OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stuart John LAMBERT**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Ipswich
FILE NO(s):	5230/09 (8)
DELIVERED ON:	28 March, 2013
DELIVERED AT:	Ipswich
HEARINGDATE(s):	17 December 2010, 12-14 April 2011; 12–15 July 2011, 14 February 2012
FINDINGS OF:	D.M. MacCallum, Coroner
CATCHWORDS:	Disabled adult, respite care, appropriateness of care and treatment, Disability Services, independent service providers

REPRESENTATION:

Counsel Assisting:	Snr Sgt K Carmont
Stuart's Parents:	Mr. C. Bushnell, Solicitor
Dept of Communities:	Mr N. Weston of Counsel i/b Crown Law
ICAS:	Mrs A. Haly, Solicitor
M. Stitt:	Mr P. Shields, Solicitor

INQUEST INTO THE DEATH OF STUART JOHN LAMBERT

1. Stuart Lambert was born on the 11 December 1977 and at the time of his death his principal place of residence was with his parents at 4 Thomas Street, Goodna. On the 2 June, 2009 Stuart had gone to stay with his carer, Michelle Stitt, and had remained there until his death on 4 June, 2009. Ms Stitt's property is situated at 169 Lowood-Minden Road, Tarampa. It is a semi rural property situated approximately 35kms from Ipswich.

2. At approximately 8.40pm on 4 June 2009, Ms Stitt discovered Stuart outside in the yard and he appeared to be having a seizure. Stuart was 183cm tall and weighed about 80kg at this time. He had since birth been diagnosed with cerebral palsy, autism and epilepsy and was on a number of medications to treat his various ailments. At the time of death his medications were prescribed as follows:

   Epilim EC 500mg - 2 in the AM and 2 in the PM;
   Epilim EC 200mg - 1 in the AM and 1 in the PM;
   Zoloft 1OOmg - 2 in the AM;
   Tegretol CR 400mg - 3 per day;
   Topamax 100mg - 4 per day;
   Zyprexa 2.5.mg - 1 per day;
   Zyprexa 1Omg - 1 in the PM;
   Zyprexa 5mg - 1 per day.

   From the information I have been able to ascertain Epilim, Tegretol and Topamax are used in the treatment of seizures; Zoloft is for depression and/or mood stabilisation and Zyprexa is an anti-psychotic drug.

3. Ms Stitt reported that she endeavoured to get Stuart back into his bedroom and ultimately had to call upon the assistance of another elderly lady; Margaret Hoffman aged 67 years, who resided at her residence. She also made contact with the ambulance and commenced CPR under verbal instruction from the QAS operator. Ms Stitt states that she continued CPR until the arrival of the Ambulance. However, they determined that Stuart had died and life was pronounced extinct at 9.10pm.

Autopsy

4. On the 5 June 2009 the autopsy was performed by Dr Beng Ong. At the time of examination he observed a number of scars as follows:

   1. A linear scar, 4 cm long on the left cheek (between the eye and external ear);
   2. A linear scar, 6cm long on the left upper chest running over the collar bone;

3. A linear scar, 2cm long on the left upper chest below the scar in 2 above;
4. A linear scar, 2.5cm long on the left upper chest below the scar in 2 above;
5. A linear scar, 6cm long on the left lower chest near the costal margin;
6. A linear scar, 4cm long on the upper front of the right chest;
7. A linear scar, 3cm long on the front of right shoulder.

Also a number of recent injuries were apparent and he listed these on pages 2 and 3 of the Autopsy Report.

In his Findings Dr Ong came to the conclusion as follows:

(1) Some of the surface injuries were consistent with an allegation that Stuart was known to self harm from time to time;

(2) Extensive fractures of the ribs were noted on both sides of the chest. Particularly on the left side it was noted that some of the bruising underlying the fractures appeared to have been caused a few hours prior to death.

(3) Dr Ong could not rule out the injuries having been inflicted by a third party but however noted there were no defence injuries and in fact he thought some of the fractures may have been as a consequence of resuscitation attempts.

(4) Dr Ong also took the view that the injuries were such that the description of falling onto a plant pot at or about the time of collapse was inconsistent as such a fall would need to be from a higher position than that of a person falling from a standing position or would have been in the nature of a forceful fall. However he did put the rider on that by saying that the fall had aggravated pre-existing injuries. There was evidence that Stuart had fallen many times previously and there was some evidence of healed rib fractures.

(5) In the report Dr Ong notes that individuals suffering from epilepsy can also die unexpectedly, a condition known as "sudden unexpected death in epilepsy (SUDEP)". Whilst this condition could not be entirely ruled out, it was Dr Ong's opinion in the autopsy report that Stuart had died from his injuries rather than from epilepsy.

(6) The Analyst certificate noted the presence of anti convulsant drugs which were within the therapeutic to high therapeutic range but none within the fatal range.

(7) The cause of death was found to be the Chest Injuries as the principal cause with autism and epilepsy as the underlying cause.

Evidence of Dr Ong

5. During his examination, Dr Ong stated that he noted on the right side on the outer aspect that ribs 1 to 7 were fractured and that on the back near to the spine, ribs 1 to 3 were also fractured. On the left side outer aspect he noted ribs 1 to 10 were fractured and on the back, near to the spine, ribs 6 to 10 were fractured (Pg 31).

6. The nature of the fractures was such that there was a complete break.

7. He stated that he thought the force required for such injuries would be substantial, likening it to the type of injuries seen in road traffic accidents and/or a fall from a height of two to three metres e.g. a one or two storey building.

8. He subsequently went on to say that the fractures could have been exacerbated because of prior injuries. He was unable to date prior fractures. In effect and if I understand his evidence correctly, it is possible there could have been rib fractures which occurred some time prior to death and the existence of these damaged ribs could have assisted in other ribs fracturing at or about the time of death as a consequence of blunt force trauma, including resuscitation attempts.

9. The presence of a punctured lung again is most likely to have occurred at or about the time of death as Dr Ong's evidence was that had it occurred some time prior, there would have been a histological reaction at the wound site and there would probably have been more extensive bleeding in the lung cavity.

10. The rupture from the right atrium to the inferior vena cava again seems to have been caused immediately prior to death or even immediately post death. This is evidenced by the lack of bleeding into the pericardium. Dr Ong has said that such a rupture is unusual but in this case may have occurred during resuscitation as the integrity of the rib cage was compromised due to the number of fractured ribs.

11. The two ruptures which appear on the spleen were, in Dr Ong's opinion caused by the fractured ribs and happened as Stuart was dying or after death. Again the doctor comes to this opinion due to the absence of bleeding at the wound site. Although there was some blood in the abdominal cavity he thought this probably occurred as the chest was being compressed during the resuscitation attempt and the blood was being forced out.

12. Overall the impression given by Dr Ong is that there could be any number of reasons for the cause of the injuries he noted at the time of

autopsy. Initially I think Dr Ong gave a very strong impression that Stuart's rib fractures were more likely than not to have been the result of significant force, unlikely to have been caused by a mere fall onto a pot plant. However, it became apparent that due to pre-existing fractures and the resuscitation attempt, some of the fractures could have resulted as ribs which were not properly healed broke and then others followed. On page 88 of the transcript, Dr Ong says that the rib fractures noted by him were on the "posterolateral aspect, so were not consistent with the application of CPR". Although this seems inconsistent with the evidence given on the first day of the hearing, it probably has little practical effect as ultimately, Dr Ong seems to be saying that although Stuart has died from "flail chest" that could have been the result of a number of falls and events over a period of time, and not from one single catastrophic event.

Evidence of Detective Emery

13. Detective Senior Constable Emery is attached to the Ipswich CIB and was the officer called to the scene in relation to Stuart's sudden death. He prepared the initial report to the Coroner concerning Stuart's death. Initially DSC Emery did not consider the death was suspicious nor that it came within the definition of a death in care as that term is understood pursuant to the Coroners Act 2003.

14. It was not until the autopsy report was provided to DSC Emery in about December 2009 that there were any concerns raised about the manner and circumstances of Stuart's death. Had that information been available earlier then DSC Emery states that a more detailed forensic investigation would have been made of the scene. One might wonder that if there were two police officers present at the autopsy on the 5 June 2009, they should have been enlivened to the possibility of a suspicious death and probably should have immediately informed DSC Emery.

15. In any event Emery's investigations at that time (i.e. December 2009) still resulted in his report that no substantiated criminal charge was evident on the information then available to him.

Evidence of Constable Simon Carter and PCC Catherine Ford

16. Constable Carter and PC Constable Ford were the first police on the scene when notified of the sudden death of Mr Lambert.

17. Constable Carter felt for a pulse and attempted EAR (expired air resuscitation) and desisted only upon the arrival of ambulance officers. He was shortly thereafter informed that Mr Lambert was deceased. Constable Carter observed certain injuries upon Mr Lambert and after being informed he was deceased, commenced a walk around the close environs of the house. He states that he observed a terracotta pot that had a blood smear on it.

18. PCC Ford confirms that she arrived with Constable Carter at the address of Ms Stitt as the first response officers. She had a conversation with Margaret Hoffman, who was at the time another resident at Ms Stitt's address. Ford indicated that Ms Hoffman was very difficult to communicate with and that it was similar to speaking with a child.

19. The best that could be obtained from Ms Hoffman was that she had seen Stuart outside shaking and had called for Ms Stitt to come and help him. PCC Ford obtained Stuart's medications from Ms Stitt and subsequently obtained a written statement from her when they had all returned to the police station. It is agreed that at the time that statement was taken there was no suggestion that Ms Stitt was a potential suspect in Stuart's death and in those circumstances no formal warnings were given in accordance with the Police Powers and Responsibilities Act 2000.

Evidence of Dr Scott Howard

20. Dr Howard was Stuart's General Practitioner since about 1989, although it seems more regularly for the last three years before Stuart's death. It was his view that Stuart had, at the highest, the intellectual functioning of a pre-schooler.

21. In early 2009, Dr Howard was investigating Stuart's health and arranged for X-Rays of his chest. This disclosed that the "anterolateral aspect of the right third, fourth and fifth ribs would be suggestive of healing .fractures”. Other tests were undertaken to check the cause of Stuart's "unwellness" and lethargy which had been noted by his mother. Blood tests indicated an inflammation of the sacroiliac i.e. the area where the spine and pelvis join.

22. The last time Dr Howard had seen Stuart was on the 19 May 2009 when he gave him a prescription for recurrent diarrhoea.

23. Of the drugs which Stuart had been prescribed, Dr Howard stated that Carbamazepine would cause giddiness, although some of the other drugs which had a sedating effect could compound the effect of the Carbamazepine.

24. Dr Howard expressed some opinions about the various injuries on Stuart at the time of his death. With all due respect to Dr Howard, and as he himself said, he is not a forensic expert and in fairness to him most of his opinion was based on photos rather than a physical examination of Stuart's body.

Evidence of Christine Lambert

25. Mrs Lambert was Stuart's mother. Initially it seems that she and her husband cared for Stuart. At some point after her husband became ill, Stuart was in a care house being cared for independently. For reasons

which are not entirely clear that arrangement broke down and Stuart returned to his parent's home. A care package of some 65 hours per week was provided via the services of ICAS (Individual Community Access Services).

26. As a consequence of that arrangement Mrs Lambert, Stuart's sister, Camilla and Michelle Stitt were the care givers.

27. Initially the arrangement was that Stuart would only have day trips to Ms Stitt's property but as time passed and as travel difficulties and constraints occurred due to the disruption caused by the upgrade of the Ipswich Motorway, the Lamberts agreed that Stuart could remain overnight at the property in Ms Stitt's care. Mrs Lambert stated that she and her husband went out to look over the property and provided a bed and bedding for Stuart.

28. This arrangement for overnight stays was at one time brought to the attention of Mr Ratnavale but he stated that it must cease. However both the Lamberts and Ms Stitt decided between themselves to continue the arrangement and Mr Ratnavale was not informed that it was continuing.

29. Each year there was a review by DSQ of the care package. Such review was a face to face meeting at the Lamberts residence but no complaints were ever made about the package, and/or the service provided by ICAS or Ms Stitt to the department representatives. Some of this appears to have come about due to the Lambert’s concern that the package would be withdrawn. Overall Mrs Lambert has a very negative attitude about DSQ.

30. The arrangement with ICAS commenced in about 1998 according to Mrs Lambert's recollection. It seems that initially the family was happy with the service supplied and also with Ms Stitt. The service package provided through ICAS was to be a one on one care arrangement. Although the Lamberts became aware of another person living at the residence (this being Ms Margaret Hoffman) they did not complain, either to ICAS or to Ms Stitt. It seems that the Lamberts were unconcerned about this as Mrs Lambert in particular considered that although Ms Hoffman had a disability she was largely able to care for herself.

31. During the time that Stuart had stayed at Ms Stitt's residence he had sustained some injuries, including two serious ear injuries before the family started to become concerned about the standard of care whilst in Ms Stitt's company. Although it was a little unclear from the time frame it seems that at about the time of Ms Stitt's separation from her partner, Steven Zammit, her behaviour was becoming somewhat erratic as evidenced by her loud arguments via the phone with Mr Zammit and the language used by her during these arguments.

32. As a consequence Mrs Lambert spoke to Mr Ratnavale and requested

that Ms Stitt not have phone contact with Mr Zammit when she was at the Lambert residence. Other than that and some of the natural distress caused to Ms Stitt by the separation, it seems there were no other concerns.

33. However about six months before Stuart died Mrs Lambert states she was becoming more concerned about the number of injuries she observed on him after returning from Ms Stitt's property. However, these concerns were never raised with ICAS or DSQ.

34. Mrs Lambert says that they were informed about the time Ms Stitt was charged with assault, that her employment was to be suspended. However, it seems that she and Mr Lambert requested that Ms Stitt continue as carer for Stuart and this was agreed to. The terms of this agreement were that she was not permitted to be alone with Stuart and had to be supervised at all times.

35. On the day following Stuart's death the family and Ms Stitt were all at the John Tonge Centre and Mrs Lambert specifically recalls Ms Stitt saying that no autopsy was required as Stuart had died from a seizure.

36. Ms Lambert was quite adamant that Ms Stitt was somehow responsible for Stuart's death but was unable to articulate any specifics. A number of complaints were made about non specific injuries sustained whilst in Stitt's care and also for some more serious injuries which resulted in medical treatment and/or hospitalisation. The cause of those injuries will probably never be known as it seems no detailed inquiry was made about some of the causes.

Evidence of Gavin Phillip Bunnett

37. Mr Bunnett was a former neighbour of Ms Stitt but had moved to another address about 12 months before Stuart's death. He had the opportunity during that time to observe some incidents involving Ms Stitt's treatment of Stuart which he considered quite disturbing.

38. These incidents included slapping, pushing, being hosed down and being yelled and sworn at. There was an occasion when he observed Stuart being hosed down outside during winter time. On other occasions he observed Stuart outside at night in winter with only underwear on. He also said that he thought the hosing down was perhaps Stuart's bath arrangement. He also said on the occasions when he observed some of the swearing, slapping and pushing behaviour that Stuart sounded upset by this.

39. In cross examination Mr Bunnett was unable to say if some of the slapping was an attempt by Ms Stitt to keep Stuart's hand away from his face, etc. He was also unable to recall the exact nature of words spoken by Ms Stitt to Stuart and which he described as abusive. He

could only say that the tone of the speech was such that he thought it was abusive.

40. Neither he nor his wife reported that matter to the authorities and only came forward when they read about the inquest in the local paper.

Evidence of Lauren Renee Bunnett

41. Mrs Bunnett is Gavin Bunnett's wife and she describes incidents when she saw Stuart being bathed outside and also one occasion when she observed Steven Zammit, Ms Stitt's partner, throw a white plastic 20 litre bucket at Stuart. She described the bucket as striking Stuart's upper back shoulder area.

42. She observed that Stuart was crying and visibly upset by this incident. She did not observe either Ms Stitt or Mr Zammit go and check that Stuart was alright but states that they appeared to continue their argument.

43. Ms Bunnett was concerned about the number of times she saw Stuart being bathed outside and that she thought he was being left to sit on a chair for some time with no clothes and also in cooler weather.

44. She also observed some incidents of Stuart being slapped by Ms Stitt but was unable to say whether there was a reason for this being done.

Evidence of George Suresh Ratnavale

45. Mr Ratnavale was at the relevant time the Principal and founder of ‘Individualised Community Access Services’ (ICAS). ICAS was established in 1996. Mr Ratnavale states that it was established mainly for the purpose of providing support for persons in respect of whom existing services were unable to meet their needs. He stated it was hoped that ICAS could tailor support to meet the individual needs of persons with disabilities.

46. Ms Stitt commenced her employment with ICAS on 14.10.02 and initially she was employed as both an administrative assistant and as a support worker. According to Mr Ratnavale she showed more interest in the support work and so her job moved into that area. Ms Stitt undertook some training which is described in paragraphs 24 to 26 inclusive of his statement dated 21.06.10.

47. In 2007, Ms Stitt was charged with common assault in respect of a client of ICAS, a Mr Ken Ironside. She was found guilty but was placed on a Good Behaviour Bond. Subsequently Mr Ratnavale arranged a psychological assessment of Ms Stitt and received a positive report from Dr Brian Hazell. He also implemented some supervision actions which are described in paragraph 31 of his statement. Further some additional training was undertaken and this is described in paragraph 24

of his statement.

48. During the time of her employment with ICAS, Ms Stitt has provided support for 10 clients of ICAS; all of whom had a variety of disabilities. It seems that she has generally been well regarded by the clients to whom she has provided assistance, as well as their families.

49. In June 2003, Ms Stitt became a carer for Stuart Lambert. The details of the training and handover procedures and the support she was to provide are set out in paragraphs 39 to 52 inclusive of his statement.

50. Mr Ratnavale states that in all the time Ms Stitt worked with Stuart, he received positive feedback about her from Mr and Mrs Lambert. To that end he provided to the Inquiry two letters from Mr Lambert setting out the family's regard for Ms Stitt.

51. ICAS is an independent service provider although the funding for the services is provided by Disability Services Queensland.

52. DSQ provided funding for a care package for 65 hours per week for Stuart. It was up to Stuart's parents to obtain a service provider who would provide assistance for up to 65 hours per week. DSQ does not have day to day oversight of the way in which each care package is managed but have a general oversight to ensure that certain policies are complied with and that the money has been expended appropriately.

53. As a part of her employment obligations, Ms Stitt was required to provide timesheets and client progress notes on a fortnightly basis. Although each package was provided on a "one on one" basis she could, at any given time, be working with more than one client. The rostering of clients was something that was done on a negotiated basis between Ms Stitt and the families such that she was never caring for more than one client at a time.

54. Prior to Stuart's death there was no specific requirement by ICAS as to obtaining and maintaining up to date First Aid training. It seems that at some time subsequent to Stuart's death that did become a requirement of employment.

55. Mr Ratnavale was also examined about the provision of financial assistance to Ms Stitt for the purpose of defending the Common Assault charge. It is also clear that Mr Ratnavale had some discussion with her Solicitor about the effect of a conviction on her employment. Upon the finding of guilt Mr Ratnavale informed DSQ.

56. After the guilty verdict Ms Stitt was initially removed from caring for Stuart but this changed fairly quickly as a result of representation from the Lambert family. The basis of the reinstatement was that Ms Stitt was to

be supervised whilst caring for Stuart. Bizarrely it seems that this supervision was to be by the Lambert family, despite the fact that care packages are intended to provide respite for the parents, etc of a disabled person.

57. Mr Ratnavale says that there is an inflexible rule that any of the persons being cared for by his organisation are not permitted to stay overnight at the home of a carer. He says that he became aware of Stuart staying with Ms Stitt and immediately told her it was not to happen. Although the arrangement continued he says that he was unaware of it. Apparently Mr Ratnavale's "supervision" of Ms Stitt involved phone calls to her mobile phone. No spot checks were undertaken by him or any independent member of his staff. One might have thought that spot checks would have fairly quickly uncovered the overnight arrangements at Ms Stitt's residence.

58. When asked by Mr Weston for DSQ to articulate the reasons why such arrangements are inappropriate, Mr Ratnavale gave a somewhat imprecise and rambling answer. It was only once he was prompted by Mr Weston that he agreed that the vulnerability of these persons is the principal reason for not permitting same as well as the need to approve the suitability of the physical surroundings.

59. After the trial for the assault on Ken Ironside had concluded Mr Ratnavale stated that he informed DSQ about the guilty verdict and spoke to a person by the name of Alex West, apparently the same person he had spoken to when Ms Stitt had first been charged. He was informed that Ms Stitt would in effect be required to show cause why her positive notice card should not be revoked.

60. Mr Ratnavale also says that he endeavoured to have Ms Stitt removed as Stuart's carer. It is his evidence that the Lambert's would not hear of it and he says that he in effect bowed to their will. I have some difficulties with this interpretation of events by Mr Ratnavale. His primary obligation was to provide a safe and secure carer for Stuart. He says that he could have obtained alternate carers but did not do so and permitted Ms Stitt to continue in her role.

61. Mr Ratnavale obtained the services of Dr Brian Hazel to provide a psychological assessment of Ms Stitt and when that came back, providing a positive assessment, one might even say glowing "verdict" on Ms Stitt he kept her on the payroll.

62. It is quite apparent that both Mr Ratnavale and Dr Hazel took a dim view of the charge and the ultimate guilty verdict. I would even go so far as to say they were somewhat dismissive of it. Mr Ratnavale protested that he accepted the verdict and respected it but it seems that despite a Court finding that Ms Stitt was in effect untruthful he continued to place

reliance on her integrity e.g. ringing her on her mobile and accepting that she was where she said she was. He was unable to recall whether she ever at any time admitted the assault but could clearly recall her saying she was sorry for the incident. It is passing strange that he can recall her expression of sorrow but not her acknowledgement of guilt.

63. Overall Mr Ratnavale expressed the view that because he had had a positive report from the psychological assessment, because Ms Stitt was being supervised by Stuart's parents and because she was undergoing some additional training with John Armstrong who he suggests is a leading trainer in "social role valorisation" he continued to employ Ms Stitt. I was told that this latter term is in effect valuing the lives and abilities of people with disabilities.

64. It seems that by the resumption of the Inquest in early 2012 her employment had been terminated, apparently because of the evidence given by the Bunnetts.

Evidence of Michelle Leanne Stitt

65. Ms Stitt was the carer for Stuart for a period of about six years prior to his death. I think it's fair to say that for a long time that care arrangement was working to the mutual satisfaction of Stuart, his parents and Ms Stitt. It seems that Stuart enjoyed being at Ms Stitt's property which had lots of animals and that he could be involved with those animals to a limited extent. I note that permission had been granted to let Ms Stitt take Stuart to the property for the purpose of engaging with the animals but he was not to stay there overnight. However, that clearly occurred with the acquiescence of Stuart's parents and I do accept that this was not brought to Mr Ratnavale's attention.

66. Ms Stitt had some first aid experience but she had never had to perform CPR on any human until the night that Stuart died. Whilst that may not be unusual it seems that she may not have had a refresher course for some time prior to Stuart's death, a fact which I think is inappropriate when carers are asked to look after people with disabilities, whether those be severe or otherwise.

67. In the statement prepared by Phillips Fox, Ms Stitt sets out her work experience, the training received when she commenced work as a carer and her general involvement with Stuart.

68. Ms Stitt has provided two statements which set out the events of the 4 June 2009 immediately prior to and at the time of Stuart's death. According to Ms Stitt, Stuart may have had a seizure at about 4.30pm on the day of his death. As a consequence Ms Stitt decided that it would be better to take him home as she said that he is better in a familiar environment if he's unwell.

69. She then bathed and fed him but as she was about to take him to the car he collapsed and she had to bring him inside the house with the assistance of Margaret Hoffman. She says that Stuart appeared non responsive but she called 000 and commenced CPR whilst getting advice about that from the operator. It seems that the police arrived before the Ambulance and Constable Carter took over CPR until the Ambulance arrived. When the Ambulance arrived they tried to resuscitate Stuart but were unsuccessful.

70. During the course of her employment Ms Stitt stated that she attended some refresher course days where it seems that if there was some new procedure or method to be employed that was discussed and some of the requirements were revised. Interestingly, Ms Stitt says that she did not realise that her first aid certificate had expired until after Stuart's death so one might reasonably wonder about the purpose of these refresher courses.

71. For a period of time Ms Stitt was the sole driver in her household as her husband had lost his licence for about two years. It seems that Mr Stephen Zammit, her husband, was also employed as a carer with ICAS. On occasions Ms Stitt would take Mr Zammit and his client to various places whilst she had one of her client's with her.

72. Ms Stitt also gave evidence that her husband was present on occasions Stuart was at the Tarampa residence. She says that she can recall "a few occasions" when Zammit threw buckets in the direction of but not at Stuart. She says that she would check to make sure Stuart was unharmed and that she never saw any marks on him.

73. The neighbours Mr and Mrs Emmett described times when they observed Stuart being hosed down in the garden and they also observed some slapping of Stuart going on whilst this occurred. Ms Stitt agreed that there were occasions when she did hose Stuart outside of the house. She said this mainly occurred when he had defecated and it was necessary to clean him down before he was properly showered. She said that Stuart didn't really like the shower at her place and that she found it hard sometimes to bathe him in the shower. It seems it was a fairly small shower. She disputed that she had ever assaulted Stuart whilst bathing him and says that if it did appear that she was slapping him it was only because he was putting his hands near his face and/or in his mouth whilst they were covered in faeces and she was slapping them away.

74. Ms Stitt agreed that Stuart did stay overnight with her more and more frequently in the time leading up to his death. She said that the Lambert's were asking her more and more regularly to take Stuart for extra time. It is clear that any of these additional overnight stays were done by Ms Stitt as a friend to the Lamberts rather than in her official capacity as a carer. She did not earn any extra for doing this additional

time.

75. There was a lot of examination about her residence and I would think that it was a less than ideal place for a person with Stuart's level of disability to be staying at for prolonged periods. The shower was not a properly constructed disability access shower and the sleeping arrangements were less than appropriate. It seems that Ms Stitt would sleep upstairs whilst Stuart was sleeping downstairs in an area under the house. Whilst this area was enclosed and weatherproofed she did say that for safety reasons she would close but not lock the downstairs area when she went to bed. This meant that Stuart could get out at night and move around in the dark.

76. Ms Stitt was aware that Mr Ratnavale had not agreed to Stuart staying at her residence overnight and that she had deliberately misled him in this regard. In the time sheets Ms Stitt does not disclose Stuart's presence overnight at her residence as she knew her employer would not permit it. She said that the reason she did this was because she felt like "the meat in the sandwich". She was of the view that the family wanted her to take Stuart as much as possible and that if she didn't comply with their wishes they would be asking for another carer and she would possibly be losing her position. It's not clear why she thought she'd lose her job as I would've thought that she would simply be moved to another client.

77. It is also apparent that Ms Stitt completed her time sheets in, at best, a fairly cavalier fashion. I also note that it seems Mr Lambert may have been signing blank time sheets, which although probably convenient, was really not the purpose of what those sheets were intended to convey.

78. At the time of his death Stuart had been at Ms Stitt's home since Tuesday 2 June and the arrangement was that he would go back to his home on Friday 5 June 2009. After the first seizure at about 4.30pm on 4 June, Ms Stitt says that she checked Stuart to make sure there were no obvious injuries that might have required medical treatment. She was aware from past experience that Stuart was usually lethargic and sleepy after a seizure so she was not overly concerned that he appeared very quiet.

79. Ms Stitt was asked if she had ever done any specialised training about caring for people with epilepsy. She says that she did undertake a course but was unsure if it was shortly before Stuart's death or if it was after he had died. She says however that she did not think the course provided her with any information additional to that which she had learned in her original first aid training, from her work as a medical receptionist or from the information she had gleaned from Stuart's family.

80. As part of her employment Ms Stitt was required to complete a "Critical

Incident Report" if there were any matters affecting the welfare of a person in her care. Ms Stitt agrees that she never told ICAS about the incidents where Zammit had thrown a bucket at or near to Stuart nor did she inform them about the need to hose Stuart down outside in the open on at least two occasions after Stuart had had an attack of diarrhoea. Her reasons for failing to do this were less than convincing.

81. Overall and whilst Ms Stitt might have thought she was helping the Lamberts, it is quite apparent that she was prepared to be untruthful with her employer by failing to disclose certain events and/or arrangements made.

Evidence of Stuart Julian Lambert

82. Mr Lambert gave evidence about the arrangements he had with DSQ, Mr Ratnavale and Ms Stitt. It was plain that as at the time of giving his evidence, Mr Lambert was dissatisfied with the provision of services by both DSQ and Mr Ratnavale and suggested that Mr Ratnavale in particular more or less forced him into giving positive reassurances to DSQ auditors about the service provided.

83. Mr Lambert has acknowledged that the arrangement with Ms Stitt whereby Stuart stayed at her residence for some days at a time was directly kept from the knowledge of Mr Ratnavale and thereby indirectly from DSQ. Mr Lambert asserted that Mr Ratnavale must have known about the arrangement but could not advance any reason why he would have been aware of this. He in effect said that because of the difficulties in caring for Stuart they were only too happy to be complicit with Ms Stitt in not directly informing Mr Ratnavale and that the time sheets were in that respect also not accurate. Whilst not condoning the deception but given the state of Mr Lambert's significant health problems and Stuart's rapidly deteriorating behaviour it is probably understandable how the Lamberts found themselves in this situation.

Evidence of Denise Pambid

84. At the time of Stuart's death Ms Pambid was the Director of Disability Programmes and Reform within Disability Services Queensland, a part of the Department of Communities. Whilst not directly responsible for the issuing of Positive Notice Cards or Yellow cards, Ms Pambid stated that all persons within a service outlet must be in possession of such a card.

85. Ms Pambid also was responsible for making the necessary funding available for the delivery of support services. This funding was derived from two types of grants, one being for post-school services funding and the other for adult lifestyle support funding. She also advised that some transport allowance can be made if it is for the purpose of being involved in community access programmes.

86. Ms Pambid advised that many services are contracted out to

independent service providers. Those providers are required to operate in accordance with their rules of incorporation, the provisions of the funding agreements with the Department and of course the legislative requirements. At the time of giving evidence Ms Pambid said that all non Government service providers are subject to a full audit every three years and maintenance audits every year.

87. If a carer was intending to take a client to a private residence pursuant to the care arrangements then it would be usual for a safety audit of the premises to be performed. Ms Pambid was not prepared to comment upon whether the service provider should in all circumstances conduct a physical observation of premises and that such was a matter for their internal management and insurance requirements.

88. Of some interest is the fact that non government service providers are not subject to the same industry standards as government employees. It seems that even within the Department there is some divergence of opinion in that some believe that formal qualification and training is paramount and others are of the view that the personal qualities and beliefs which individual carers bring to the position is what matters most. The Department does provide funding to non government providers for training but as at the time of giving evidence she stated that this was not a mandated requirement.

89. Ms Pambid was of the view that inter department co-operation should be encouraged so that information about persons with whom and environments in which a client might be attending should be available for comparison. At the time of giving evidence she said that there were a number of matters being reviewed by the Department to ensure better compliance.

90. In cross examination by Ms Haly, the representative for ICAS, Ms Pambid said that the Department was not concerned about community access as such, as that could involve attending a shopping centre, a zoo or some place usually frequented by the public and therefore the Department would not seek to exercise any control over that, nor could it or would it in the normal course of events. However, if the location were to be termed a "service location" then the Department would be interested in some assessment of the suitability of the premises. Further that which is done as a private arrangement between the parents or guardians and a third party is not a matter within the purview or control of the Department.

Evidence of Branka Carter

91. Ms Carter is the Regional Director of the Department of Communities, Disability Services. Her evidence is that the Dept oversees the service provider but not the people employed by the provider.

92. She also confirmed that the Dept employs external auditors to ensure the Departmental standards are maintained. The auditors are accredited with

the Department.

93. Ms Carter stated that no complaints had been received by the Dept about ICAS, apart from that received from the Lambert family subsequent to Stuart's death. Upon receipt of that complaint the Dept investigated it but closed their file not considering any further action was needed. However, were this Inquest to make any recommendation the Dept would re-open the file and take the appropriate action.

94. Ms Carter confirmed that the Dept received advice from ICAS that Ms Stitt had been found guilty of a criminal offence and were provided with the transcript of the Judgment, personal references and the report of a psychologist. She says that to her knowledge the transcript of evidence was not provided and there was no check with the referees. She stated that the decision as to what level of investigation and perusal of what evidence is made by the Director General of the Department. Ms Carter was not the Regional Director at the time of Mr Lambert's death so was unable to comment on how she would deal with the matter if she were confronted with a person who can't avoid the fact of a finding of guilt but who still maintains that the incident did not occur.

95. Ms Carter advises that she was unaware of the legislative power to suspend a positive notice card but said they she would expect the service provider to be monitoring the person charged. As a rule the Dept would not be making specific enquiries as to how the monitoring was being carried out but at the regular meetings with the providers would probably make some enquiries.

96. Interestingly and at the time of giving evidence, she says that she was unaware of any other notifications of a carer charged with a criminal offence.

97. Ms Carter also stated that the Dept does not approve or oversee all of the places at which care is provided. As she reasonably comments, funding for outside activities can involve any number of venues which it is not the Dept's job to check for suitability. She said that type of decision making is between the provider and the family and that essentially the family is the primary decision maker. It seems that only in the circumstances where funding for services from a particular venue is made that there would be some inspection of the premises for suitability.

98. When shown photos of the Stitt residence and the area where Stuart was sleeping she agreed that it was, in some respects, not a place the Dept would approve as a venue from which funding activities would be supported. She did say that she would expect the provider to check the suitability of the place from which any supported activity was to be carried out to ensure that it complied with safety obligations to both the client and the carer.

99. Ms Carter was referred to the situation where Stuart was hosed down outside and stated that was unsuitable and remained unsuitable even where Stuart may have been suffering from diarrhoea. She was of the view that such situations came within the definition of a "critical incident" and should be reported.

100. It also seems that during the audit process and due to privacy requirements, client files cannot be accessed unless permission is given. She agreed that this could result in cases of neglect or abuse going unnoticed.

101. During questioning by Counsel for Disability Services, Ms Carter agreed that the Dept oversees some 321 NGOs throughout the State and which collectively employ thousands of people to provide care. The majority of those people are employed in homes assisting families with the care of disabled people. In those circumstances the Dept relies upon the service providers to in effect "self police".

102. The Dept relies upon contractual obligations, reports, quarterly meetings, financial audits and independent auditing of the organisations to ensure the proper provision of services. Within the current financial constraints under which all government departments operate she was unaware of any additional procedures that could be put in place to more closely monitor service providers.

103. Ms Carter did agree that any alterations to the Stitt residence to make it more suitable for a person with a disability such as Stuart would have to personally meet those expenses. It would not be funded by the Department or the service provider.

Evidence of Kimberley Louise Kovacevic

104. Ms Kovacevic was a neighbour of the Lambert family for many years, between the years 1981 and 2002. In her statement she describes a number of incidents she observed over the years which included incidents of Stuart being left at home alone, of objects being thrown at him which would cause him to be distressed, of him being hosed down in the yard and of shouting at screaming at Stuart having been heard and observed by her and members of her family.

105. It was her view that he often appeared dirty and smelt of urine and she states that she regularly saw him walking on the street unsupervised. On at least one occasion she saw him naked in the street and she and her sister had to get him and return him home as no one from the Lambert family seemed to be looking for him. She also told of occasions where she became aware that he had been left home alone while the rest of family went out.

Observations

106. This is a tragic tale of a young man born with significant disabilities such that he could never hope to have a life which in any way resembled normal. After having considered all of the evidence given in these lengthy proceedings it is clear that his death was not as a consequence of any provable criminal act. There is no evidence upon which the circumstances of his death require me to refer the matter to the Director of Public Prosecutions for the laying of criminal charges.

107. Initially this Inquest was called as the autopsy report indicated that there may have been criminal behaviour which caused Stuart's death and that there may have been a failure of the system to ensure his safety and proper care. That being the case it was my view that a thorough investigation was required and I think it is a fair observation that the investigation which has ensued has been as thorough as possible. I would be the first to acknowledge that some of the paths travelled in the course of these proceedings may have not produced any obvious information but in my opinion it was necessary to ascertain whether the system was failing and whether there was anything that could reasonably be done to improve services to those most vulnerable members of our society.

108. I must now make some comments about the evidence and the witnesses. At the outset I will be saying little about the witnesses Mr and Mrs Bunnett and Mrs Kovacevic. Suffice to say that I am satisfied that these witnesses were truthful and gave their evidence to the best of their recollection and observations. Both the Bunnetts and Kovacevic came forward with a view to putting as much information as was possible to the Inquest and so that any final decision would be informed at least in relation to the treatment of Stuart. They certainly deserve credit for doing their duty as concerned citizens.

109. Dr Ong was the witness whose original information was the primary cause of the Inquest being held. This is not to be critical of Dr Ong but clearly his observations as to the nature of the rib fractures was such that it was probable that the cause of Stuart’s death was inconsistent with the only version of events as supplied by Ms Stitt. However as the examination of Dr Ong unfolded it became apparent that the number of fractures may have been the consequence of previously damaged ribs giving way both as a consequence of the two falls on the day as well as the resuscitation attempts. Once that is accepted there cannot be said to be any evidence of a compelling nature which would suggest death was caused by an assault of a criminal nature or that it was due to criminal negligence.

110. Ms Stitt was Stuart’s carer and was the only person to have contact with him on the day of his death. It was she who provided the only evidence as to what happened in the hours preceding Stuart's passing. There

was another person at the residence, a Ms Margaret Hoffman for whom Ms Stitt gave some assistance but who was not able to be interviewed about what happened. It seemed Ms Hoffman was not capable of being interviewed and therefore no other version of events was obtained.

111. Of course the compelling aspect of Ms Stitt's past was the assault on Mr Ironside; another person for whom she provided care. I remain of the view that Ms Stitt still does not accept that she unlawfully assaulted Mr Ironside and that she and a number of other people considered she had been badly dealt with by the Court and in fact was probably, in their opinion, wrongfully found guilty. That is a shame and reflects badly on those persons. The protestations that they "respected and accepted" the Court's decision rang hollow. It is quite clear that His Honour Magistrate McLaughlin found that her behaviour went beyond that which might have been necessary to control Mr Ironside. It is also the case that two independent witnesses felt so upset by the behaviour that they took action to report the matter.

112. However what really should have been recognised by Ms Stitt and her referees, Mr Ratnavale, the psychologist and even the Department was that Magistrate McLaughlin accepted that the job being undertaken by her was difficult and that it might have been to some extent a momentary aberration. I accept that Ms Stitt has had a clear record and seems to have been well liked by the families of those for whom she cared. It can even be said that the Lambert family were quite supportive of Ms Stitt following the Court hearing and both prior to and in the days following Stuart's death.

113. There is another aspect of Ms Stitt's behaviour which requires comment. That is in effect the collusion between her and the Lamberts to hide from Mr Ratnavale the private arrangement which they had about Stuart's stays at her residence at Tarampa. Whilst it is clear that Mr Ratnavale had knowledge of Stuart going to the premises for a few hours at a time, I accept that at no time was he ever made aware that Stuart was staying there overnight and sometimes for consecutive days. To some extent the house was not suitable for a person of Stuart's high needs and such visits were probably inappropriate, except on a very limited basis.

114. Having said that it is well within the scope of the parents' rights to agree to Stuart going to stay with people they approve of and of course neither ICAS nor the Department are responsible to oversee those private arrangements. What creates the problem is that Ms Stitt did this at times when she was leading Mr Ratnavale to believe that Stuart was only there for a couple of hours at a time. On the other hand it can be argued that Stuart was there in accordance with care arrangements for which ICAS had responsibility but that after that time was over, the remaining time was a private agreement and no business of anyone other than the Lamberts and Ms Stitt.

115. It is accepted that it is very important that someone such as Stuart have opportunities open to him and to pursue those things which he loved best such as being around animals. Equally a person with disabilities such as Stuart was a full time job with minimal respite from the unrelenting task of having some free time in the belief that Stuart was in good hands. Equally it must be said that much of the time given by Ms Stitt was not something for which she did actually receive any payment so it cannot be said to have been a money making enterprise.

116. What I think everyone has overlooked however was the difficulty of Stuart being somewhere that was not properly catering to his physical needs. I note at one point in cross examination of Ms Carter from the Department she was asked who would pay for any modifications to Ms Stitt's residence to satisfy disability needs. Her response was that it would be Ms Stitt's responsibility. However I note that Ms Stitt was having some work done about the premises and that the downstairs shower was a fairly recent installation so one wonders why she did not have proper rails and sloping entries done to allow for the needs of the disabled.

117. The habit of washing Stuart down outside when he had an accident involving bodily functions was inappropriate, whether it was done by the Lamberts or Ms Stitt. He was entitled to ordinary human dignity and if it was necessary to do that then some appropriate cover should have been provided. The situation of having Stuart at the residence when her marriage was clearly in trouble was also inappropriate in that it exposed Stuart to domestic violence and put him in the way of harm. Indeed even to have Stuart in a country environment with someone who was not properly trained in CPR was also a risky venture. It may have been done with good and kind intentions but put Ms Stitt in the way of considerable risk.

118. Mr Ratnavale is the owner operator of ICAS. I accept that Mr Ratnavale is a person who seems to have a genuine concern for those less fortunate. However as I have already observed, I found his protestations about accepting the verdict of the Court in relation to the assault on Mr Ironside less then compelling. As I also noted previously I think that whole incident was minimized and generally thought to have been an incorrect verdict. I should mention that Mr Ratnavale is a lawyer by training.

119. I have already made a number of comments throughout my recitation of his evidence but I wish to emphasize that he should in my view have been conducting "spot checks" on Ms Stitt during the period she was supposed to be being monitored after the Ironside case. His view that phone calls were appropriate is not what I would expect of a person being monitored. In fact the very fact that her version of events was not

accepted by the Court is a clear example of a person who was found to be an unreliable witness. At least initially one might have expected random checks to ensure that she was exactly where she said she was.

120. Having said that, I acknowledge that in many respects he was misled about certain arrangements. I accept that many of these organisations have limited resourcing and therefore have to rely upon the integrity of their employees. However I reiterate my earlier comment that Ms Stitt was at that time a person who had been found to be an unreliable reporter of events by a Court and he should have been more cautious.

121. I am also of the view that knowing that Stuart was going to Ms Stitt's private residence; albeit he thought only for a few hours every couple of days he should have gone and inspected the residence to ascertain if it was appropriate for a person of Stuart's needs.

122. Some audit of the premises as to whether there were any hazards that needed to closed off or removed, whether there was adequate toilet arrangements, whether having regard to Stuart's difficulty with bladder and bowel control, appropriate shower facilities were available to clean him, where meals were going to be taken and whether there were any hazards which having regard to his propensity to fall needed to be allowed for. One might also have thought that if he was being taken to an area remote from immediate hospital and medical care that Ms Stitt had the capacity to cater for any emergencies.

123. Both Mr and Mrs Lambert gave evidence about their son, Stuart and the care arrangements in place via ICAS as well as the additional assistance provided by Ms Stitt on what seems to have been a voluntary arrangement. Whilst having a number of complaints about both DSQ and Mr Ratnavale neither Mr nor Mrs Lambert were able to articulate any specific areas of concern. In essence they feel that both of those organisations were in some way responsible for Stuart's death, although why and how they were responsible is unclear. At the end of the day they were agreeable to Stuart staying at Ms Stitt's residence and were prepared to keep this from Mr Ratnavale. Apart from one visit prior to the commencement of Stuart's overnight visits for the purpose of delivering some bedding they made no inspection of the premises and did not themselves perform any audit of the facilities at the house.

124. From the evidence of the Department witnesses, Ms Pambid and Ms Carter it is clear the Department has a fairly hands off attitude to the provision of services. The Department clearly abides by its legislative responsibilities but as I noted to Ms Carter, it was my impression that the Department was somewhat reactive rather than proactive. I accept that the Department like Mr Ratnavale has to rely upon the honesty of those reporting to them but rely heavily upon outside auditors to oversee the providers.

125. The police investigation was thorough but due to the late receipt of the autopsy report no early forensic investigation was done. This is unfortunate in that an early investigation may have provided more evidence to assist this inquiry.

126. However, after considering the evidence there are no formal recommendations I wish to make. It is always difficult with limited resources for additional oversight to be put in place and in some cases such oversight can have other unforeseen effects which might reduce the quality of life of disabled persons. I have made some comments throughout these findings and perhaps these are matters which should be considered by those concerned as to whether any changes can and should be implemented.

FINDINGS REQUIRED BY s. 45

Identity:	Stuart John LAMBERT
How death occurred:	Stuart died at the residence of Michelle Stitt after falling on to a pot plant and said to be having an epileptic seizure. Resuscitation attempts were unsuccessful.
Place of Death:	169 Lowood-Minden Road, Tarampa.
Date of Death:	4 June, 2009.
Cause of Death:	1 (a) Chest injuries and 1 (b) autism, epilepsy.

To Mr and Mrs Lambert and to his sisters, I extend my condolences on the passing of Stuart. I also apologise for the delay in delivering these findings, another example of a lack of resources and time availability.

The inquest is now closed.

D.M. MacCALLUM
Coroner
IPSWICH

28 March 2013