QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Steven Thelander**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/293
DELIVERED ON:	15 January 2026
DELIVERED AT:	Brisbane
HEARING DATE(s):	15 October 2024 – 18 October 2024 22 October 2024
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, death in care, disability, type 1 diabetes, ketoacidosis, capacity issues, disability support, residential facility, intake assessment for care, medical needs

REPRESENTATION:

Counsel Assisting:	Ms L Willson, Counsel Assisting Ms C Leach, Senior Counsel Assisting, Coroners Court of Queensland
Family:	Mr N Congrum, instructed by Caxton Legal
Multicap Limited:	Mr M O'Sullivan, instructed by Clyde and Co.
Dr Brockman	Mr A Luchich, instructed by Avant Law

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Introduction

1. Steven Thelander was born on 19 February 1988. He was nearly thirty (30) years old when he died.

2. In line with the family's wishes, I will refer to Steven Thelander as "Steven" throughout these findings.

3. On 15 January 2018, Steven was found unresponsive in his bed at a shared residential facility at Redland Bay operated by Multicap Ltd ("Multicap"). This location was at 71 Emperor Drive, Redland Bay Queensland 4165.

The Coronial Jurisdiction

4. Steven's death was a reportable death because it is defined by the *Coroners Act 2003* (the "Act") as a "*death in care*", specifically, section 9(a)(1)(a)(ii) of the Act.

5. At the time of his death, Steven did suffer a "*disability*" within the meaning of the *Disability Services Act 2006*.

6. Because the circumstances of the death raised issues about care, section 27(1)(a)(ii) of the Act mandated that inquest must be held.

7. Pursuant to section 34 of the Act, a Pre-Inquest Conference was held on 24 April 2024. At this conference, the issues for the inquest were determined:

    (a) The findings required by section 45(2) of the Act, namely how Steven died, when he died, where he died and what caused his death.

    (b) Given the co-morbidities of Steven, what services did he require with respect to:

        (i) food management, and or

        (ii) medication management ("services")?

    (c) Whether those services were offered to Steven by Multicap prior to his placement?

    (d) Did Multicap have capacity to provide those services appropriately?

    (e) Did Multicap provide those services?

(f) Whether the placement of Steven at Multicap was appropriate.

(g) Whether the care provided to Steven by his general practitioners appropriate, including care plans.

(h) Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Act.

8. An inquest is not a trial as between opposing parties but an inquiry in the death of a person[1] to determine these issues. Findings must be given to each of the matters to the extent they are able to be proved.

9. The parties who appeared at the inquest included Steven's family, Dr Brockman (a General Practitioner) and Multicap, who was the organisation who received funding for providing disability support and residential services to Steven.

10. Although the court is not bound by the rules of evidence, pursuant to section 37 of the Act, undoubtedly there is a requirement to accord natural justice to any person upon whose conduct the findings may reflect unfavourably.[2] It has been well established that personal reputation is a relevant interest in this regard.

11. The standard of proof is the civil standard of probabilities. Dixon J in *Briginshaw v Briginshaw,*[3] stated that:

> *"..when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence ... It cannot be found as a result of a mere mechanical comparison of probabilities." His Honour went on to explain that the standard is one of "reasonable satisfaction":*

12. In relation to "*reasonable satisfaction*" Dixon J stated:

> *"...but reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer.... In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences."*[4]

13. This means that the more serious the allegation, the more probative or stronger the evidence needs to be. The High Court in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd*[5] stated that:

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[1] Lord Lan CJ in *R v South London Coroner; Ex parte Thompson* (1982) 126 SJ 625
[2] ibid, 608
[3] [1938] HCA 34; (1938) 60 CLR 336 at 361–362.
[4] ibid
[5] [1992] HCA 66; (1992) 110 ALR 449 at 449–50

"the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove".

14. The High Court also cautioned against generalisations about the need for 'clear' or 'cogent' evidence, even where the standard of proof was correctly understood. These were *'likely to be unhelpful and even misleading'*.[6]

15. This threshold is relevant in considering the evidence of the witnesses and the weight that that I attach to it in assisting me in coming to findings.

16. I am also aware of the issue of hindsight bias. Hindsight bias refers to the tendency to overestimate the probability (and foreseeability) that an event will occur, after the event has occurred.[7] Objective expert evidence has also assisted the court in avoiding this bias.

17. I have also had regard to whether the factual basis for the propositions, have been properly put to the witnesses to allow them to respond. This is also a feature of procedural fairness which underpins the natural justice afforded to the witnesses and parties in this court.

18. The jurisdiction of this court is also referred to in section 46 of the Act, which permits the coroner to make relevant comments in relation to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Right of appearance

19. The right of parties to appear at the inquest is pursuant to section 36(1)(c) of the Act.

20. In line with the interpretation of the State Coroner in the *Findings of the inquest into the death of Hamid Khazaie,*[8] I have interpreted that s 36(1) of the *Coroners Act* 2003 provides for the right of parties with a 'sufficient interest' to make submissions. The limitation on the right to make submissions that was held to exist in *Annetts v McCann*[9] does not apply to an inquest under the *Coroners Act* 2003.

21. I have considered each parties submissions in their entirety.

[6] Ibid
[7] Australian Government Law Reform Commission, (2021) *Judicial Impartiality, Cognitive and Social Biases in Judicial Decision-making*, Background paper JI6. p7
[8] 2014/3292 at [34]
[9] (1990) 170 CLR

The Investigation

22. The coronial investigation involved the obtaining of statements, records of Multicap, medical records and support records and expert opinions.

23. Materials gathered during the investigation were admitted into evidence.

24. It is relevant to note the short time that Steven was with Multicap (40 days). Steven first moved into the Multicap residential facility on 7 December 2017, he was found unresponsive and died on 15 January 2018. During his placement at Multicap, I note that Steven still visited his family for periods of time.

25. Prior to Steven moving into to Multicap's residential facility, there was earlier engagement taken by Disability Services.[10] This was the government department that provided disability support funding. Multicap was a provider of disability support services. These preparatory steps to Steven's placement are documented from June 2017.

26. A basic timeline of Steven's relevant involvement with Multicap and other services and relevant events is provided below:

DATE	**EVENT**
22/06/2017	Intake assessment and assessment of disability support needs (ICAP Assessment) by Pamela Trickey, Disability Services, ICAP score of 50
03/07/2017	Date of the QUT Psychological Assessment
29/09/2017	Steven matched with a co-tenant and Multicap for accommodation.
07/09/2017	Steven meets with Stacey Hemera from Multicap – discussion of *"a trial sleepover in Multicap House"*
14/09/2017	Customer Profile ("All About Me") Completed
16/10/2017	Multicap requests that the Case Manager complete "*my support plan"* for Steven
11/09/2017	Consent Forms and Policies including *"3.1 Responding to Individual Needs"* sent to Social Worker, Emily-Templeton-Dillon for the family
14/09/2017	Multicap customer profile ("*All About Me*") completed
14/09/2017	Consent Forms including *"Medication Authorisation Form"* were signed by Steven's mother, Margaret Thelander
18/09/2017 -20/09/2017	Trial Sleep Over at Multicap facility

[10] The Queensland Government's Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP) as it was then known

DATE	EVENT
16/10/2017	Multicap requests that the Case Manager complete "*my support plan"* for Steven
16/10/2017	Dr David Brockman, General Practitioner completed the *"Diabetes Mellitus Management and Emergency Response Plan"*
07/12/2017	Steven moves into Multicap's facilities at 71 Emperor Drive Redland Bay, QLD 4165
02/11/2017	The *"Support Plan"* for Steven was sent to Multicap
02/01/2018 – 04/01/0218	Steven's mother, Margaret Thelander wrote a note in the communication book about Steven's diet with example meal plans
11/01/2018	Consultation with Diabetes Educator, Ms Lisa Tarca Steven attended this appointment alone.
15/01/2018	Ambulance arrives on scene commence CPR
15/01/2018	21.33.09 QAS notes deceased

27. Over the time that Steven was in residential care with Multicap, some records of Blood Sugar Levels (BSLs) were recorded. This data along with file notes of the support workers and other materials obtained during the investigation were referred to during the inquest.

The Inquest

28. An inquest into the death of Steven was heard in the Coroner's Court at Brisbane between 15 and 18 October 2024 and then 22 October 2024.

29. A brief of evidence with all the investigative documents was tendered at the beginning of this inquest. Some additional material was tendered throughout the Inquest.

30. On commencement of the Inquest a family statement about Steven was read to the court.

31. Written submissions from Counsel Assisting and the other parties were received after the evidence closed. I thank Counsel Assisting and other representatives for their efforts in this respect.

The Evidence

Background

32. Before moving to Multicap on or about 7 December 2017, Steven had lived with his parents on North Stradbroke Island. He also enjoyed good relationships with his siblings including Tracey and Kim.

33. Steven lived with several conditions including:

    (a) cerebral palsy (intellectual);

    (b) diabetes mellitus (type 1); and

    (c) epilepsy.

34. Due to family dynamics changing at home and with the agreement of Steven, it was decided that residential placement for Steven was needed.

35. Once eligibility for funding for disability support had been determined, steps were taken to find as suitable residential facility for Steven. It is relevant to note that at this time (2017) the National Disability Insurance Agency (NDIA) had not been rolled out to this part of Queensland, despite the National Disability Insurance Scheme (NDIS) coming into effect in July 2013.[11]

36. Ms Pamela Trickey of the Department of Disability Services[12] gave evidence that she assessed Steven for eligibility for funding from the Department of Disability on 22 July 2017.

37. Emily Templeton-Dillon was a social worker and case manager at Yulu-Burri-Ba Aboriginal Corporation and Community Health.[13] It was part of her role to liaise with Steven, his family and Multicap up and until the placement.

Steven's capacity to manage his diabetes

38. The witness evidence at the inquest was that Multicap viewed Steven as a person who could *"self-manage"* his diabetes *"with supervision".*

39. The origin of this repeated phrase is unknown, but it is present in the client profile authored by Ms Pamela Trickey from Disability Services dated 10 July 2017.[14]

[11] On commencement of the NDIS, trial sites and locations were conducted across Australia with the final roll out of the NDIS for Queensland commencing in October 2017. *A timeline of the National Disability Insurance Agency*. https://www.ndis.gov.au/about-us/history-ndis

[12] Disability Services, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnership

[13] T1-24, L35

[14] Exhibit B13 Page 22

40. There was no clear evidence of the date Multicap received the psychological assessment report prepared by Queensland University of Technology (QUT).[15]

41. That psychological assessment conducted on 22 June 2017, along with the evidence of the writer, Dr Carolyn Youle, Clinical Psychologist was clear. In terms of general intellectual functioning, Steven was assessed as *"severely impaired".*

42. This evidence was valuable as it provided a detailed review of the areas of Steven's working memory as it related to activities of daily living.[16] Importantly, this evidence also provided insight into how Steven may have presented as being more capable than he actually was, in managing his diabetes. For example, in assessing Steven's adaptive skills, Dr Youle observed in her testing, that Steven's insight into his own capacity was very limited. Steven "*thought he was doing really well on many of the test items where he was not. He would state that he could do things that then, later on in testing, it was clear that he could not".*[17]

43. This means that Steven might have presented with better functioning than he actually enjoyed.

44. Parties through their Counsel, have conceded appropriately, the fact that Steven did not have the capacity to self-manage his diabetes.

45. The evidence also demonstrated that Steven had been booked in for various medical appointments in the lead up to and after placement at Multicap.

46. However, what also became evident was that prior to his placement at Multicap, Steven was not independently assessed (from a capacity perspective) for the purpose of identifying what support he needed to manage his medical needs.

47. It was evident that Multicap and the support workers, at least at placement were not appraised of the importance of his medical condition or the type of support he actually needed to ensure his safety.

48. The lack of understanding of Steven's true capacity to manage his diabetes by those who were involved in his care is paramount in considering the cause of his death.

Expectations of Parties

49. The understanding of the services that were being provided by Multicap was

[15] Exhibit C9
[16] T3-81 generally
[17] T3-82, L34-35

not the same for all of the witnesses examined during the inquest.

50. The promotional material refers to Multicap as a provider of "*High needs disability support*".

51. Ms Joanne Jessop, the Chief Executive Officer (CEO) of Multicap and other Multicap staff were clear that they understood that Multicap was providing disability support only and that Multicap services did not extend or were ever expected to cover clinical care issues.

52. Steven's family asserted that their expectations of Multicap included clinical oversight or management of his diabetes.

53. Paragraph 17 of Kym Thelander's statement[18] stated: *"We did not expect that our family would remain responsible for Steven's diabetic management after the first month"*.

54. These references are in addition to the *All About Me* document[19] and *The Support Plan*[20], which outline expectations of the staff in supporting Steven.

55. The *Medical Authorisation Form* signed 14 September 2017, showed that Steven's mother, Maragret Thelander ticked the box that stated, *"I authorise Multicap Staff to assist the above named individual with the administration of their medication in accordance with the prescribing doctor's instructions".* [21]

56. The documents the *All About Me* document and *The Support Plan* are not care plans, nor sophisticated documents that refer to medical reports or emergency actions.

57. Other sources of information about Steven included the *Diabetes Mellitus Management and Emergency Response Plan,* although this was not competed by Dr Brockman until 16 October 2017.

Trial sleep over

58. Ms Hemera-Sewell, Acting Regional Manager for Multicap, at the time, gave evidence that a planned overnight stay with a co-tenant for Steven was an opportunity for Multicap to monitor how Steven managed his diabetes.[22]

59. This occurred from 18 to 20 September 2017.

60. The records for this period show the BSLs that were recorded over this time.[23]

[18] Exhibit B14
[19] Exhibit C1
[20] Exhibit B8.3
[21] Exhibit C18.2, page 4
[22] T1-63, L8-16
[23] Exhibit C16.1 page 8

These results not only showed repeated high readings (BSL of 24 and 20) but importantly, the results also recorded a very low reading on awakening for the last day of the period, 20 September 2017, with a BSL of 2.

61. Additionally, these records also capture reporting of Steven's behaviour including documented distress of Steven when he could not contact his mother on the phone and the fact he threw his phone on the floor.[24]

62. This trial sleep over occurred after Multicap had been provided with the *All about Me* document and the Consent Forms including the Medication *Authorisation Form*.[25]

63. However, at the date of the trial sleepover, Multicap was yet to receive *The Support Plan* or the *Diabetes Mellitus Management and Emergency Response Plan* from Dr Brockman, General Practitioner.

64. For reasons unknown to the Court, the previous diabetes management plan, or the one relevant to this time period was unable to be produced.

65. However, the *Weekly Meal Planner* document for Steven had been completed for this period by Multicap.

Diabetes Management

66. Prior to Steven's placement at Multicap, Steven lived at home with his parents. His mother, Margaret Thelander played an essential role in the management of Steven's diabetes including BSL management as well as diet.

67. It became evident through witness testimony that the support workers at Multicap had an understanding that Steven's mother was the person assisting him with managing his BSL testing and insulin management.

68. The disability support workers had no knowledge of a response plan (other than to contact his mother) for what to do in response to the situation where Steven did not take his blood sugar levels or in response to particular readings.

69. Mr Vass gave evidence that the extent of his role related of prompting and supporting Steven to take his readings.[39]

70. This understanding was reinforced by the training provided by Multicap that did not address the fundamental science or rationale behind BSL testing.

71. With respect to supporting Steven in taking his blood sugar levels I asked Ms

[24] Exhibit C16.1 page 6
[25] Exhibit C18.2

Jessop a question:

"What was your expectation if he declined to have his blood sugar levels taken?"

72. Ms Jessop responded:

"Then the staff would remind him again, and if he still didn't do that, then my expectation is that they would have escalated that to either their manager or the family to assist Steven to understand that was important for him. They couldn't take his blood sugar or blood glucose level for him. That was his responsibility"[26]

73. Ms Jessop, Multicap's CEO was surprised that there was no evidence of escalation of non-compliance with taking blood sugar level readings[27] and agreed that an escalation should have occurred when either there was a failure to take blood sugar levels three times a day or a level was above 10.[28]

Dr Brockman

74. The *Diabetes Mellitus Management and Emergency Response Plan* was written by Dr Brockman on 16 October 2017.[29]

75. The *Diabetes Mellitus and Management and Emergency Response Plan* provided by Dr Brockman was not appropriate for the reasons that are accepted by Dr Brockman in his evidence.[30]

Food Management

76. Steven's mother, Margaret Thelander wrote a long note in relation to Steven's diet with suggestions for meal plans.[31]

77. Despite this, no *Weekly Meal Planner* was prepared or recorded for the entire time Steven was placed at Multicap.[48]

78. There was a consultation with a diabetes educator, booked for 11 January 2018. The support worker did not attend. The reasons for this are not entirely brought out in the evidence.

[26] T3-26, L40-44
[27] T3-27, L 1-3
[28] T3-27, L33
[29] Exhibit C18.7
[30] Exhibit B10.1
[31] Exhibit C16.6 page 6

Other relevant issues

Responsibility

79. Steven's file at Multicap contained a number of documents, charting records over time. Specifically, the *BSL Chart, Daily Communications* and *Weekly Meal Planner documents* provided the inquest with information about how Steven was being manged at Multicap.

80. In addition, the support workers used a communication book to record concerns and other notes.

81. There were two examples in relation to worker and supervisor communication that stand out as being relevant to issues in this inquest. Firstly, a supervisor made an entry in the communications book asking for improved recording of blood sugar levels on 16 December 2017:

> *"Staff, please fill in Steve's BSL Readings. We are trying to create a pattern for Steve's new doctor to make a new management plan for his diabetes that's easier."*

82. In evidence, the supervisor stated that it was her expectation that testing would result in three readings per day.[32]

83. That request from a supervisor did not improve the number entries of records of BSL readings.

84. The reason for this could be that Steven didn't take his BSLs and so no record could be made. Nevertheless, such an observation by a supervisor demonstrates that there was some understanding of the need for testing regime for BSL by the support workers.

85. Secondly, a support worker documented her concerns about Steven's BSL readings from 13 January 2018 and up to and including 15 January 2018, the day of Steven's death. This issue was not escalated past the supervisor level.

86. These two examples do show a lack of communication and escalation of issues at Multicap.

Policy

87. Multicap had a policy that they provided to Steven (and his family) titled *"3.0 Responding to Individual Needs".*[33] Within this policy there were detailed responsibilities for support staff including:

[32] T2-15, L37
[33] Exhibit 14.7

"Responsibilities of Key support staff for individual clients:

1. *Responsible for keeping up to date all documentation i.e. Client Profile, Behaviour management strategies (in conjunction with the team), signed consent forms, medication folder to be kept up to date with all forms in numerical order etc.*

2. *Responsible for keeping up to date with all information about their client through liaising with other support staff involved in the client's care.*

3. *Be the first port of call for all stakeholders i.e. Medical practitioner, family members, managers etc. including organizing and liaising with program services i.e. Monte Lupo day services, community access services, hydro therapy etc.*

4. *Be kept up to date by all other support staff as to anything that occurred with the client while they were on shift. This communication is to be vis the communication book, staff are not to be called when off duty.*

5. *Ensure that any necessary issues have been reported to the appropriate manager.*

6. *Responsible for the co-ordination of medical practitioner for all long term health needs. If the client has a simple short term medical condition i.e. cold, flu, emergence etc. then the staff on duty needs to arrange medical visit and treatment.*

7. *Responsible for the follow through of all new medications being set up with chemist to be placed into Webster packs.*

8. *Responsible for ensuring relevant policy is followed regarding medication management*

9. *Monitor and review money tins and money recording books and report to the Coordinator any suspected mis use. At least once per week key support staff count and review the week's use of money.*

88. Counsel Assisting made submissions that in light of the evidence at the inquest, there was a degree of non-compliance in meeting the responsibilities outlined by this policy.

Expert Evidence

Trial sleep over

89. Expert witness, Adjunct Associate Professor Davis considered the BSL readings in for this trial period. In particular, he considered the high BSL readings of 24 and 20 coupled with the low BSL reading of 2 *'on wakening'* on 20 September 2017. It was his view that the readings over this period showed a *"problem"* and did not show that Steven was managing well.[34]

[34] T1-63,L8-16

90. Associate Professor Senator opined that the blood sugar level readings over this time suggests that Steven was not capable of managing his diabetes by himself at that time.[30]

Management of Diabetes

91. Associate Professor Senator did highlight his view that Steven should have been referred to specialists in endocrinology as part of his ongoing management.[35]

92. There was some evidence that this had occurred in the past, in 2014 and in 2015. There were issues with making and attending appointments in 2015 and he was ultimately discharged for this specialist's care in mid 2017.[36]

Days leading to Steven's death

93. Adjunct Associate Professor Davis provided a written opinion.[37] He considered that if there were successive readings of 13.3 millimoles per litre, *"you would be looking to investigate it further with looking at urinary ketones. If you have an absolute level of around 17 millimoles per litre, then you'd be calling the medical specialist about action to control that."* [38]

94. Having considered the blood sugar level readings over time on 13 and 14 January 2018, Adjunct Associate Professor Davis opined that if Steven had presented at emergency on the 14 January 2018, then the outcome for Steven would likely to have been different. He opined that Steven would have had a 95% survival rate. [39]

95. Associate Professor Gordon Senator provided a written opinion.[40] In his evidence he also provided an assessment of Steven's HbA1c levels over time:

> *"These were levels records in the patient's original dossier, and they were, as I recall, between 8.9 and 9.1 per cent which would indicate levels of blood sugars overall of two to three times as high as they should be*."[41]

96. In submissions, Counsel Assisting has relevantly referred to the Associate Professors opinion of the records BSLs over time:[42]

> *"... in 24 – in 22 days he had an average of 34 readings if all of the readings were in fact recorded. This would imply an average of 1.5 or thereabouts readings per day. In patients with unstable diabetes we would usually warrant three to four*

[35] Exhibit G4
[36] T4-26, L5-13
[37] Exhibit G3
[38] T4-41, L 27-31
[39] T4-43, L20-23
[40] Exhibit G4
[41] T5(1)-5 , L 33-40
[42] Exhibit C15.1

measurements per day to assist with refining the insulin program. Further, in the last – in the last interval of time, in the last – sorry, let me just check my notes – in the last three days there were only five readings recorded. All of these were markedly elevated. Two of these were even above the threshold of measurement by the meter, including the very last reading which would imply a sugar reading perhaps more than six times as high as would be warranted."

97. Associate Professor Senator opined that Steven may have needed intervention in the preceding three days, not just the final day, to save his life.[71]

Consideration of the Issues

98. The evidence borne out by this inquest clearly demonstrates that there were a number of failings in the way that Steven was cared for before and after his placement with Multicap.

99. I acknowledge that the purpose of an inquest is not to lay blame at any party but to find out how and why Steven died.

100. Fundamentally, there was insufficient appreciation by his providers of the degree of assistance that Steven needed in order to adequately manage his diabetes and diet. This lack of understanding was brought about by the lack of information.

101. In addition, there was a lack of skill by people supporting Steven to identify the emerging needs of Steven during his stay at Multicap. Indicators of an emergency situation developing in the form of ketoacidosis, were not actioned by the organisation and the inevitable tragedy occurred.

102. This inquest also had an opportunity to hear about changed practices and procedures at Multicap that will undoubtedly reduce risk for clients with diabetes into the future.

103. This inquest has also allowed me to make further recommendations to reduce the risk of adverse health outcomes for people with chronic health and disability needs, and when capacity becomes an issue.

Consideration and Conclusions

Expectations

104. With respect to the services of Multicap, it is clear that from the beginning, that there was a misunderstanding of the scope of intervention that Multicap support

workers would have in the day to day support of Steven. This misunderstanding involved not only the care Steven needed to manage his diabetes, but the recognition of the extent of Steven's intellectual capacity due to his cerebral palsy.

105. Steven's family did not understand that he would not be receiving any clinical care from the support workers in managing his diabetes. It seemed that even Steven's case worker, and general practitioner did not understand that clinical involvement with Steven's diabetes would not be occurring at Multicap.

106. In addition, Multicap placed strong reliance on the description that Steven could "*self manage*" his diabetes "*with supervision*".

107. Counsel for the family specifically made the submission that the Court should accept Kim Thelander's evidence about what was discussed between the family and Multicap at the meeting on 14 September 2019, that throughout the course of Steven's time at Multicap the family raised concerns with Multicap staff about Steven's diet and the management of his diabetes.[43]

108. Applying the *Briginshaw* principle in determining on the balance of probabilities as to nature of the conversation, I am unable to make such a finding.

109. I do make the finding that whatever was discussed (with the family and Multicap), Kim Thelander did form a particular belief about the services provided by Multicap. This may have been a result of the lack of clarity of the services being offered to Steven or a misunderstanding of the role of Multicap's services, given their funding model or other reasons, not specifically borne out by the coronial investigation.

110. I do accept the submission of Multicap[44] that greater clarity of the services provided by Multicap before Steven was placed into Multicap would have been beneficial.

111. On my evaluation, this illustrates a need for clearer communication to prospective Multicap clients about the nature and scope of support and care that is provided.

The Trial Sleep Over

112. With respect to the sleep over trial, submissions of Multicap suggest in regard to management of Steven's diabetes, the only information that Multicap had been provided was the profile that Steven could '*self manage with supervision'* from his mother.

113. The initial misunderstanding should have been resolved in the early stages of Multicap's involvement with Steven. An opportunity to do this was during the trial, or directly after the trial sleep over on 18 to 20 September 2017.

[43] Paragraph 12 of Counsel submissions for the family dated 19 December 2024
[44] Paragraph 3 of Counsel submissions for Multicap reply submissions dated 31 January 2025

114. There were objective indicators recorded on that day that warranted urgent review as to whether his placement at that time was appropriate.

115. The fact that Steven's blood sugar levels were measured at very high levels and a very low level supports this finding. In the circumstances, this was a missed opportunity in Steven's care.

116. A cursory review would have identified that logically, the involvement of Steven's mother as the primary person for managing Steven's BSLs was not feasible in practice:

    (a) When Steven didn't take his blood sugar level readings;

    (b) When Steven didn't contact his mother;

    (c) If Steven's mother was not always available;

    (d) If Steven did not follow the advice from his mother.

117. The *Diabetes Mellitus Management and Emergency Response Plan* from Dr Brockman was provided after this event.

118. Stacey Hemera-Sewell in her evidence stated that the referral received by Multicap would also contain the fact the Steven had an *"intellectual impairment".*[45]

119. Given that it was at least known to Multicap that Steven was diabetic and he had an intellectual impairment, some further attention to his ability to manage himself and his diabetes was warranted at that time.

Diabetes medication management and support

120. In relation to placement, I note the submissions of Multicap.[46] I do find that the support provided by Multicap was insufficient and did not appropriately meet Steven's needs. The underlying reason for this situation is multifactorial, but I do find Multicap had opportunities to identify any emerging needs of Steven in the lead up to and once he was placed at Multicap.

121. Counsel for Multicap submitted that: "*Multicap could not investigate that which it did not know"*[47]

122. I do not accept that proposition because there were a number of well evidenced events that, on any review, should have raised concerns about how Steven was being treated after his placement at Multicap. These events included:

    (a) Non-compliance with record keeping for BSL;

    (b) BSLs levels that are recorded demonstrating risks;

[45] T1-82, L25-27
[46] Paragraphs 113 to 115 of Counsel submissions for Multicap primary submissions dated 31 January 2025
[47] Paragraph 34 of Counsel submissions for Multicap reply submissions dated 31 January 2025

(c) Concerns raised in the communication book.

123. There were other objective signs that Steven was at risk because of poor management of his blood sugar levels. The lack of knowledge of the support workers and their failure to escalate non-compliance with blood sugar monitoring practices directly contributed to the fact that there was no effective intervention at any time.

124. The level of support provided to Steven with respect to the supervision and escalation of non-compliance with blood sugar level practices and medication regime also fell below the expectations of the CEO of Multicap.[48]

125. When blood sugar levels were being recorded, the frequency of high risk blood sugar level readings were frequent. At least theoretically, on each and every occasion where there was a non-compliance in testing or medication regime or a reading too high or low presented as an objective indication that Steven was at risk.

126. I note the submission of Multicap[49] concerning the lack of knowledge of the support workers. However, their lack of skill and action in light of BSL readings is not entirely because of the deficiencies of the *Diabetes Mellitus Management and Emergency Response Plan*. It was clear in the evidence that the support workers had very little or no appreciation of BSL and the role that plays as a risk to diabetics.

127. Proper evaluation of these issues would have alerted Multicap that Steven's support for the management of diabetes was not adequate. The fact that the abovementioned matters did not trigger a review or response by Multicap, demonstrates missed opportunities in identifying emerging health issues whilst Steven was at Multicap.

128. It is also relevant to note that Multicap had no restrictions preventing them from requiring Steven to undergo an assessment to determine whether he was suitable for placement at Multicap.

129. If the true extent of Steven's needs were appreciated by Multicap, then there were services that could have been organised to provide clinical care to Steven to ensure his BSL testing was being performed and that he was receiving at the right time the appropriate amount of insulin. It was generally accepted by the witnesses and Multicap that this nursing service (along with any other clinical services) could have been organised for Steven during his placement.

[48] T3-26, T3-27
[49] Paragraphs 28 and 29 of Counsel submissions for Multicap reply submissions dated 31 January 2025

Food management

130. Steven's family has raised concerns about Steven's diet and the contribution of a poor diet in managing diabetes.[50] I acknowledge these submissions so far as they related to the findings I am required to make.

131. Reference was made to a file note made at or around the time of Steven's death the following notation:

> "*Family not happy [with] ↑ BSL/diet of customers. Had concerns for 2 weeks now.*"[51]

132. In applying the *Briginshaw* rule, I am unable to find that this is evidence of any particular event. However, it is clear on the facts that Steven's mother did write a note to the Multicap support workers regarding Steven's diet and suggested meal plans.

133. There is also some evidence of support workers working with and preparing meals in advance with Steven.

134. With respect to food management issues, I note the submission of Multicap[52] and find that the there was a failing by Multicap to prepare and plan through the established *Weekly Meal Planner,* suitable meals for Steven.

135. With respect to compliance with internal policy *"3.0 Responding to Individual Needs"*,[53] The evidence demonstrates that support provided to Steven did not comply with the internal standards of Multicap in relation to:

    (a) the preparation of Weekly Meal Plans;

    (b) checking that BSL testing was done keeping records of blood sugar readings;

    (c) escalating for attention, non-compliance with the *Diabetes Mellitus Management and Emergency Response Plan*;

    (d) the use of communication book during handover;

    (e) following the support plan for checking blood sugar levels and checking that medication is taken.

136. These failings have been repeatedly identified as contributing to the death of Steven.

[50] Paragraphs 11 to 15 of Counsel submissions for the family dated 19 December 2024
[51] Exhibit C17.4
[52] Paragraph 94 of Counsel submissions for Multicap primary submissions dated 31 January 2025
[53] Exhibit C14.7

137. I do accept the submission of Multicap[54] that it did have the capacity to intervene and provide Steven with a higher level of support in the day-to day management of his diabetes, save for where the services required were of a clinical nature.

138. The state of the evidence regarding in the reasons for why Multicap support staff did not attend the dietician appointment does not permit me to make any adverse findings on any party on that issue. However, I do recognise that there may be benefits to the client when support staff are included in clinical appointments. Details covering these arrangements with clients should be clear to the client, clinical provider and support worker.

Dr Brockman

139. Dr Brockman in his supplementary statement[55] was open about the deficiencies in the *Diabetes Mellitus Management and Emergency Response Plan*, including the following:

(a) the plan was rushed (paragraph 30);

(b) the plan was not a comprehensive diabetes management plan (paragraph 31) and was written as an interim plan;

(c) the interim plan was insufficient and lacking (paragraph 47):

(i) information was missing on the form that Steven was "*to check his BSL an hour and a half after a meal and before bed*" (paragraph 34);

(ii) the section on page two "Symptoms for this patient" was not adequately completed and should have included "*vomiting and thirst*" (paragraph 36);

(iii) the form should have stated that an ambulance should be called in the event of a hyperglycaemic emergency (paragraph 42);

(iv) the review date of the plan should not have been one year (paragraph 43).

140. This information demonstrates that there were some failings in the care provided to Steven with respect to the provision of the *Diabetes Mellitus Management and Emergency Response Plan* dated 16 October 2017.

[54] Paragraph 72 of Counsel submissions for Multicap primary submissions dated 31 January 2025
[55] Exhibit B 10.1

141. Despite, evidence to suggest that Steven should have been referred to an endocrinology specialist,[56] I do not make any adverse findings as against Dr Brockman on the basis that he did not make the referral because:

(a) Dr Brockman had an understanding (albeit incorrect) that Multicap were going to devise a "*care plan*" for Steven once he moved to Multicap;[57]

(b) The *Diabetes Mellitus Management and Emergency Response Plan* dated 16 October 2017 was specifically requested as a pre-placement requirement;

(c) No specialist referral was requested from Steven, Steven's family or other person; and

(d) Steven had been previously referred to specialist and did not attend.

142. As a matter of procedural fairness, I also note that this issue (that Dr Brockman did not refer Steven to a specialist) was not put to Dr Brockman in evidence.

143. I note the submissions of Multicap that the risk of similar events is reduced by the current onboarding procedures or through the Complex Health Forum Procedures.[58] Ms Joanne Jessop, CEO of Multicap gave evidence of how a high blood glucose reading would trigger a review of that issue.[59]

144. I also note the other changes in process and procedure that Multicap have adopted since the death of Steven,[60] including the introduction of the *Diabetes Management Support Procedure*.[61] This procedure appropriately identifies that non-compliance events and high risk BSL readings are reportable events within Multicap's *RiskMan* system. Review and follow-up of such events is now a mandatory step within that process.

145. One issue that remains outstanding is the situation where a Multicap client either does not have capacity or loses capacity during the time that person is placed with Multicap.

146. The concern that I still hold relates to a scenario where the client does not have capacity (so this is not an issue of the human rights of refusal of treatment), but where this person declines or refuses to comply with a care plan or regime that is necessary for life.

[56] Exhibit G4
[57] Exhibit B10.1 at paragraph 48
[58] Paragraph 5 of Counsel submissions for Multicap primary submissions dated 31 January 2025
[59] T3-41, 40 - 45
[60] Paragraph 6 of Counsel submissions for Multicap primary submissions dated 31 January 2025
[61] Appendix E to Supplementary statement of Joanne Jessop dated 26 August 2024, Exhibit B3.1J

147. I understand Counsel's submission for Multicap that: "*if an issue of legal capacity is identified Multicap can only be expected to follow the framework already in place under the Guardianship Act and Powers of Attorney Act*"[62]

148. However, I am still unaware of the steps or processes that Multicap have in place to deal with that situation. I understand logically that it may constitute some type of contractual breach which may ultimately involve them leaving the residential facility. A high or low BSL reading may also trigger a review, but I am concerned that without an adequate response plan to ensure that the client receives appropriate medical care at that time, a medical emergency may occur.

Findings

149. The following are findings required by section 45(2) of the Act, namely how Steven died, when he died, where he died and what caused his death. I also make findings on the issues defined by the Pre-Inquest Conference.

Findings required by s45:

Identity of deceased:	Steven John Thelander
How he died:	Steven Thelander was found unresponsive in his bed in the shared residential facility where he lived. He had poorly controlled diabetes and had recorded very high blood sugar levels in days prior to his death. He was treated by QAS at the scene but died.
Place of death	71 Emperor Drive, Redland Bay Queensland 4165
Date of death	15 January 2018
Cause of death	Ketoacidosis as a consequence of diabetes mellitus (Type 1)

[62] Paragraph 55 of Counsel submissions for Multicap reply submissions dated 31 January 2025

Given the co-morbidities of Steven, what services did he require with respect to food management, and or medication management?

150. Given that his psychological evaluation showed Steven was severely impaired, Steven required direct care in the preparation of his meals. Steven was unable to decide or evaluate what meals would be suitable for him. He required a special diet that promoted stability of blood glucose levels.

151. Steven also required direct care akin to nursing services for the management of his diabetes including:

    (a) the prompting and timing of blood sugar tests;

    (b) interpretation of results;

    (c) determination and administration of insulin if needed;

    (d) re-testing if needed.

Whether those services were offered to Steven by Multicap?

152. The services required by Steven as outlined above were not explicitly offered by Multicap prior to his placement. However, there was lack of clarity as to the services that Multicap were offering which did lead to a misunderstanding of the services that were being offered by Multicap.

Did Multicap have capacity to provide those services appropriately?

153. Multicap did have the capacity to provide the services referred to above, however it was clear there was a lack of understanding on behalf of Multicap, that Steven did in fact need these services.

Did Multicap provide those services?

154. No.

Whether the placement of Steven at Multicap was appropriate.

155. In the circumstances, where the services that Steven needed were not offered to him, the placement at Multicap was not appropriate.

Whether the care provided to Steven by his general practitioners was appropriate

156. The *Diabetes Mellitus and Management and Emergency Response Plan* provided by Dr Brockman was not appropriate for the reasons that are accepted by Dr Brockman in his evidence.

Preventative recommendations made pursuant to section 46 of the Act.

157. Sections 46 of the Act permits a coroner to comment on anything connected with the death that relates to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances into the future.

158. Given that Multicap has retained the nomenclature of "*high needs disability support*", I recommend that Multicap review promotional material with the purpose of clarifying specifically the services that they will provide to a prospective client. This information should be detailed with examples of what is and what is not provided in the service.

159. I also recommend that Multicap prepare a response plan or procedure for circumstances where a client does not have capacity but where this person declines or refuses to comply with a care plan or regime that is necessary for life. The process should detail of the appropriate response for individual support workers who find themselves unable to support the client to comply with their health plan. This plan should be properly implemented and form part of the responsibility for support workers, supervisors and managers.

160. I close the inquest

Stephanie Gallagher

Deputy State Coroner

BRISBANE