a. Clearly labelling each set of straps;

b. Conduct regular audits of the straps in each of its vehicles to ensure the straps are present and serviceable; and

c. Amend its policy documentation to make it clear that those staff responsible for refurbishing a vehicle used to transport residents are to ensure that after a trip has concluded, all straps used to secure residents in their wheelchairs are stowed away neatly in pairs, so that the straps are available for the next user of the vehicle.

Recommendation 3

I recommend Brightwater Care Group amend its policy documentation to mandate annual mandatory refresher training for all staff responsible for driving vehicles used to transport residents.

Comments relating to recommendations

75. In accordance with my usual practice, a draft of these recommendations was emailed to Ms Panetta on 3 October 2023.[105] On 4 October 2023, Ms Panetta emailed the Court to advise that Brightwater had been discussing implementing recommendations 1 and 3 before the inquest, and considered it already complied with recommendations 2(b) and 2(c). Nevertheless, Ms Panetta advised that Brightwater was "*happy to accept the proposed recommendations as drafted*".[106]

76. Finally, although not a recommendation as such, in her statement, Ms King noted that a "*user guide diagram*" (User guide) had been affixed to the side of the Bus at the time of the accident. The User guide contains a great deal of relevant information and depicts a wheelchair occupant restrained by "*a lap belt and shoulder restraint*", and the procedure for correctly securing the occupant.

77. The User guide is clearly intended as a memory jogger for drivers, however there is a problem. The first of two photographs of the User guide attached to Ms King's statement shows an unobscured view of the User guide. However, the second photograph confirms that when the Bus is being used to transport wheelchairs, a bench seat which must be folded away, largely obscures the User guide, rendering it essentially useless.[107] This is obviously unhelpful.

78. In her statement, Ms King notes: "*The bench can be folded down with ease if a person needs to consult the User Guide*". With respect, I do not find this a particularly helpful observation as it seems to rather defeat the purpose of the User guide in the first place. At the inquest, Ms King agreed it would be sensible to move the User guides so they remained visible when wheelchairs are being transported. I therefore **strongly urge** Brightwater to ensure that User guides and other relevant guidance signs in its community access fleet remain visible when wheelchairs are being transported in those vehicles.[108]

[105] Email - Ms K Christie to Ms R Panetta (03.10.23)
[106] Email - Ms R Panetta to Ms K Christie (04.10.23)
[107] Exhibit 1, Vol. 1, Tabs 18.AK6 & 18.AK7, Photographs of the User guide in the Bus
[108] ts 02.10.23 (King), pp45-46

CONCLUSION

79. Ms Papanastasiou was a dearly loved family member who died from the injuries she sustained when she fell from her wheelchair after the bus she was travelling in suddenly braked. At that time, Ms Papanastasiou was being secured in her wheelchair in a manner contrary to Onslow policy and thereby, the relevant Australian Standard.

80. Since her death, Brightwater have made comprehensive changes to their policies and driver training regime aimed at enhancing the safety of residents being transported in its vehicles. I have made three recommendations which I hope will further strengthen resident safety.

81. In conclusion, as I did at the conclusion of the inquest, I wish to thank members of Ms Papanastasiou's family for their attendance at the inquest and to express, on behalf of the Court, my very sincere condolences to them for their loss.

MAG Jenkin
Coroner
11 October 2023