RAPPORT TAL-IMHALLEF IRTIRAT DR.GEOFFREY VALENZIA

Inkjesta Interna fil-Facilita' San Vincenz wara li nstab nieqes Karmenu Fino (karta ta' identita' numru [redacted] mill-facilita' fit-28 ta' Gunju 2022.

Seduti u xhieda mismugha.

Seduta 7 ta' Lulju 2022

- Dr. Ronald Fiorentino
- Dr. Josianne Cutajar

Seduta 11 ta' Lulju 2022

- Ms.Karen Muscat
- Mr.Bernard Piscopo
- Dr. Celine Quattromani
- Dr.Marisa Abela
- Ms.Marilyn Galea

Seduta 13 ta' Lulju 2022

- Spettur .Paul Camilleri

Seduta 18 ta' Lulju 2022

- Ms.Jacqueline Cassar
- Ms.Marygrace Dalli
- Mr.Robert Belli
- Mr.Thomas Jose
- Mr.Thomas Zammit

Seduta 26 ta' Lulju 2022

- Paul Fino
- Norman Borg
- Antonia Falzon

Inkjesta Interna fil-Facilita' San Vincenz wara li nstab nieqes Karmenu Fino (karta ta' identita' numru[redacted]) mill-facilita' fit-28 ta' Gunju 2022.

Illi l-esponent gie nkarigat mill-Ministru ghall-Anzjanita' Attiva Dr. Jo.Etienne Abela sabiex izomm inkjesta interna fil-facilita' ta' San Vincenz skont ittra datata l-1 ta' Lulju 2022 fejn inghata s-segwenti termini ta' referenza.

Termini ta' Referenza[1]

Internal Inquiry into the case of Mr Carmelo Fino (ID No. [redacted]

Reference is made to the unfortunate case of Mr Carmelo Fino, an 83-year-old man who resides at Saint Vincent de Paule LTCF who was reported missing on 28 June 2022 and, until today, remains so.

The Commissioner of Police was informed accordingly and searches for Mr. Fino are continuing. Investigations by the Commissioner of Police are also underway.

That notwithstanding, as Minister responsible for the Aged, I feel compelled to have the case investigated further. In the circumstances, I hereby entrust you to investigate independently on the case of Mr Carmelo Fino, and on the events preceding, concomitant with, and following upon his disappearance, with a view:

1. to determine whether any wrongful action or omission by any person from any department/section at the Facility facilitated the disappearance of the resident or failed to prevent it. In particular whether

[1] Annex 1

(i) any person knew or ought to have known of, or caused, a real and immediate risk to Mr Fino's well-being and;

(ii) failed to take measures within the scope of his/her powers which, judged reasonably, s/he might have been expected to take in order to avoid that risk;

2. to determine whether the Management at the Facility has fulfilled and is fulfilling its obligation to take preventive operational measures to protect residents who are vulnerable and at risk of being lost due to diseases which affect older persons such as, but not limited to, dementia and whether residents are provided with any tracking devices;

3. to determine whether nursing and medical case notes are properly and regularly documented and whether in the case under reference this procedure was strictly adhered to and observed;

4. to determine whether there was any procrastination or hesitation from the part of the Management at SVP to inform the Commissioner of Police and the Minister for Active Ageing that Mr Fino went missing;

5. to determine whether standard operating procedures are in place at the Facility, and whether members of staff are aware of what procedures to follow in similar circumstances;

6. to determine whether in the carrying out of their duties and for the case under reference, members of staff at the Facility failed to act in a manner that reflects the values promoted in the Code of Ethics at Schedule 1 of the Public Administration Act (Cap 595 of the Laws of Malta) which serves, amongst others, as an ethical benchmark;

7. to present any formal or informal recommendations for due consideration by the authority.

The inquiry shall be conducted in such a way as not to impede or compromise any criminal investigation which may be considered appropriate by the Commissioner of Police.

Relazzjoni tal-Imhallef (Irtirat) Dr.Geoffrey Valenzia

In adempiment ta' dana l-inkarigu l-esponent zamm hames seduti [fis-7 ta' Lulju 2022; 11 ta' Lulju 2022; 13 ta' Lulju 2022; 18 ta' Lulju 2022 u 26 ta' Lulju 2022] fejn sema x-xiehda ta' Dr.Ronald Fiorentino Medical Superintendent ta' San Vincenz de Paule[2], Paule, Dr. Josianne Cutajar, CEO SVP, Karen Muscat, Director SVP, Dr. Marisa Abela, Consultant Lourdes Ward SVP, Dr.C. Quattromani Resident Specialist SVP, Mary Grace Dalli, Chief Nursing Manager SVP, Bernard Piscopo, Senior Nursing Manager, M.Galea A/CN , Spettur Paul Camilleri, Jacqueline Cassar Officer in charge Security, Thomas Zammit u Robert Belli, Health workers, Thomas Jose carer, Norman Borg u Antonia Falzon neputijiet ta' Karmenu Fino, Paul Fino, iben Karmenu Fino

Fatti

Fit-28 ta' Gunju 2022 fil-11.45 am kien sar-rapport l-Ghassa ta' Pulizija ta' Hal-Luqa minn membri tal-istaff ta' San Vincenz li pazjent mill-facilita', certu Karmenu Fino, kien gie nieqes. Il-Pulizija giet infurmata li l-ahhar li raw lil Fino fil-facilita' kien fil-5.45 am. Il-Pulizija nghataw informazzjoni fuq Fino, x'kien liebes, fejn kien joqghod qabel dahal San Vincenz u l-isem tal-familjari.

Mic-CCTVs li gew ezaminati minn wara l-5.00 am Fino ma kienx deher hiereg mill-facilita' u ghalhekk it-tfixxija tkompliet tiffoka fuq gewwa u madwar il-facilita'.

Minn investigazzjonijiet ulterjuri li ghamlet il-Pulizija kisbet informazzjoni li seta ma kienx veru li Fino kien ghadu fil-facilita' fil-5.45 am kif kienet l-informazzjoni moghtija lill-management mill-istaff tal-ward ta' bil-lejl. Il-Pulizija regghet

[2] Minn issa 'l quddiem SVP

rat ic-CCTV mill-gurnata ta' qabel u sabet li fil-2.45 am tat-28 ta' Gunju 2022 Fino kien deher fuq il-kameras hiereg mill-kancelli tal-facilita' li kienu miftuhin dak il-hin tal-lejl. Hu gie rikonoxxut minn Norman Borg in-neputi ta' Fino mill- mixja tieghu.

Il-Pulizija ghalhekk estendiet is-search ghal barra mill-facilita'. Infurmaw l-Ghassa taz-Zurrieq fejn kien joqghod qabel Fino u tellghu l-isem ta' Fino fis-sistema tal-Pulizija. Bdew jezaminaw diversi CCTVs ta' stabilimenti u entitajiet fil-vicin u irnexxilhom isibu filmat fejn Fino deher ghaddej fejn il-Lidl ta' Hal-Luqa fil-3.17:51 am. mill-kameras tal-istabilment *Sicily by Car*[3]. Minn hemm il-quddiem il-kameras ma qabduhx lil Fino ghal diversi ragunijiet kif spjega l-Ispettur Paul Camilleri.

Il-Pulizija firxet it-tfittxija ghad-diversi postijiet li kien jiffrekwenta Fino: ezaminat il-kameras ta' fuq tal-Linja, uzat d-drones u l-klieb tal-Pulizija u nfurmat ic-civil protection.

Il-Pulizija baqghu sejrin bit-tfittxija u kellhom diversi *sightings* pero' kienu fin-negattiv. Fl-14 ta' Lulju 2022 instab kadavru ta' persuna f'Birzebbuga u l-identita' taghha ma' setghetx tigi stabbilita definittivament dak il-hin u kellha ssir awtopsja u ezami tad-DNA. Konkluzjonijiet tal-ezami tad-DNA,sal-prezentata ta' dana r-rapport, ghadhom ma nghatawx.

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[3] Dan ir-ritratt deher fuq il-media ara Annex 3.

Termini ta' Referenza

Fl-inkarigu tieghu l-esponent zamm quddiem ghajnejh it-termini ta' referenza fejn jinghad li:

The inquiry shall be conducted in such a way as not to impede or compromise any criminal investigation which may be considered appropriate by the Commissioner of Police.

L-esponent hu konsapevoli li hemm ukoll Inkjesta bil-Magistrat ghaddejja . Gie infurmat ukoll li l-Spettur Paul Camilleri kien informa lill-Aministrazzjoni[4] biex ma jinterrogawx lin-nies tas-security li kienu ghassa dak il-lejl billi kien se jinterrogahom hu.

L-esponent semgha l-iSpettur Paul Camilleri jixhed dwar l-indagini li ghamlet il-Pulizija u semma li hu kien interroga lill-membri tas-Security li dak il-lejl kienu assenjati mal-kancell imma li ma kienx interroga l-istaff tal-ward, hlief lil Robert Belli, wiehed mill-carers.

L-ispettur semma li l-membri tas-security gew kollha assistiti mill-Avukati taghhom. Ivan Dimech u Emmanuel Aquilina ghazlu li ma jixhdux, mentri Jacqueline Cassar, l-ufficcjal inkarigata mill-grupp tas-security dak il-lejl, semmiet xi affarijiet mal-iSpettur.

[4] Xiehda tac-CEO Dr.Josianne Cutajar.

L-esponent inghata l-inkarigu:

1. to determine whether any wrongful action or omission by any person from any department/section at the Facility facilitated the disappearance of the resident or failed to prevent it. In particular whether

(i) any person knew or ought to have known of, or caused, a real and immediate risk to Mr Fino's well-being and;

(ii) failed to take measures within the scope of his/her powers which, judged reasonably, s/he might have been expected to take in order to avoid that risk;

Security

L-esponent baghat ghall-Ufficjal Inkarigata, Jacqueline Cassar li kienet assistita mill-Avukat Dr. Marion Camilleri. Hi ghazlet li tixhed anke wara li giet imwissija mill-esponent li kellha d-dritt li taghzel li ma tixhidx jekk thoss li b'dak li tghid tista' tinkrimina ruhha.

Hi qalet li dak il-lejl kien bhas-soltu. Ivan Dimech u Emanuel Aquilina gew assenjati minnha mal-kancell u fil-22.45 qaltilhom biex jaghlqu il-kancell. Kien hemm ukoll Raymond Psaila li suppost kien qieghed patrol imma qalilha li ma kienx jiflah u baghtitu fir-rest room u li jekk jinqala xi haga, iccempillu. Regghet ratu filghodu ghal xi 4:15am.

Hi ghandha ufficcju hemmhekk fejn il-kancell. Hemm bhal *foyer* u l-kamra taghha ghandha bieb tal-hgieg. Mill-ufficju taghha hija ma tarax barra pero` tista' tara in-nies li jkunu assenjati mal-kancell. Huma jkunu gewwa fejn il-kamra taghha mal-lejl mhux mal-kancell ghax din tkun maghluqa. Bejnha u dawn it-tnejn hemm *partition*. Dak il-lejl hija rathom hemm. Hi tkun fil-kamra taghmel il-*paper work* cioe` x-

xoghol taghha. Hi tkun hemmhekk ghal li jista' jkun jinqala` xi haga. Kellhom lejl bhas-soltu. Dakinhar gew tad-*danger list*[5] pero' ma tiftakarx il-hinijiet. Il-kancell tkun maghluqa, jifthuha biex jidhlu u jerghu jaghlqu. Dawk ta' mal-kancell kienu hemm il-lejl kollu. Giet ambulanza u gara l-istess. Xil-4.30am jigu ta' James Caterers u jifthulhom il-kancell. Imbaghad fil-5:00 am jinfetah il-kancell biex jidhlu l-haddiema u tibqa' miftuha. Sakemm telqet mill-kamra fis-6:30 am hadd ma infurmaha li kien hemm persuna nieqsa. Filghaxija fit-20.00 l-ufficjali ta' bil-lejl, li kien xoghol warajha, cempillha u qallha li l-pulizija riedu l-particulars taghha ghax raw il-kameras u persuna dehret hierga fit-2:45am. Hi qaltlu "Kif jista jkun", u dan qalli "Iva, kien hemm il-gate miftuha".

L-esponent ma baghatx ghall-membri l-ohra tal-grupp tas-*security* ghax it-tnejn li kienu mal-gate ghazlu li ma jixhdux quddiem l-ispettur Paul Camilleri mentri Raymond Psaila jidher li skont ix-xhieda ta' Cassar u anke tal-iSpettur Camilleri dan kien hafna mill-hin fir-*rest room* u m'hemmx prova li matul il-lejl hareg mir-*rest room*.

L-esponent inghata kopja tal-Memo dwar il-Procedura ezistenti u godda fir-rigward tas-*Security Personnel* kollha ghal min ikun xoghol matul il-lejl kif ukoll l-Standard Operating Procedures ghas-Security Section[6].

L-esponent ezamina c-CCTV cameras[7] u kkonferma li fil-2.45am jidher Karmenu Fino niezel it-triq quddiem il-kancell, dahal lejn il-guard room, rega` hareg qisu sejjer lura minn fejn kien gie u f'daqqa jerga' jdur lura u johrog mill-kancell li kien miftuh. Dak il-hin hadd ma kien hemm fejn il-kancell u hadd

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[5] Dawn ikunu relatives li jigu jaraw qrabathom ghax ikunu fid-danger list.
[6] Ara Annex 5. Dawn l-operating procedures iridu jigu aggornati.
[7] Ara Annex 3.

ma hareg biex iwaqqfu. Il-kancell kien miftuh. Dak il-hin li hareg Fino, jew ftit qabel, ma kinitx dahlet jew harget xi ambulanza jew karozza. L-ambulanza tidher diehla fin-nofs siegha u l-kancell miftuh kien u miftuh baqa'. Fil- 12:55am l-ambulanza telqet u ma kien hemm hadd mal-kancell. Fit 3:39 am dahlet karozza u l-kancell ukoll kien miftuh u baqa' miftuh anke wara li dahlet il-karozza.

Il-kameras jixhdu wahedhom li Fino baqa' hiereg billi l-kancell kien miftuh u ma kien hemm hadd fejn il-kancell u hadd ma hareg biex iwaqqfu. Is-*securites* ma jidhrux fil-filmati tac-CCTV la jifthu u lanqas jaghlqu l-gate.

Skont l-**Standard Operating Procedure** (SOP) il-kancel jrid jinfetah biss bil-lejl meta tidhol emergency vehicle u l-kancell irid jerga' jinghalaq. Il-kancell irid jinghalaq fil-11pm u jinfetah fis-7am.

L-esponent gie imqabbad biex jiddetermina ***whether any wrongful action or omission by any person from any department/section at the Facility facilitated the disappearance of the resident or failed to prevent it.***

Mill-provi jirrizulta li taht l-ghassa ta' Jacqueline Cassar, Ivan Dimech u Emanuel Aquilina, l-kancell thalla miftuh kontra r-regolamenti u minhabba f'hekk Fino seta johrog liberament bil-konsegwenza li sa llum ghadu ma nstabx. Il-kancell baqa' kwazi l-lejl kollu miftuh, jekk mhux kollu, ghad-detriment tal-facilita' u l-pazjenti u hadd mis-*security* ma deher izomm lill Fino milli johrog.

L-ufficjal inkarigata ma' dawn il-membri tas-sigurta' li kienu assenjati minnha mal-kancell, kienet hemm mhux biex toqghod maghluqa fl-ufficcju l-lejl kollu, u ma tidher imkien,

imma wkoll, fi kliema stess, "ghal li jista` jkun jinqala xi haga". Ghaliha dak il-lejl kien wiehed normali, bhas-soltu, mentri fir-realta' ma kien xejn minn dan. Ma hu normali xejn li anzjan jithalla johrog wahdu mill-facilita' u jsib il-kancell miftuh berah, meta dan suppost ikun maghluq, u hadd ma jzommu meta s-*security* suppost qeghdin hemm ghalhekk. L-ufficjal inkarigata kellha l-obbligu li tara li l-persuni li assenjat mal-kancell jaghmlu xogholhom.

Fil-fehma tal-esponent kien hemm nuqqasijiet da parti tas-*security* assenjati dak il-lejl li wasslu sabiex Karmenu Fino hareg wahdu mill-facilita' ta' SVP meta sab il-kancell miftuh matul il-lejl bejn is-27 u 28 ta' Gunju 2022.

Nurses heathworkers u carers

Timeline

Fit-8.00 am. tat-28 ta' Gunju 2022 l-staff ta' filghodu kienu infurmaw lil Maryln Galea, A/CN, li ma kienux sabu l-pazjent Karmenu Fino fil-ward meta hadu over il-ward minghand tan-*night shift* u marru biex jahsluh.

Brian Piscopo, SNM cempel lil Ryhs Xuereb SN, u lil Robert Belli, Carer, biex ighidulu x'gara dak il-lejl.

Robert Belli qallu li kien ta t-te lil Fino u li sal 5.45 am kien ra lil Fino fil-ward.

Sar rapport lil Pulizija fil-11.45 am fejn issemma li Fino l-ahhar li kienu rawh fil-facilita kien fil- 5.45 am.

Tibda s-search fil-facilita' ghal Karmenu Fino.

Brian Piscopo, SNM, intalab li minflok jistennew sakemm jerghu jidhlu ghax-xoghol l-istaff tan-night shift, cioe 48 siegha wara, jigbor l-istatements tal-carers u tan-nurse minhabba l-urgenza tal-kaz. Dawn gew ipprezentati lill-Management[8].

Fuq informazzjoni li kellhom sa dak il-hin, ic-CCTV gew ezaminati mill-5:00 am il-quddiem u Fino ma deherx hiereg minn SVP. It-tfittxija baqghet ikkkoncernata fuq gewwa ta' SVP u l-madwar.

Wara nofsinhar dahlet informazzjoni li skont il-pazjent certu [redacted] Karmenu Fino fit-3:00 am ma kienx hemm u zgur li t-te' ma kienx hadu ghax hu ma kienx hemm. Dan ma qabilx ma' dak dikjarat mill-istaff ta' bil-lejl tal-ward.

Ghalhekk ghal xi 18.30 rega' gie ezaminat ic-CCTV mill-gurnata ta' qabel u bdew mill-23:00 ghax il-carer Robert Belli kien qallhom li kien halla l-caffée lil Fino fil-11 pm.

Fuq ic-CCTV fil-2:45 am deher Fino hiereg mill-kancell principali tal-SVP. In-neputi ta' Fino, Norman Borg gharaf lil zijuh mill-mixja tieghu.

Fino rega' intebah u ngharaf fejn il-Lidl minn fuq il-kameras ta' Sicily by Car fit-3:17:51am.

Is-search ghalhekk giet estisa ghall-barra mill-facilita'.

[8] Ara Annex 2

L-esponent jaghmel referenza ghal-partijiet tas-Standard Operating Procedure [SOP] dwar ***the duties to be performed during a night shift***

Duties for Night Shift

1. Purpose

1.1. The objective of this Standard Operating Procedure (SOP) is to establish the procedure that should be followed by the staff in St. Vincent De Paul (SVP) when on night duty.

2,2, ***The SOP will apply to all SVP nurses and supporting staff on night duty.***

3.4. When ward is settled
3.4.3. Nurse to do any necessary documentation
3.4.7 ***Nurse to check on residents as needed and walk through in all rooms to be performed at 11p.m./1 a.m./3/a.m. Such walk through should be documented in nursing report or ward communication book.***

After 5 am.

3.5.1. Nurse administers medicines as per SOP
3.5.2 Supporting staff gives out hot drinks at the same time and in the same room and other rooms consecutively
3.5.12 Nurse to do any investigation required
3.5.13 Nurse to do any necessary documentation

Safety issues

4.3. Any significant emergency must be reported to the night manager.

Fix-shift ta' bil-lejl kien hemm Thomas Zammit, Robert Belli u Anthony Jose, carers u Rhys Xuereb, nurse.

Skont ic-CEO, dakinhar fil-ward fejn kien hemm is-sur Fino kien hemm tlett carers u nurse u dan minkejja illi kien hemm ftit anqas minn 36 pazjent fis-sala. Dakinhar kienu 34 pazjent u xorta hallellwlhom nurse u tlett carers avolja ma kienux fit-*threshold* li jahdmu b'4.

Ryhs Xuereb tramite l-Union talab ir-revoka tal-istatement li ghamel ghax allega li saret pressjoni fuqu. Ghal dina r-raguni l-esponent ma kienx baghat biex jintervista lil dan ix-xhud.

Robert Belli ghazel li ma jixhidx.

Thomas Zammit u Thomas Jose kkonfermaw l-istqarrijiet li kienu ghamlu.

Jidher li fl-istqarrijiet li nghataw a tempo vergine lill-Management donnu kien hemm qbil bejn l-istaff li sal-5:30 ta' filghodu Karmenu Fino kien ghadu fil-ward u fuq dina l-informazzjoni l-Management beda s-search ghal Fino fil-facilita'.

Indipendentement minn dana, l-istaff ta'bil-lejl kellhom skond ir-regolamenti l-obbligu li jekk jinghataw handover ta' 34 pazjent, huma kellhom jaghmlu l-istess handover ta' 34 pazjent lis-*shift* ta' filghodu. Jirrizulta pero' li meta dahlu tad-day shift dawn sabu li kien hemm nieqes pazjent u hadd ma kien infurmahom b'dana. Ghalhekk jew tan-night shift kienu jafu b'dan in-nuqqas u ma rrappurtaw xejn jew inkellha b'negligenza lanqas indunaw li sa mill-2:45am kellhom pazjent nieqes. Huwa inverosimili li huma ma ndunawx li kien hemm pazjent nieqes ghal kwazi lejl shih meta huma

suppost jaghmlu r-*rounds* kwazi kull saghtejn. Skond l-istaff ta' bil-lejl kollox kien deher bhas-soltu meta fil-fatt Fino kien ilu li hareg mill-ward qabel it-2:45am.

Il-health workers, il-carer u s-senior nurse kellhom jassikuraw ruhhom li l-pazjenti jkunu hemm prezenti fil-ward matul il-lejl kollu u ma jistghux jassumu li pazjent qieghed hemm ghax raw id-dawl jew ghax hallewlu l-caffee jew ghax raw id-dell tieghu. Huwa kellhom jassikuraw ruhhum mhux biss bil-prezenza fisika tal-pazjent imma li l-pazjenti ma jonqoshom xejn u jaghtuhom il-kura li jkollhom bzonn. Jidher li dana ma sarx fil-kaz ta' Fino.

Jigi rilevat li minhabba l-agir tal-membri tan-*night shift* l-Management gie zvijat u t-tfittxija kkoncentrat principalment fl-intern tal-facilita' ghal hin twil, kwazi gurnata, minflok fuq barra kif kellu jsir li kieku l-informazzjoni li nghatat kienet korretta. B'hekk intilef hin prezzjuz u r-rizultat seta' kien differenti.

Ghalhekk l-esponent iwiegeb ghad-domanda billi ighid li kien hemm nuqqas da parti tal-istaff ta' bil-lejl tal-ward billi naqas mid-doveri tieghu li jiehu hsieb li l-pazjent ma jitbieghedx mill-ward bil-lejl u kif ukoll billi bl-agir sussegwenti taghhom svijaw l-investigazzjoni u ntilef hin prezzju.

L-esponent gie mitlub ukoll

2. to determine whether the Management at the Facility has fulfilled and is fulfilling its obligation to take preventive operational measures to protect residents who are vulnerable and at risk of being lost due to diseases which affect older persons such as, but not limited to, dementia and whether residents are provided with any tracking devices.

CEO

Ic-CEO Dr. Josianne Cutajar xehdet li dik il-gimgha hija kienet imsiefra fuq vaganza. Kien hemm minflokha Karen Muscat bhala direttur biex tiehu hsieb fl-assenza taghha. Ghalkemm kienet barra hija kienet qed issegwi kollox billi seta jkun hemm bzonn ta' direzzjoni. Fl-10 am tat- 28 ta' Gunju 2022 hija ttawwlet fl-emails taghha u sabet email minn Mary Grace Dalli CNM u kien hemm in copy Karen Muscat fejn qaltilha li kien hemm pazjent li gie rappurtat nieqes mis-sala bejn 6:30am u 6:45 am. Giet infurmata li bdiet tfittxija interna u li l-pazjent kien ghadu ma nstabx. Kitbet lura biex tara jekk il-pazjent kienx f'*closed* jew *open* ward jew kellux approval li jista' johrog. Hi baqghet issegwi l-kaz minn barra.

Tobba

Dr.Marisa Abela kienet ghamlet statement fuq talba ta' Dr.R. Fiorentino[9] li hija kkonfermat. Dwar il-pazjent Karmenu Fino qalet li dan kien gie mid-dar, dahal go sala ohra

[9] Ara Annex 2

minhabba l-COVID u gie swabbed, imbaghad baghtuh PP2 Lourdes Ward, f'Marzu 2021. Hu tpogga go open ward.

[redacted]

Fil-bidu kellu *constant watch* imma tnehhitlu wara jumejn ghax ma kienx hemm bzonn.

Fino qatt ma pprezenta perikolu. Meta kienu jigu ghalih tal-familja biex jarawh hu kien jimxi maghhom san-nursing station u meta jigu biex jitilqu kien jmur lura f'postu. Hu kien ikun tiela' u niezel fis-sala u qatt ma hareg mis-sala. Hu kien imur sal-gallerija tal-Kappella ghax tinfed mas-sala. [Dan gie kkonfermat mill-membri tal-familja tieghu.] Hu kien irid jigi *prompted* biex jilbes. Kien dejjem pulit u kien fizikament kapaci u jimxi. Il-komunikazzjoni tieghu verbali kienet limitata u ma kienx kapaci jghidlek biex taghtih jixrob. Kif tkellmu kien jghidlek *Number 1*. Hekk biss kien jikkomunika. Hi tahseb li qabel kien ighix wahdu. Kieku xi darba ipprova johrog, huwa kien jintbghat go *closed ward* imma qatt ma ghamilha u lanqas ma wera tendenza suwicidali. Bil-lejl ma kienx iqum. Kien iqum xil-5:30/6.00 u jaghmlulu tazza te. Ma kinitx soltu li jqum fit-tlieta ta' filghodu kif jidher li ghamel. Qatt ma kellhom rapport li hareg. Qatt ma kellu *challenging behaviour* jew kien hemm xi *issues*. Hu seta hareg kemm mit-tarag kif ukoll bil-lift izda t-tarag aktar facili ghax il-lift irid jaghfas il-buttuni u dana qatt ma kien hareg mis-sala. Fit-tarag hemm grada li suppost tinghalaq. Hi grada tal-hadid u tista' tinfetah b'firroll.

Dr.C.Quattromani, resident specialist, xehdet li Dr.Fiorentino kien talabha taghmel statement li hija kkonfermat. Kienet marret fil-ward xit-8 ta' filghodu mal-junior doctor u n-nurse Marylyn Galea. Din qaltilha li kellha pazjent li nstab nieqes meta marru biex jahsluh. Il-pazjent tafu ghax kien fil-ward taghha. Hu pazjent ferriehi, *manageable* hafna, qatt ma kellhom problemi bih. Hu kellu problemi bil'-qalb; kienu ghamlulu by-pass. Kienu investigawh f'Karen Grech ghax kellu problemi biex jitkellem. Anke bhala mard ma kellhomx problemi bih. Fino ma kien jipprezenta ebda riskju. Hu ma kellux kazijiet precedenti ta' *wandering.* Kien dejjem ferhan u meta tkellmu ighidlek Number 1. Dejjem bid-dahqa f'wiccu, kif gabuh fir-ritratti. Hu seta' jimxi perfett u ma kellux *issue* ta' *mobility*.

Dwar il-policy ta' closed u open wards xehdu Dr.R. Fiorentino u Dr.J. Cutajar.

Dr.R. Fiorentino xehed li Fino kien fl-open ward, Padre Piju 2. Fil-Facilita' hemm zewg tipi ta' swali. Dawk li huma *closed* u dawk *open*. San Vincenz mhux habs. Il-*closed wards* huma ghal dawk il-persuni li jkunu *cognitively impaired*, li jkollhom *behavioural conduct associated with dementia.* Huma jistghu jkunu *severe wanderers*. **Huwa l-Multiplinary Disciplanry Team li jiddeciedi fuq il-kondizzjoni tal-pazjent u fejn ipogguh**. Fi *closed wards* il-bibien ikunu imsakkrin u jkun hemm il-push buttons biex jinfethu. Normalment ikun hemm *combined method of pushing of buttons*. Hemm ohrajn fejn il-control ikun ghand in-nurse. Gieli gara wkoll li persuna bid-dementia jirnexxilha tiftah il-bieb anke b'din is-sistema u johorgu. Hemm bibien ohrajn li

jinfethu bis-*swipe card* li tkun ghand il-professjonisti. *Open ward* tfisser li persuna tkun tista' tohrog mis-sala. Skont ir-rapport tal-konsulent Dr. Marisa Abela u l-ispecjalista Dr. C. Quattromani, is-sur Fino kellu id-*dementia* imma seta jpogguh go *open ward.*

Dr.J.Cutajar fuq dana l-punt, xehdet li hemm *spectrum* ta' sitwazzjonijiet. Hemm minn hu *physically independent* u jkun jista' johrog wahdu u dina kienet hekk minn dejjem u ghadha hekk sa llum. Ohrajn li jistghu jduru fil-*grounds* u dawk li jesklaw ghal *limitation of mobility*. Tista' tiskala ghal *closed ward, harness*, u ghal *constant watch.* Kif tiskala hija a *clinical decision.* Ghanda 60 pazjent fuq constant watch, 9 closed wards u jistghu jzidu 2 closed wards ohra. Il-*constant watch* hija *one to one* u mhux *collective.*

From *top to bottom* hemm *drive* kbira biex l-kuncett ta' *open ward* jigi abolit. Iridu li s-sala tkun maghluqa u tinfetah min-*nurse* jew mill-*carer.* Dan hu kuncett gdid ghal SVP ghax l-infrastruttura hija antika u mhijiex mibnija ghalhekk imma fuq kuncett ta' *open ward* li anzjan jista' jiccaqqlaq u jdur. Ic-*challenge* mhijiex zghira ghax ghandek hafna *interconnecting wards* anke ma' dawk ta' fuq u t'isfel u anke mac-*Chapel.* L-ordni hi li jinghalaq kullimkien, ikun hemm bieb wiehed ghal ward li jinfetah u jinghalaq minn persuna, u anzjan ma jistax johrog jekk ikun *unattended.* Qed jimxu fuq dina l-istruzzjoni izda din mhux se ssir mil-lum ghal ghada. Hemm *infrastructural challenges* kbar plus li hemm battibekki mal-Unions, dwar min se jiehu hsieb il-bieb. Il-Union harget direttiva li ma tridx li n-*nurse* ikun responsabbli ghal bieb.

Tagging

Ic-CEO giet mistoqsija dwar mizuri ohra li ttiehdu biex pazjenti ma jigux niesqa. Hi wiegbet li l-bazi tal-kuncett li jahdmu bih f'San Vincenz hu ta' *dignity u s-self determination.* Hi ma kinitx toghgobha xejn l-idea li anzjan johrog minn SVP u jigi x'hin irid, ghax kollu nkwiet ghalihom. Is-sena l-ohra l-Gvern kien dahhal sistema ta' ***telecare on the move***[10] u ntqal li la l-Gvern accetta dina s-sistema kellhom jaddottawha huma wkoll bhala SVP. Diga nxtraw dawn il-pendenti u ghamilna SOP dwar kif trid tahdem u min hu responsabbili ghaliha u meta se titlibbes *tag* u minn min. Imma hemm opposizzjoni ghax irid jinstab min se jkun responsabbili u min se jlibbisha lill-pazjent. F'dan l-istadju kienu se jaghtuha lil dawk li johorgu minn SVP biex ikollhom it-tracking taghhom. Kellhom lista ta' dawk il-persuni li t-tobba qalulhom li jistghu johorgu barra minn SVP bihom. Hemm assessment li jrid isir. Is-Sur Fino ma kienx wiehed minn dawk fuq din il-lista. Qeghdin ukoll jigu *challenged* mis-superjuri taghhom li l-prodott mhux *safe* ghax il-pazjenti jista' jnehhuh x'hin iridu jew jaghmlu hsara fuqhom infushom. Qeghdin jahdmu biex isibu *device* li hu *safe* u accettabili.

[10] Ara Annex 9

SVP u MUMN

Saret dikjarazzjoni mill MUMN li dehret f'artikolu fil-Media fejn inghad:

> *The Malta Union of Midwives and Nurses said yesterday there was only one nurse in the man's ward at the time he left.*
>
> *It said the latest incident confirmed what the union had long been saying: that the shortage of nurses was jeopardising the safety of patients.*
>
> *MUMN president Paul Pace said in a statement that Fino's ward accommodates 35 residents and should be manned by a minimum of two nurses. However, due to a chronic lack of nurses, on the day of the incident only one nurse was assigned to the ward. And the nurse was from the reliever pool and not one who habitually worked in the ward, the union added.*
>
> *Pace said the union was now expecting the home's management to take disciplinary action against the nurse as they usually did rather than take the necessary remedial measures to address endemic problems once and for all.*
>
> *The nurses' complement, he said, had reached a critical level and, unless the government took the necessary measures to effectively remedy this chronic problem, one could only expect a repetition of such incidents.*

The MUMN has also formally requested the SVPR management to put aside all statements on this case that nurses have made to date. It said these statements were given under duress and without allowing the nurses to seek the assistance of their union or legal consultants.

Nurse shortage 'an issue worldwide'

Asked to react to the union's criticism regarding the shortage of nurses, Health Minister Chris Fearne said this was a worldwide issue.

He said that, in Malta, recruitment interviews were held before exam results were even out.

The health authorities have even called for a study, by the European branch of the WHO, about the low uptake of nursing as a profession so that the government would be better able to tackle the issue, the minister said.

Ic-CEO ta' San Vicenz xehdet fuq din il-problema u qalet hekk:

Il-blokka l-gdida hija taghhom u hemm Kumpannija/l-konsorzju privat li qed imexxi dik il-blokka. Huma ghandhom l-amministrazzjoni tal-Blokka. Kellhom bzonn dina l-blokka minhabba l-*waiting list* li kellhom. Dwar nurses hemm kuntratt u l-kumpannija trid tiehu hsieb hi biex tipprovdihom.

F'SVP il-problema hija differenti. Is-setting huwa differenti ghax hemm element qawwi ta' Unions u l-amministrazzjoni u *management* hu aktar *challenging*. Hawnhekk il-Unions

dejjem iridu aktar, dejjem m'ghandhomx bizzejjed. Kien sar studju *in combination* mal-MUNM. L-istudju jismu IDEA. Gew suggeriti l-*benchmarks* skont id-daqs tas-sala u jekk hux *day* jew *night* shift. **Wara dak l-istudju li gara kien li huma qatt ma setghu jkollhom 4 nurses**. Il-Union imbaghad ordnat li jekk f'sala ta' 36 jew 36 plus jekk ma jkunx hemm 4 nurses, in-nurses ma jahslux, ma jitimawx u ma jibdlux nappies. Din il-Union ghamlitu mil-lum ghal ghada u kien hemm *ripple effect* tal-Unions l-ohra, ghax qalu li x-xoghol li mhux se jaghmlu n-nurses se jaqa' fuq il-carers. Ghalhekk kellhom jittopjaw bil-carers biex il-pazjenti jibqghu dejjem moqdija. Ilhom snin issa jahdmu hekk. In-nurses gew *focused* biex jaghmlu xoghol ta' nurses biss. Dan kien fil-2015/6 meta sar ir-rapport. F'daqqa wahda kellhom izidu mal-100 carer a spejjez tal-Gvern. Imbaghad kienu dahlu f'agreement mal-Union li meta jkollhom in-nurses rikjesti – ghax huma jiddependu mill-Health fuq in-nurses li jaghtuhom - hemmhekk jaqghu d-direttivi bil-patt u kundizzjoni li in-nurses ikunu jridu jaghmlu kollox. Dina ma nislitx tajjeb man-nurses ghax kienu aktar kuntenti kif qeghdin. Ghaddew sentejn/tlieta u rega` gie z-zmien ghall-*collective agreement* iehor u ovvjament il-Union bdiet tghid li ghandha n-nuqqas u li x-xoghol zdied u ma jlahhqux. Il-verita` hija li vera li x-xoghol zdied. Ghandna nurses li rtiraw, ohrajn li gew *trasferiti* u dawn ma jigux rilaxxati jekk ma jaghtuhomx *replacement*. Dawn l-ahhar sentejn *top up* ta' nurses ma giex. Dawk li marru gew *replaced*. Huma jitolbu mal-150 nurse fis-sena. Billi ma kellhomx in-numru rikjest ta' nurses kellhom isibu l-kompromess li semmejt. Huma ukoll ghamlu kuntratt biex isir *outsourcing* ta' *nurses* minghand kuntattur privat biex jghinuhom bil-lejl. Il-Union kienet accettat dana ghax kien hemm hafna *shortages*. Wara dan hargu kuntratt iehor biex igibu 14-il nurse mal gurnata ukoll, pero` anke l-

kuntrattur privat kellu problema biex jaghtihom dawk l-14-il nurse. Dawn nuzahom fir-*relieving pool* biex inkunu nistghu naghtu leave u nillapazzaw ghas-*sick leave*. Bhala nurses il-maggoranza huma Maltin daqs 75% jew aktar. Il-healthworkers hemm 300 Maltin u xi 500 carers barranin.

Konkluzzjoni fuq term of reference (1) u (2)

Konsidrati c-cirkostanzi kollha msemmija, nonostante n-nuqqasijiet li hemm fis-sistema f'SVP, dak li huwa lampanti f'dan il-kaz huwa l-fatt li dak li sehh dak il-lejl gara ghax ma gewx segwiti pratici basici li huma dover ta' nies li ghandhom f'idejhom ir-responsabilita` tal-hajja ta' nies anzjani u vulnerabbli.[11]

Fil-fehma tal-esponent kien hemm nuqqasijiet:

da parti tas-security assenjati dak il-lejl li wasslu sabiex Karmenu Fino hareg wahdu mill-facilita' ta' SVP meta dan sab il-kancell miftuh matul il-lejl bejn is-27 u 28 ta' Gunju 2022 meta dan kellu jkun maghluq.

Da parti tal-istaff tal-ward li naqqsu mid-doveri taghhom li jiehdu hsieb li l-pazjent ma jitbieghedx mill-ward bil-lejl kif ukoll billi bl-agir sussegwenti taghhom zvijaw l-investigazzjoni u ntilef hin prezzju.

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[11] Paul Fino, iben Karmenu Fino, xehed: He [Karmenu] came to this facility to be looked after and to be safe.

L-esponent intalab biex

3. to determine whether nursing and medical case notes are properly and regularly documented and whether in the case under reference this procedure was strictly adhered to and observed.

Fuq dana il-punt **Dr.Fiorentino** xehed li kull pazjent ghandu il-*medical file* tieghu. Hemm in-*nursing reports* u *incident reports*. L-*incident report* hija formula li giet introdotta fis-sena 2000 fejn kull incident zghir jew kbir jigi dokumentat. Qatt ma kienet l-intenzjoni li biha huma jsawtu lil xi hadd . Ghalihom kienet isservi bhala *root cause analysis,* per ezempju, rapport ta' *area* fejn hemm hafna qed jizolqu. B'hekk jaraw li hemm xi haga hazina, imorru jaraw x'inhi r-raguni u jsolvu l-problema. Kienet issir ghal kollox anke ghal *medication error*. Imbaghad darba gara incident fejn l-amministrazzjoni ta' dan l-isptar uzat *incident report* biex, skont il-Union, issawwat in-*nurse*, u l-Union harget direttiva biex ma jintlewx dawn ir-rapporti. Fil-blokka il-gdida dawn l-incident reports isiru dejjem. Min-naha taghna ta' San Vicenz hemm min jaghmilhom u hemm minn ma jaghmilhomx. L-Union f'dan il-kaz sostniet li l-istqarrija tan-Nurse R. Xuereb ma tinghatax ghax saret *under duress*.

Brian Piscopo fuq dan il-punt xehed li hu kien gie mitlub mis-superjuri tieghu biex jigbor l-istqarrijiet tal-persuni li kienu *night shift* fil-ward dak il-lejl u ma ghamel ebda pressjoni fuq hadd. Huma tawh l-istqarrijiet minn jeddhom.

Dr.C. Quattromani fuq dana il-punt xehdet li hija ma kinitx ghamlet ir-rapport billi dak il-hin kienu mohhom biex jaraw fejn spicca l-pazjent. Ir-rapport sar wara. Fl-istqarrija taghha

hi tghid :'*Writing on the patients file was not a priority at the time, since we did not know how this incident was going to evolve. I felt that the most important thing was liaising with the staff to alert all SVP about the missing resident. The search was ongoing and we were all very hopeful that we would find him*'.

L-esponent intalab ukoll

4. ***to determine whether there was any procrastination or hesitation from the part of the Management at SVP to inform the Commissioner of Police and the Minister for Active Ageing that Mr Fino went missing;***

Mix-xiehda mismugha jirrizulta li r-rapport l-Ghassa kien sar fil-11:45 am, cioe` 6 sieghat wara, billi Fino gie rappurtat nieqes fit-8 ta' filghodu u li l-ewwel kienu ppruvaw iffittxuh huma gewwa il-Facilita' u billi l-*area* kienet kbira kien hadilhom il-hin. Imbaghad meta ma setghux isibuh avvzaw lill-Pulizija. Hemm ukoll il-kwistjoni li management inghata informazzjoni skorretta u t-tfixxija giet svijata u ntilef hin prezzjuz.

L-esponent intalab ukoll

5. to determine whether standard operating procedures are in place at the Facility, and whether members of staff are aware of what procedures to follow in similar circumstances;

Dr. R. Fiorentino xehed li bhala standard operating procedures hemm zewg binarji: il-binarju mediku fejn huma juzaw kemm dawk il-proceduri ghal kura li juzaw Mater Dei billi ghandhom access ghalihom bhala tobba u kif ukoll juzaw in-Night Guidelines- Il-linja gwida tal-Ingilterra u ta' l-Iskozja.

Dawn il-proceduri huma specifici fuq il-mard per ezempju x'taghmel fil-kaz ta' attakk tal-qalb, stroke. Dawn huma jsegwuhom fedelment bhala *the best practice*. Dawn il-prattici jigu segwiti mit-tobba kollha, mill-*medical student* sal-konsulent. Imbaghad amministrattivment f'SVP ghandhom *policies* taghhom cioe' Standard Operating Procedures u Guidelines. Dawn huma relatati mal-anzjanita' u management tal-post fejn ikun hemm l-anzjani. Huma indirizzati ghal klinici kollha bhal tobba, nurses etc bhala per ezempju in-nonsmoking policy li tapplika ghal kulhadd. Hemm guidelines li japplikaw ghal diversi tipi ta' persuni. Huma jsegwu hafna mill-proceduri ta' Mater Dei. Fejn jistghu huma jaddottawhom ghalihom ghax m'hemmx bzonn li huma jivventaw ir-rota.

Dwar il-Code of Ethics tal-Professjonisti u dak tal-Anzjani huma jsegwu dak il-Kodici fedelment kemm jistghu minn mindu kien hemm l-SCSA - Social Care Standard Authority. Dawn kull sena jaghmlulhom *assessment* fuq il-Protocols taghhom u jaraw jekk kollox hu in vigore. L-assessors huma zewg entitajiet: il-Heath, li ghandhom l-Istandards unit li jillicensjawna bhala entita' li nistghu noffru kura medika ghal anzjani, imbaghad hemm is-SCSA li tillicenzjana fl-ambitu socjali. Jigu darba fis-sena. Huma jaghtuhom rapport dettaljat bis-suggerimenti b'kollox. Biex tohrog il-licenzja tas-sala huma jaghtuhom rapport u jghidulhom x'sabu tajjeb u x'irid jigi rrangat. Ir-rapport jghadduh lic-*charge nurse* tas-sala biex jiehu azzjoni. Kultant ikunu affarijiet zghar bhal per ezempju ma jkunux sabu bizzejjed xugamani u kultant ikunu affarijiet ftit aktar serji bhal per ezempju nuqqas ta' ndafa. Il-kwistjoni dwar nuqqas ta' *nurses* taqa' f'ambitu iehor.

6. to determine whether in the carrying out of their duties and for the case under reference, members of staff at the Facility failed to act in a manner that reflects the values promoted in the Code of Ethics at Schedule 1 of the Public Administration Act (Cap 595 of the Laws of Malta) which serves, amongst others, as an ethical benchmark

Ir-rizultanzi f'dana l-kaz imorru oltre kwistjonijiet ta' Etika. In-nuqqasijiet huma aktar gravi.

7. to present any formal or informal recommendations for due consideration by the authority.

Qed jigi suggerit li jinstab device/s [telecare/bracelet/ arlogg jew aggeggi ohra] ghal tracking li hu dinjituz, sikur, u accettabili medikament u legalment.

Jigu delinejati il-kriteri li jintuzaw mill-Multiplinary Disciplinary Team biex jiddeciedu fuq il-kondizzjoni tal-pazjent u f'liema ward jitpogga.

Veru li l-facilita' mhijiex habs imma hemm bzonn li jkun hemm sorveljanza fuq min hu diehel u hiereg u jkun hemm aktar kontrol kif isir f'homes ohra privati.

Issir aktar *vetting* fuq il-persuni li jigu impjegati u li jkunu adattati ghax xoghol li jridu jaghmlu mhux jigi accetta kull min japplika ghax jezisti nuqqas.

Tigi solvuta l-kwistjoni dwar l-incident report.

Cases notes iridu jigi mimlija kollha u dokumentati. Hemm nuqqasijiet f'dan ir-rigward.

L-SOPs kull tant zmien ghandhom jigu aggornati.

Isir ezami ta' kif tpoggew ic-CCTV u jekk iridu jizdiedu u/jew jittpoggew ahjar. Hemm bzonn ta' kameras li jiehdu l-vetturi li jkunu diehlin u hiergin.

Irid jinstab post iehor ghad-dawl li qed jostakola il-kamera li tidher fir-ritratt[12] billi bil-lejl kwazi ma jidher xejn.

Il-persuna in charge mis-Security ikollu fil-kamra tieghu apparat elettroniku li bih ikun jista' jissorvelja dak li qed jigri barra u l-madwar.

Li l-management u l-istaff jipprovaw jifhmu lil xulxin u s-sitwazzjoni li qed jahdmu fiha fl-interess kemm taghhom kif ukoll tal-pazjenti.

Iridu jigu ben delinejati r-rwoli tal-carers, health workers u tan-nurses.

Imhallef G Valenzia

[Irtirat]

[12] Ara Annex 3

ANNEX 1

TERMS OF REFERENCE

MINISTERU
GĦALL-ANZJANITÀ ATTIVA

MALTA

MINISTRY
FOR ACTIVE AGEING

1 July 2022

Judge Geoffrey Valenzia,

Internal Inquiry into the case of Mr Carmelo Fino (ID No

Reference is made to the unfortunate case of Mr Carmelo Fino, an 83-year-old man who resides at Saint Vincent de Paule LTCF who was reported missing on 28 June 2022 and, until today, remains so.

The Commissioner of Police was informed accordingly and searches for Mr Fino are continuing. Investigations by the Commissioner of Police are also underway.

That notwithstanding, as Minister responsible for the aged, I feel compelled to have the case investigated further. In the circumstances, I hereby entrust you to investigate independently on the case of Mr Carmelo Fino, and on the events preceding, concomitant with, and following upon his disappearance, with a view:

1. to determine whether any wrongful action or omission by any person from any department/section at the Facility facilitated the disappearance of the resident or failed to prevent it. In particular whether

(i) any person knew or ought to have known of, or caused, a real and immediate risk to Mr Fino's well-being and;

(ii) failed to take measures within the scope of his/her powers which, judged reasonably, s/he might have been expected to take in order to avoid that risk;

2. to determine whether the Management at the Facility has fulfilled and is fulfilling its obligation to take preventive operational measures to protect residents who are vulnerable and at risk of being lost due to diseases which affect older persons such as, but not limited to, dementia and whether residents are provided with any tracking devices;

3. to determine whether nursing and medical case notes are properly and regularly documented and whether in the case under reference this procedure was strictly adhered to and observed;

4. to determine whether there was any procrastination or hesitation from the part of the Management at SVP to inform the Commissioner of Police and the Minister for Active Ageing that Mr Fino went missing;

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T +356 2590 3058 E info.mfaa@gov.mt

5. to determine whether standard operating procedures are in place at the Facility, and whether members of staff are aware of what procedures to follow in similar circumstances;

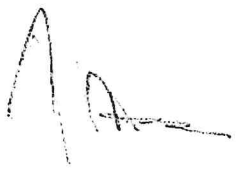
6. to determine whether in the carrying out of their duties and for the case under reference, members of staff at the Facility failed to act in a manner that reflects the values promoted in the Code of Ethics at Schedule 1 of the Public Administration Act (Cap 595 of the Laws of Malta) which serves, amongst others, as an ethical benchmark;

7. to present any formal or informal recommendations for due consideration by the authority.

The inquiry shall be conducted in such a way as not to impede or compromise any criminal investigation which may be considered appropriate by the Commissioner of Police.

The outcome of the inquiry is to be concluded and presented to me within a timeframe of four weeks. The contents of the report will be made public. However, disclosure of any parts which are considered necessary to safeguard data protection, ongoing or future criminal or disciplinary investigation may be restricted.

You shall have access to all information held at the Facility and a Secretary shall be appointed to assist the Inquiry, as necessary.



Dr Jo Etienne Abela MD MPhil FEBS FRCS MP
Minister for Active Ageing

Stqarrijiet bil-miktub: **ANNEX 2**

- Mr. Anthony Galea
- Mr.Bernard Piscopo
- Mr.Thomas Jose
- Mr.Gill Fizer
- Ms.Annakutty Anupama
- Mr.Thomas Zammit
- Ms.Marilyn Galea
- Ms.Mary Grace Dalli
- Mr.Robert Belli
- Dr.Marisa Abela
- Dr.Celine Quattromani
- Mr.Godwin Brooks
- Mr.Jeffrey Borg
- Mr.Julian Cassar
- Ms.Karen Muscat
- Mr.Rhys Xuereb
- Mr.Rengith Radjakrishnan
- Mr.Pillakondoor V Sreejith
- Mr.Thomas Phulyaveettil Anthony.

Souness Jorgen at Health-MDH

From: Galea Anthony at SVP
Sent: Tuesday, 28 June 2022 16:40
To: Cutajar Josianne at SVP; Dalli Mary Grace at SVP; Muscat Karen A at SVP; Fiorentino Ronald at SVP
Cc: Piscopo Bernard at SVP; Borg Christopher A at SVP
Subject: Missing resident PP2

Dear Dr Cutajar M'Grace Dalli

Missing resident Carmelo Fino PP2

Unfortunately today 28th of June 2022 charge nurse Marilyn Galea informed me that a resident by the name of Carmelo Fino [redacted]m was not found as usual near the bed in preparation for routine bathing.
Ms. Dalli CNM and assistant Director briefed. Security main gate officers were immediately informed of the incident, my colleagues Mr. Bernard Piscopo and Mr. Chris Borg were informed, and an intensive search started. Mr. Bernard Piscopo with Mr. Micheal Demanuele reviewed security cams from 5 am in the morning onwards resident was not seen leaving the residence, but has been seen exiting the lift on the left-wing administration area and entering the main square at about 6.22 am. Staff from PP2 were instructed to assist in the search. All wards were instructed to perform a headcount of all their residents. Mr. Chris Borg covered the basement area of the new SVP area, and area security informed including management. Bernard and I covered all outer areas including the basement. At about 10.30 am all efforts to find the resident failed and Ms. Karen Muscat and my CNM instructed us to go to the local police station LUQA and file a missing person report. Mr. Bernard Piscopo filed a report with police Surgent P567 at 11.30.
Another search has been conducted this afternoon by Luqa police with the participation of the Police Force Dogs Section .
Another search shall be conducted in SVP area later on .
Till time of report resident still missing.

I shall be requesting statements of facts from Charge Nurse Marilyn Galea .
Staff nurse Mr Rhis Xuereb night duty between 27th and 28th .
Mr Thomas Zammit HC2 ,
Mr Belli Robert Social assistant , and
Anthony Jose carer.

NB: All nursing and medical notes sent to the medical superintendents office. copies of nursing report and px chart sent to my CNM.

Regards

Souness Jorgen at Health-MDH

From: Piscopo Bernard at SVP
Sent: Tuesday, 28 June 2022 22:13
To: Fiorentino Ronald at SVP; Dalli Mary Grace at SVP; Muscat Karen A at SVP
Cc: Galea Anthony at SVP; Spiteri Carmela at SVP; Borg Christopher A at SVP; Galea Anthony D at SVP; Camilleri Robert at SVP
Subject: Missing patient from PP2

At 0830 hrs the SNM covering PP2 for the day (Mr Anthony Galea) received a call from Marilyn Galea A/CN that a patient Carmelo Fino was not in the ward as was his usual. He was reported missing at about 0800hrs. I attended the ward and found that already the ward staff were searching and looking for the patient on the hospital grounds.
I contacted the nurse on duty during the past night (Rhys Xuereb SN) who ascertained me that he gave the treatment of the night to the patient. The support staff Robert Belli (SA) assured me that he gave tea to the patient at 0530hrs and that the patient was in the ward at 0545hrs. He also told me what the patient was wearing - short jeans and chequed shirt - and was ready to repeat this statement even under oath.

While the ward staff were looking for the patient on the hospital ground, myself attended in the security office where I scrutinised the CCTV images mostly those that cover the main gate entrance and the corridor that gives a direction to the lifts between PP2 and MT2. Since I do not know the patient, I was accompanied by one of the ward personnel for better identification of the patient.
The relatives were informed and promised every update about their patient.
After all usual measures proved fruitless, I was requested to attend Luqa Police station and there submitted a report for a missing person to PS67. At Luqa police station I was accompanied by Anthony Galea SNM and Marilyn Galea A/CN PP2.
After giving the necessary details, we returned to SVP.

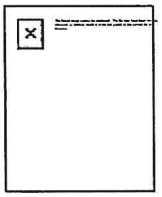
At repeated intervals, all the wards were ordered to perform a headcount to identify any patient in the ward.

During the afternoon, a thorough search under the guidance of a police inspector from the police force and the K9 section of the CPD was again performed in the hospital grounds but the search proved again fruitless. During this search, the top managers, SNM's, PDN's on duty, and members from the transport division, maintenance, care-workers, customer-care officers and security officers all gave a helping hend.

At 2000hrs, another search by the EFRU/CPD K9 service commenced in the hospital grounds and this was ordered to stop at about 2115hrs. We were informed that the patient was seen exiting SVP at about 0300hrs.
The case will be further investigated by the police corp.

Bernard

Bernard Piscopo
Senior Nursing Manager
Nursing Administration Unit
St Vincent De Paule' - Long Term Care Facility



Declaration of Thomas Jose holder of residence permit card number taken today 1st July 2022.

I am a care worker with Support Services Limited and I was on Night shift on the 27th of June 2022 7pm to 7 am on Tuesday 28th June 2022. I was scheduled during the Night Shift in Ward PP2 and I was there as a reliever.

I had a break from 9pm to 930pm during that night. The nurse during that night told me to take the break during that time. I do not know the name of the nurse, but he was Maltese.

With me during the night shift, I was working with 2 other care workers who work within the Government of Malta, not with the Company I work with.

I went into the room, where Mr Fino was before I took the break, approximately at 730pm in order to change a nappy of another patient in his same room. I saw him and I gave him coffee at 730pm.

I saw Mr Fino at around 5am – 530am again, when I went again to change the nappies and he gave him coffee again. He was in the bed, awake and not sleeping. He did not have the bed side raises up around his bed. I was with other care workers at that time doing the nappy changes and giving coffee, both of them were in government workers, one was wearing blue uniform and one was working brown uniform.

He took his coffee without sugar at that time.

I was working on the full ward, not only in his room as a reliever, during the night shift, because we were there only 3 care workers.

Thomas Jose

Declaration of Gill Fizer holder of residence permit card number [redacted] taken today 1st July 2022.

I am a care worker with Support Services Limited and on Tuesday 28th June 2022 I was working day duty from 7.30am to 6pm. Usually that is not my Ward. I am a reliever which at that time I was sent on the day to ward PP2.

I have not seen Mr Fino on the day during my day shift at any point, anywhere in the building on Tuesday 28th June 2022.

Gill Fizer

Declaration of Annakutty Anupama holder of residence permit card number taken today 5th July 2022.

I am a care worker with Support Services Limited and on Monday 27th June 2022 I was working night duty from 7pm to 7am. Usually that is not my Ward. I am a reliever which at that time I was sent on the night to ward PP2.

I was on constant watch with a patient whom in that ward – is the only patient requiring constant watch. I have not seen Mr Fino during the night shift at any point, as I was constant watch with my patient.

Annakutty Anupama

28-6-2022

Jiena Thomas Zammit, [redacted]. Il-Grad tiegħi huwa ta' Health Carer II. Kont Night Shift fis-27-6-2022, sbieħ it-28 ta' Ġunju 2022, fis-Sala Lourdes Ward. Staff konna jiena (Thomas Zammit), Robert Belli - Carer, Rhys Xuereb - Nurse, Thomas Josè - Carer barrani/Extra u kien hemm Carer mara ġo kamra oħra (Constant-watch).

Kif dħalna xogħol bdejna nbiddlu n-Nappies, inbattlu l-Urines u wara għamilnilhom it-tè u l-kafè. Il-lejl kien normali, għax kull ċertu ħin kif ngħamlu s-soltu niċċekkjaw il-pazjenti. Għal-ħabta tas-siegħa u nofs u s-sajjen ta' filgħodu il-pazjent Carmelo Fino kien ġo soddtu bħal ma kienu l-pazjenti l-oħra.

Għal ħabta tal-5-am (ta' filgħodu) bdejna nbiddlulhom in-nappies u nbattlu l-Urines u wara kif lestejna għadna it-tè u l-kafè. Pero jiena (Thomas Zammit) f'dan il-ħin ma dħaltx fil-kamra ta' Carmelo Fino għax kienu għaddhom kif daħlu l-kollegi ta' miegħi, Robert Belli u Thomas Josè (il-Barrani) u jiena bqajt sejjer għal ġol-kmamar l-oħra inkompli x-xogħol.

THOMAS ZAMMIT

Souness Jorgen at Health-MDH

From: Piscopo Bernard at SVP
Sent: Tuesday, 28 June 2022 19:10
To: Muscat Karen A at SVP
Subject: Fw: Statement regarding the absence of patient from lourdes ward.

Bernard Piscopo
Senior Nursing Manager
Nursing Administration Unit
St Vincent De Paule' - Long Term Care Facility

t: +356 22912466 m: +356 79076280 e: bernard.piscopo@gov.mt
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MINISTRY FOR THE FAMILY,
CHILDREN'S RIGHTS AND
SOCIAL SOLIDARITY

From: Galea Maria Assunta at SVP
Sent: 28 June 2022 14:25
To: Dalli Mary Grace at SVP; Fiorentino Ronald at SVP; Muscat Karen A at SVP
Cc: Spiteri Carmela at SVP; Farrugia Joseph at SVP; Galea Anthony at SVP; Piscopo Bernard at SVP
Subject: Statement regarding the absence of patient from lourdes ward.

To whom it may concern,

In the morning of Tuesday 28/06/2022 I Marilyn Galea acting charge nurse at Lourdes ward gave out the allocation

to the ward staff.

At 8.00am I was informed by nurse and carers allocated at side B that patient Carmelo Fino was not in his place. I

and the said carers searched for him around the ward and nearby areas but without success. Immediately I informed the SNM on

duty and put most of the staff on full alert so as to go and look for him around the whole premises of SVP. Still without success.

At 10.45am I was asked to see the office of Ms. Dalli and to answer some questions regarding photos taken by CCTV cameras.

At 11.00am I with SNM Mr. Bernard Piscopo and SNM Mr. Anthony Galea went to Luqa Police Station to make a report that patient

Carmelo Fino was missing from the Lourdes ward.

Souness Jorgen at Health-MDH

From: Dalli Mary Grace at SVP
Sent: Wednesday, 29 June 2022 10:33
To: Cutajar Josianne at SVP; Fiorentino Ronald at SVP
Cc: Muscat Karen A at SVP
Subject: Missing person- Carmelo Fino of PP2

At around 09:00 hrs, I was informed by Bernard Piscopo SNM that the above resident, residing at PP2 was not in his room when the carer went to assist him with bathing at 08:00hrs. The ward staff had searched in all areas of the ward and also in the nearby surrounding s including outdoor areas. It was claimed that the last time that the resident was seen on the ward was about 05:45hrs after the health carer Robert Belli had distributed tea.

As is normal practice in such situations the first search is done internally and to date has always been successful. In this case the internal search was inadequate and since this was a case of a missing person, the police and not the Civil Protection Department were informed. I informed Ms Karen Muscat (Director Elderly Care) and sent an email to Dr Cutajar CEO. An enlarged photo of the resident and later several others were produced for the police and search parties respectively. Mr Piscopo, Mr Galea and Ms Marilyn Galea A/CN were called in my office; Ms Galea claimed that the resident used to go to the church in the balcony area which lies on the same floor as ward PP2 and that verbally he did not communicate well. I called the transport section and all three officers went to Luqa police station to file the report. Relatives of the resident were informed as well.

Meanwhile, I went to the ward checking in his bedroom; I spoke to Dr Abela who was in the ward and she claimed that the resident never wandered off the ward; it was his normal routine to go to the church and back.

We alerted all wards including New wards to check for any residents who do not reside in their wards, to do head counts and to check all ward areas including remote areas. This process was repeated again in early afternoon and later we instructed all wards to check the residents by the name and ensure that the resident who belong to the ward are actually there. In the afternoon, several search parties were organised to cover all hospital grounds under the direction of the police inspector Paul Camilleri. Staff from various sections participated committedly in the search.

I kept in contact with Dr Fiorentino, Ms Muscat and SNM and Nursing Admin staff with regards to the ongoing operation and gave instructions to staff accordingly.

Police section then took over of the operation.

At 22:00hrs I was informed by Mr Piscopo that CCTV recordings showed a man leaving SVP through the Main Gate at around 03:oohours of 28/6/2022; possibly being resident Carmelo Fino.

Police investigation is ongoing.

Mary Grace Dalli
Chief Nursing Manager
Nursing Administration Unit
St Vincent de Paul Long Term Care Facility

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MINISTRY FOR ACTIVE AGEING
St Vincent de Paul Long Term Care Facility, Florence Nightingale Road,
Luqa, Malta

28/6/22

Jien Robert Belli [redacted] Jiena
Kont Night Shift Fil- 27/6/22 Sbieh il- 28/6/22
Fir- Roster Kamra In- nurses Rhys, Nursing Aid
Thomas Zammit kien hemm carer barrani
Extra Imma ismu ma nafux u kien hemm carer
Resident wahde go kamra ohra u Jien. Aghmilna
r- routine tas- Soltu kif nithlu Il- inbidu IN-
leppes kien go Sodda Carmelo firo u ma' tul
. iejt aghmilna Rounda kien aghdu go Sodda
Ilghoda kif bidlna il- nappejs u bniegna bit- te'
al habta ta' 5.45 am kif thalt fil- kamra Rajtu
kamra ta' toilet ghax kien gejjad Juza it-
let. Sa kemm konna aghalna go Sala u
ww Jibdluna ma rajna xejn mhux ta' Soltu
ex kwiet.

Dejjem tiegħek

Robert Belli

R. Belli

28th June 2022

Re: Mr Carmelo Fino

Lourdes Ward, SVP

Mr Fino was admitted to Lourdes Ward from home in March 2021. He has a history of cognitive impairment and needs assistance in bathing and dressing. He is independent in feeding and he walks unaided. He is medically very stable.

On his admission to Lourdes Ward, in view of the change in his environment, he was placed on constant watch in order to observe him well and to make sure that he settles well in the ward.

However, Mr Fino settled very well in Lourdes Ward. He was very happy and he got on very well with all the staff members and with the other residents. In fact, was never given and the constant watch was stopped after around 48 hours since he had already settled well in the ward.

Mr Fino never showed any challenging behaviour and he was never aggressive or agitated. He never tried to leave the ward, and he never used the stairs or the lift or wandered out of the ward. He enjoyed walking up and down the corridor of the ward and he liked to walk to the balcony of the church, which opens up from the ward corridor and attends mass from there. Then he always came back to the ward. He never wandered away or got lost on the way from the church balcony to the ward.

He was never deemed to be in danger of wandering away since he never exhibited any tendency to do so. He did not need any constant watch as his behaviour was never challenging and he was never deemed to be a candidate for a closed Dementia-friendly ward since there was never any tendency for him to wander outside of Lourdes Ward.

Dr Marisa Abela

Consultant Lourdes Ward

Saint Vincent De Paul

Office of Medical Superintendent
St. Vincent de Paul Long-Term Care Facility
Florence Nightingale Street
Luqa LQA 3301
Tel: 2291 2203
ronald.fiorentino@gov.mt

Friday, 8 July 2022

Dear Dr Cutajar,

I would like to present how the situation evolved today 28th June, regarding Mr Fino of Lourdes ward.

I together with the foundation doctor of the ward were in Lourdes ward at round 8.30am as usual. The charge nurse informed us that one of the residents was missing, namely Mr Fino. Mr Bernard Piscopo (DNM) was also present in the ward. I asked the charge nurse about the all details they know about this incident. I went round the ward and in the adjacent wards looking for him. Went out in the court yard, church and church gallery. Looked in laundry chutes and all the possible whereabouts that we could think of. The staff (nurses and carers and all) teamed up and went to different location around all SVPR. I even went to speak to residents who Mr Fino used to be with and asked if they knew anything about his where about.

Writing on the patients file was not a priority at the time, since we did not know how this incident was going to evolve. I felt that the most important thing was liasing with the staff to alert all SVPR about the missing resident. The search was still ongoing and we were all very hopefully that we will find him.

regards
Dr C Quattromani

23

Għaziza Sinjura Dalli, CNM

1/7/2022

Nireferi għal litra tiegħak datata 30 ta Ġunju fejn tlabtni raport fuq li ġara 28 ta Ġunju rigward Sur Carmeno Fino .

Jien Godwin Brooks kont overtime fit 28 ta Ġunju ġewwa sala PP2 u bdejt xogħol fis 7.00 ta filgħodu kief ngħamel dejjem immur għand Nursing Officer u jinfurmani fejn irrid nibda xogħol bħala kmamar.

Jiena u sieħbi bdejna naħslu fejn ordnana Nursing officer din kienet il kamra fejn kien hemm is-sur Fino , peres li sur Fino jimxi bdejna naħslu il-pazjenti li kienu fis-sodda wara li lestejna rajna li Sur Fino ma ġiex fis-sodda dan kien għal xi 8.00 u minufih infurmajna lin Nursing Officer Sinjura Merilyn Galia fejn min hemm bdit tfitxija għalih.

Sur Godwin Brooks

Brooks

7/7/2022

Għaziza Sinjura Dalli, CNM

Nirefferi għal littra tiegħak datata 30 ta Ġunju fejn tlabtni raport fuq li ġara fit 28 ta Ġunju rigward il-pazjent is-Sur Carmeno Fino.

Jien Jeffry Borġ kont overtime fit 28 ta Ġunju 2022 mis 7.00 sa nofsinhar ġewwa sala PP2 kief ngħamel isoltu mort għand Nursing officer Sinjura Merilyn Galea biex tinfurmani fejn irrid nibda xogħol.

Jien u sieħbi bdejna xogħol fil-kamra kief indikat mil NO u ma kienitx il-kamra ta Sur Fino aħna sirna nafu li ma kienx fpostu għax ġew ifftxuħ fil-kamra fejn konna aħna dan kien għal ħabta ta 8.00.

Jeffry Borġ

Mary Grace at SVP

From: Dalli Mary Grace at SVP
Sent: Thursday, 30 June 2022 10:02
To: 'Julian Cassar'
Subject: RE: Statement

Thanks Julian

Imma tista taghtina il-hin li mort biex tahslu

Mary Grace Dalli
Chief Nursing Manager
Nursing Administration Unit
St Vincent de Paul Long Term Care Facility

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MINISTRY FOR ACTIVE AGEING
St Vincent de Paul Long Term Care Facility, Florence Nightingale Road,
Luqa, Malta

From: Julian Cassar <cassj7332@gmail.com>
Sent: Thursday, 30 June 2022 08:36
To: Dalli Mary Grace at SVP <mary-grace.a.dalli@gov.mt>
Subject: Statement

Jiena Julian Cassar carerworker ta lourdes ward.
Fi 28 gunju kien imsini duty fil kamra tal carmelo fino uhh x hin mort nahslu ma kienx f postu fis sodda fittixtu fil kmamar ta hdejhom uhh meta ma sibtux mort ninforma il-manger ta sala Marlene.

17

Dalli Mary Grace at SVP

From: Julian Cassar <cassj7332@gmail.com>
Sent: Thursday, 30 June 2022 10:19
To: Dalli Mary Grace at SVP
Subject: Statment

Hin kien xi 8am

Saint Vincent De Paul
Malta

29th June 2022

Re: Mr Carmelo Fino

Lourdes Ward, SVP

At approximately 8.45am on Tuesday 28th June, I was informed by Ms Mary Grace Dalli, Chief Nursing Manager, that Mr Carmelo Fino resident at Lourdes Ward, was unaccounted for. She informed me, that from the information collected till that time from Bernard Piscopo, SNM, Mr Fino was last seen in the ward at 545am when carer, Matthew Belli distributed tea. Ward staff realised that he was not in ward when carer went to assist him to bathe at around 8am.

As is practice in such a situation, search was already ongoing within SVP facility both in the buildings and also in the grounds. Having been informed that Mr Fino was last seen at 545am, I asked to have filming from cctvs checked from that time onwards. Footage from entrance gate, exit gate and other cctvs were viewed. Footage from both gates were negative whereas initially footage of corridor at ground level showing a male resident exiting lift was initially thought to be Mr Fino. It was later confirmed by staff member at Lourdes ward that it was not Mr Fino.

Relative of Mr Fino had been informed earlier in the morning by SNM.

Since the search was unsuccessful, at around 1030am it was decided that a report is filed at the police. Both SNMs, Bernard Piscopo and Anthony Galea together with Marilyn Galea A/CN of ward filed a report at Luqa Police Station.

Large photos of Mr Fino were printed to assist in the search, driver was sent to check out of SVP including Zurrieq, Luqa etc. Other personnel including securities, carers and many other sections all assisted in the search within SVP. Staff of each ward were asked to check all rooms in their wards including stores, bathrooms etc. Headcount of each ward was carried out in the morning and repeated again twice in the afternoon.

At around 245pm officers and search dogs from the K9 section of the Civil Protection Department were onsite. We accompanied them to the bedroom of Mr Fino for the dog to pick up his scent from his personal belongings. They were shown around all areas of SVP and carried out a thorough search within the boundaries of SVP which unfortunately was unsuccessful.

Later on in the afternoon I accompanied Inspector Paul Camilleri and other police officers to Mr Fino's bedroom. They were provided with site maps of SVP and intensive search was continued with the assistance of Police, CPD, AFM and SVP staff. At around 730pm, CPD officers with infra red image drone together with other officers with trekking dogs arrived.

Later I was informed that Mr Fino had actually left the premises at 245am in contrast to the versions given to us earlier in day by nurse and carer who had informed us they Mr Fino was seen last in the ward at 545am. CCTV footage showed Mr Fino exiting SVP from the main gate.

Karen Muscat
Director

Souness Jorgen at Health-MDH

From: Piscopo Bernard at SVP
Sent: Tuesday, 28 June 2022 19:54
To: Fiorentino Ronald at SVP; Muscat Karen A at SVP; Dalli Mary Grace at SVP
Cc: Galea Anthony at SVP; Borg Christopher A at SVP; Spiteri Carmela at SVP; Galea Anthony D at SVP; Camilleri Robert at SVP
Subject: statement of facts from Rhys Xuereb

Please receive the statement of Mr Xuereb.

Bernard

Bernard Piscopo
Senior Nursing Manager
Nursing Administration Unit
St Vincent De Paule' - Long Term Care Facility

. +356 22912466 **m:** +356 79076280 **e:** bernard.piscopo@gov.mt
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MINISTRY FOR THE FAMILY,
CHILDREN'S RIGHTS AND
SOCIAL SOLIDARITY

From: Rhys Xuereb <rhysxuereb@hotmail.co.uk>
Sent: 28 June 2022 19:49
To: Piscopo Bernard at SVP
Subject:

Good evening Bernard,

In light of the events that happened this morning, I was advised to provide a statement. I was accompanied by 4 nursing aids/carer, one of them was constant watch.
I entered the Lourdes ward at 7pm on the 27/6/2022 where I received handover and started my night shift. I prepared the pills for the patients and started to administer them around 7:15 whilst the other staff where doing their work. I administered Carmelo Fino's treatment around 8pm and I continued with my work.
I saw Carmelo sleeping in his bed until 5:30am where I last checked the patients, in the meantime the other ward staff where changing nappies and then providing tea to the ward patients including Mr. Fino. Then I continued with my work until I gave handover to the day shift incharge.

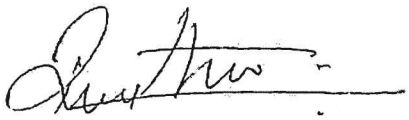
Regards,

Rhys Xuereb

Declaration of Rengith Radhakrishnan holder of residence permit card number [redacted] taken today 1st July 2022.

I am a care worker with Support Services Limited and on Tuesday 28th June 2022 I was working day duty from 7am to 7pm. I am a reliever which at that time I was sent on the day to ward PP2.

I have not seen Mr Fino on the day during my day shift at any point, anywhere in the building.



Rengith Radhakrishnan

Declaration of Pillakondoor V. Sreejith holder of residence permit card number taken today 1st July 2022.

I am a care worker with Support Services Limited and on Tuesday 28th June 2022 I was working day duty from 7am to 7pm. I was put on constant watch with another patient, and not with Mr Fino.

My patient is the only constant watch individual in the room inside ward PP2. In the room I was situated there were 4 patients.

I have not seen Mr Fino on the day during my day shift at any point, anywhere in the building.

Pillakondoor V. Sreejith

Declaration of Thomas Phuiyaveettiil Antony holder of residence permit card number [redacted] taken today 1st July 2022.

I am a care worker with Support Services Limited and on Tuesday 28th June 2022 I was working day duty from 7am to 6pm. I am a reliever which at that time I was sent on the day to ward PP2.

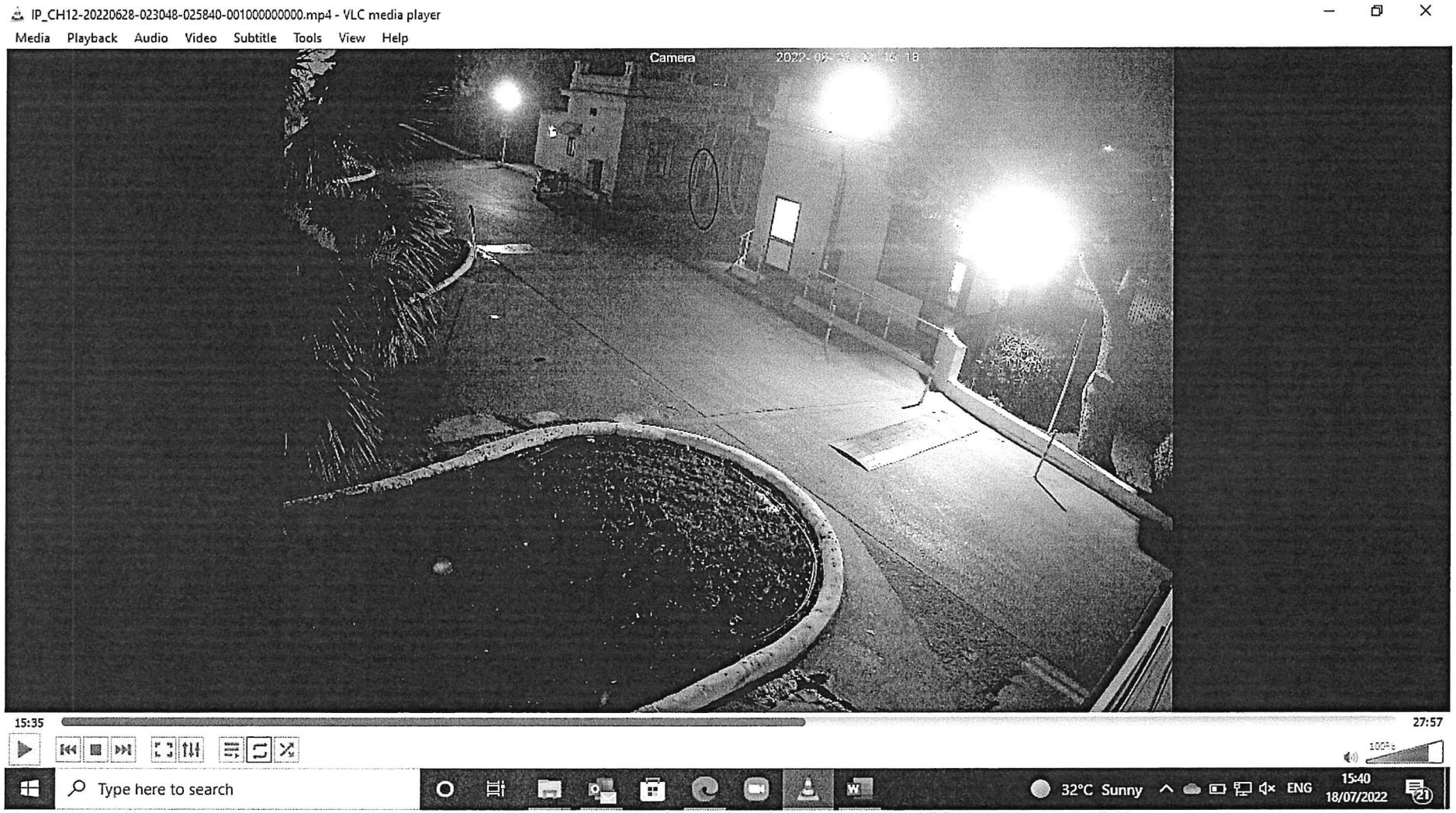
I have not seen Mr Fino on the day during my day shift at any point, anywhere in the building on Tuesday 28th June 2022.

Thomas Phuiyaveettil Antony

ANNEX 3

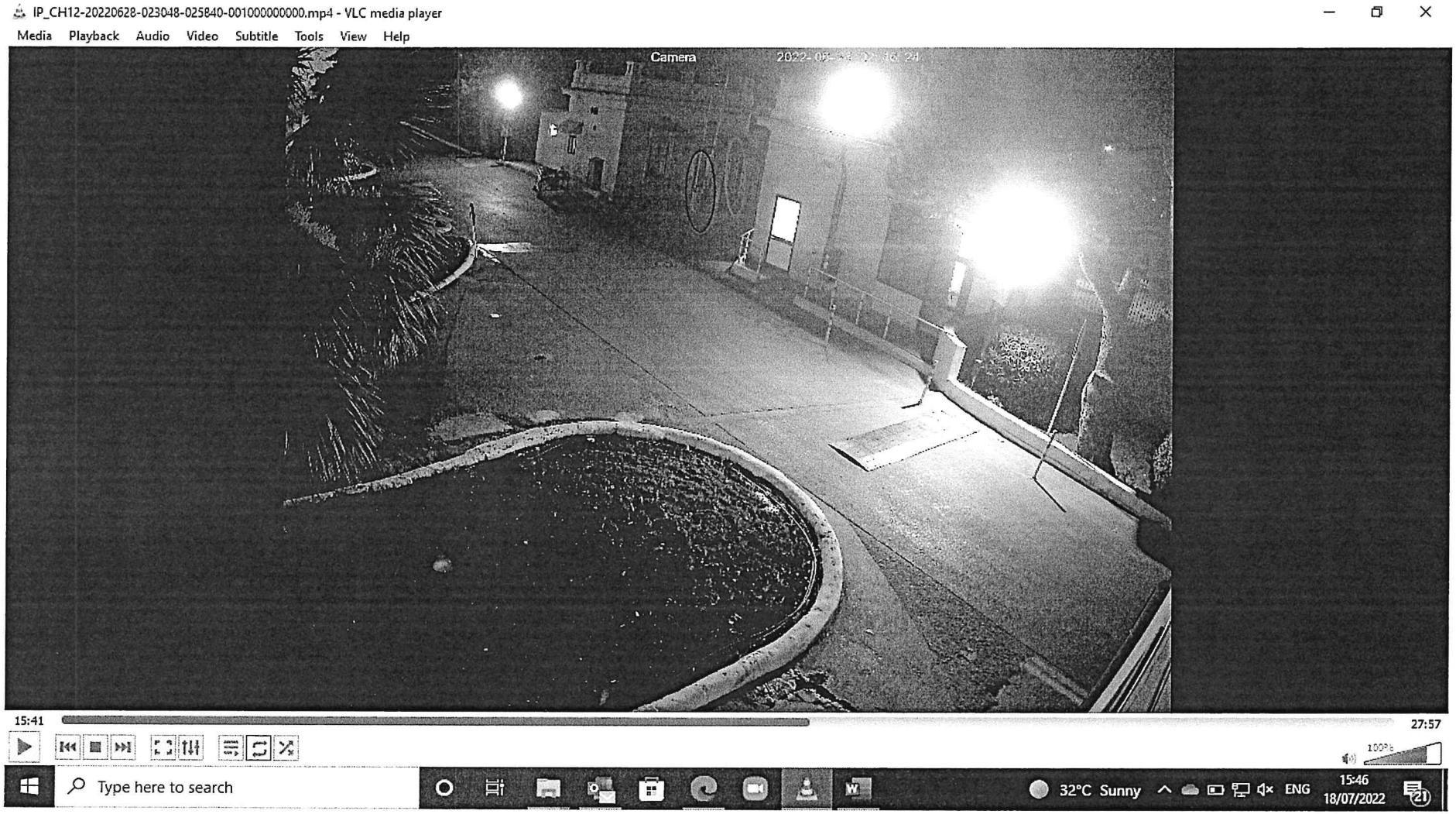
SVDP CCTV Footage

Mr.Fino walking towards control room at 02:46am on the 28th of June 2022



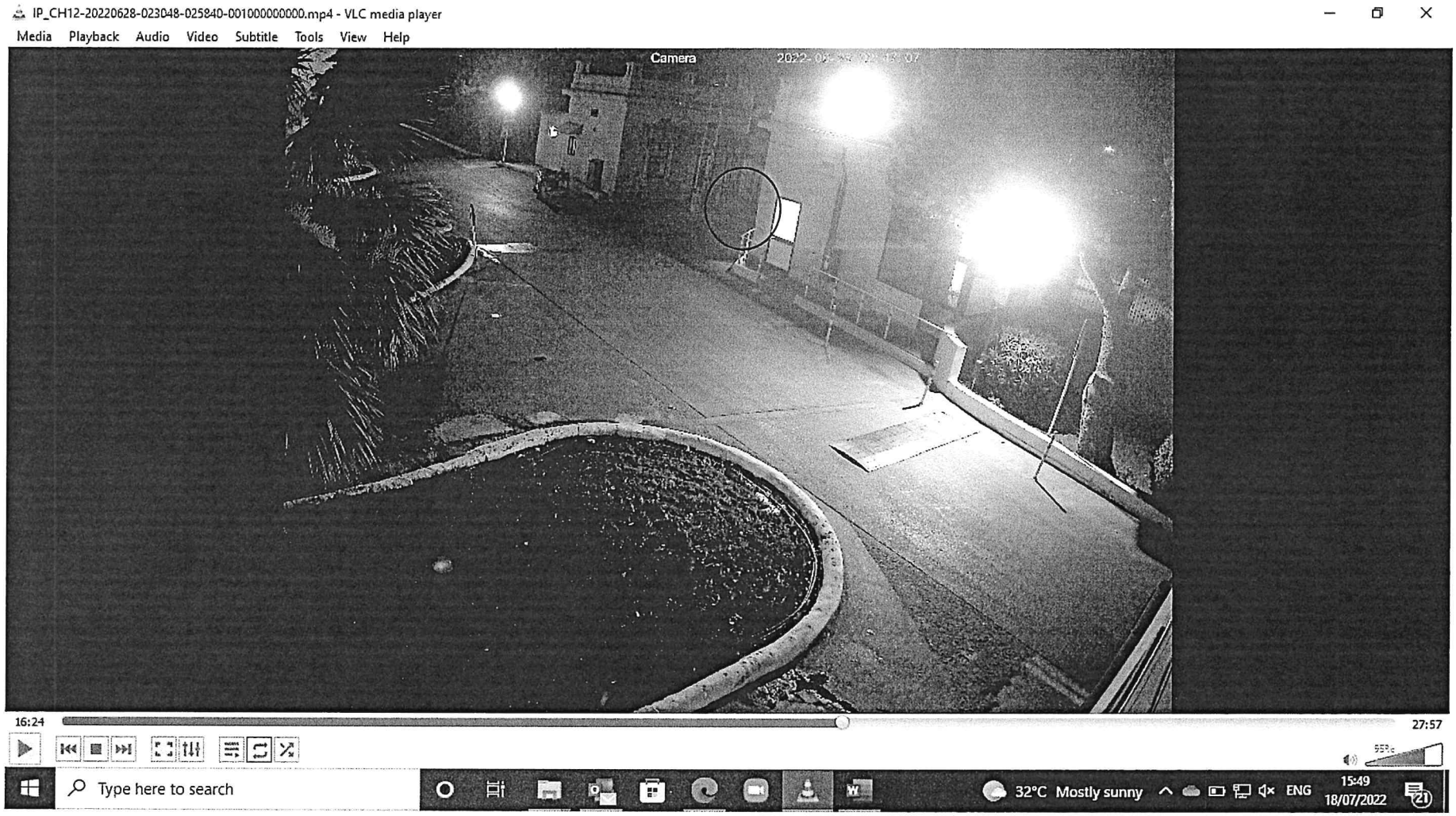
Red circle : Mr.Fino standing in front of the security room at 02:46am on the 28th of June 2022

Blue Circle: Gate is open

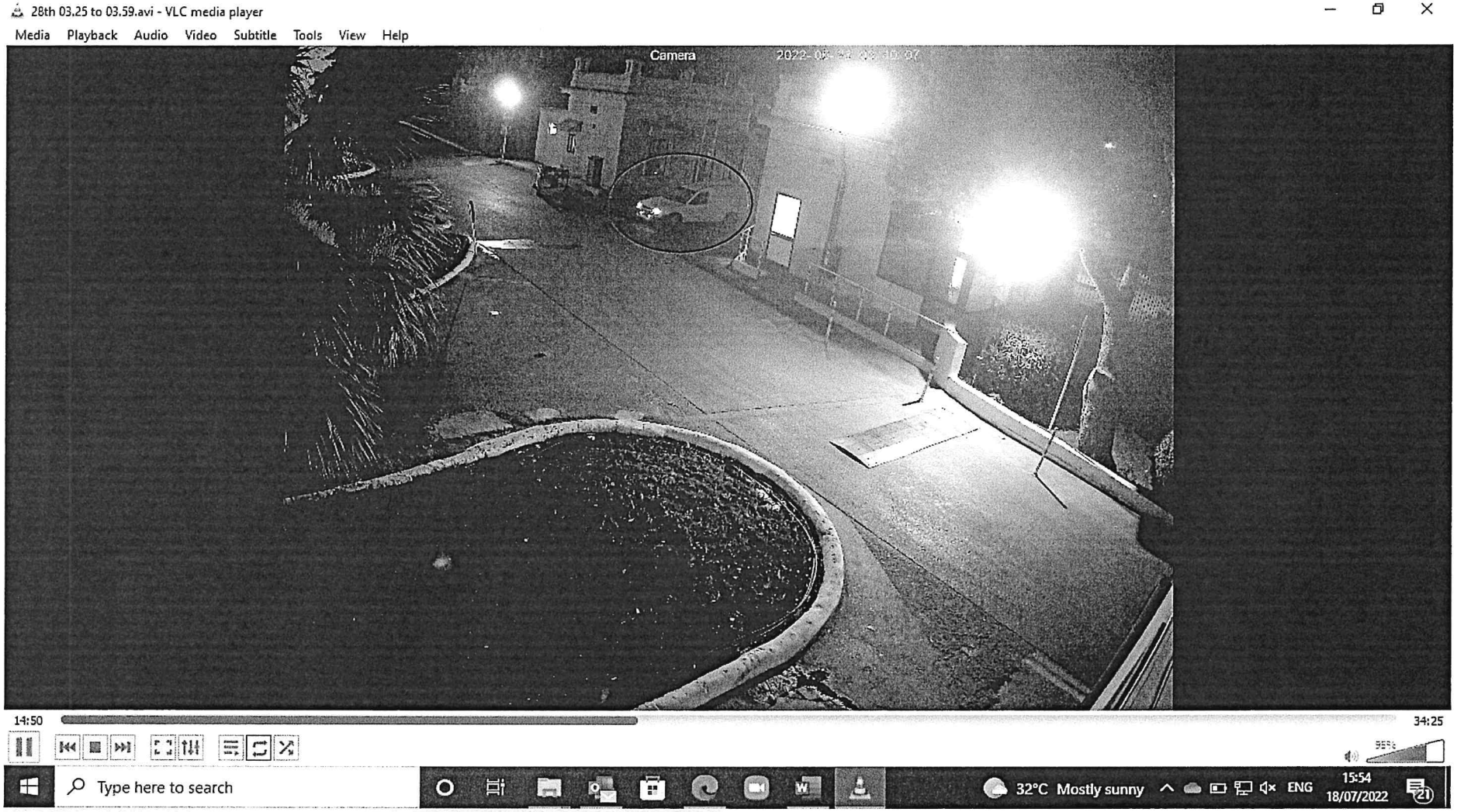


Red circle : Mr.Fino entered the security room at 02:46am on the 28th of June 2022

Blue Circle: Gate is open



Red circle : Mr.Fino on his way out at 02:47am on the 28th of June 2022



Red circle : Car came in at 03:40am on the 28th of June 2022

ANNEX 4

Duties for Night healthcare workers- SOP

SOP 6

ST. VINCENT DE PAUL RESIDENCE

Keeping residents at the heart of our services

MEMO

IMSVPR 69/15

ST. VINCENT DE PAUL RESIDENCE
REGISTRY
15 JUN 2015
RECEIVED

Date: 15th June 2015

To: ALL NURSES IN CHARGE

From: Mr R. Cini – Chief Nursing Manager

Cc: Dr. J. Cutajar - CEO
Dr R. Fiorentino – Medical Director
Mr. James Carabott – Hospital Planning Manager
Ms. Audrey Anne Bugeja – Support Services Manager
All Senior Nursing Managers
Night Charge Nurses

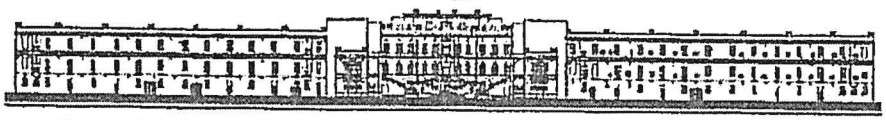
RE: SOP: Duties for Night Staff

Please find attached SOP regarding the duties to be performed during a night duty..

Kindly make sure that all the Nurses in your section are made aware of this SOP

Thank you for your support,

Mr Rudolph Cini
Chief Nursing Manager
SVPR



ST. VINCENT DE PAUL RESIDENCE

Keeping residents at the heart of our services

Issue Date	15th June 2015
Review By	15th June 2017

SOP

DUTIES FOR NIGHT STAFF

SOP: 06/2015

1. Purpose

1.1. The objective of this Standard Operating Procedure (SOP) is to establish the procedure that should be followed by the staff in St Vincent De Paul (SVP) when night duty.

2. Scope

2.1. This SOP refers for all those procedures that require during night duty.

2.2. This SOP will apply to all SVP nurses and supporting staff on night duty.

3. Method

3.1. Handover:

3.1.1. Night staff are given handover from day staff

3.1.2. Nurse in charge reads nursing report to other staff on duty

3.1.3. Nurse in charge prioritise ward assignments / load of work / sequence of work assignments according to current needs

3.1.4. Nurse in charge gives directions and work assignments to other staff on duty

3.2. Commencing Patient's care:

3.2.1. Supporting staff prepares trolley for a hot drink distribution and a snack if available

3.2.2. Nurse prepares medicine trolley for night treatment administration

3.2.3. Nurse administers medicines according to Medicine distribution SOP.

3.2.4. Nurse administers medicines and supporting staff give out hot drinks at the same time and in the same room and other room s consecutively.

3.2.5. Supporting staff collect dirty crockery

3.2.6. Nurse administer parental feeds (according to schedule and current needs)

3.3. From 9pm onwards:

3.3.1. Nurse and supporting staff prepare residents for night;

3.3.2. Changing soiled disposable containment products e.g. nappies

3.3.3. Heavy absorbent (4 drops) nappies may be more useful for the night

3.3.4. Changing soiled bed linen, clothes, dressings according to needs

3.3.5. Assisting residents with other hygiene needs as necessary

3.3.6. Assists other semi-dependent residents to toilet

3.3.7. Assists residents to change positions and any other personal needs

3.3.8. Catheter bags are emptied and night collection bags secured to leg bags

3.3.9. Ensure resident bed areas are tidy and free from footstools etc.

3.3.10. Ensure that residents are left comfortable and call bells are left within reach

3.3.11. Lights in common areas must be out by 11pm

3.4. When ward is settled:

3.4.1. Supporting staff to set up linen trolleys for early morning residents' round.

3.4.2. Supporting staff to prepare any items for next day's breakfast trolley but not the preparation of sandwiches.

3.4.3. Nurse to do any necessary documentation

3.4.4. Nurse in charge to allocate staff breaks which have to start after 11pm

3.4.5. Nurse to do nursing procedures required during the night

3.4.6. All staff to answer any call bells during night

3.4.7. Nurse to check on residents as needed and walk through in all rooms to be performed at 11pm / 1am / 3am. Such walk through should be documented in nursing report or ward communication book.

3.5. **At 5am:**

3.5.1. Nurse administer medicines as per SOP

3.5.2. Supporting staff gives out hot drinks at the same time and in the same room and other rooms consecutively

3.5.3. Changing soiled disposable containment products e.g. nappies

3.5.4. Least absorbent (2 drops) nappies are to be used at 5am

3.5.5. Changing soiled bed linen, clothes, and dressings according to needs

3.5.6. Assisting residents with other hygiene needs as necessary

3.5.7. Assists other semi-dependent residents to toilet

3.5.8. Assists residents to change positions and any other personal needs

3.5.9. Catheter bags emptied

3.5.10. Ensure that resident bed areas are tidy

3.5.11. Nurse to do any nursing procedures required

3.5.12. Nurse to do any investigations required

3.5.13. Nurse to do any necessary documentation

3.5.14. Night staff give handover to day staff

4. Safety Issues

4.1. Call bells to be answered as soon as possible by all grades of staff.

4.2. Any changes to this SOP deemed necessary by the nurse in charge must be justified and documented.

4.3. Any significant emergency must be reported to the night manager.

5. Appendix

5.1 Check list to be performed by Night Charge Nurses.

Appendix

Check List Performed by Night CN's

Please tick where applicable	Yes	No
Medicines administered according to Medicine distribution SOP		
Nurse administer medicines and supporting staff gives out hot drinks at the same time and in the same room and other rooms consecutively		
After 9pm: Changing of soiled nappies, linen, clothes, dressings etc		
Catheter bags emptied		
Bed areas are tidy and free from clutter etc		
All necessary documentation documented		
Nurse in charge allocates staff breaks from 11pm onwards		
Any changes from night duties SOP?		
If yes, is it documented?		
Was night manager notified?		

Signature of Night CN

ANNEX 5

Security Memo - 2015

Night detail security form

Security SOP 2014

Saint Vincent
De Paul

Memo

30 ta Novembru 2015

Lis-Security Personnel kollha ta'

San Vincenz de Paul

Re : Proceduri Ezistenti u Godda

B'effet immedjat is-Security li jkunu dettaljati l-gate ghandhom ikunu qed jaghmlu xoghol taghhom min barra, biex ikunu jistaw iwaqfu lil publiku meta jkun diehel qabel il-hin tal-parlatorju, kemm bil-mixi u anke bil-karozza. Dawk il-persuni li ghandhom permess biex jidhlu qabel il-hin ghandhom jithallew jidhlu kemm bil-mixi u anke bil-karozza.

Il-bieb iz-zghir tal-faccata ghandu jinghalaq mat- 8.00 am u jerga jinfetah fl' 10.00am u wara jerga jinghalaq 20.00pm halli min ikun gej bil-mixi jghaddi min quddiemkom. Il-barrier ghandha tkun imnizla jekk ma jkunux ghaddejin karozzi.

Min ikun xoghol matul il-lejl.

Il-gate ghandha tinghalaq fit 20.00 pm u terga tinfetah meta jibdew jigu l-haddiema filghodu. Dawk li jigu wara l-hin ta' 20.00 u jkollhom raguni valida ghalfejn ghandhom jidhlu ghandhom jittiehdu d-dettalji ta' fejn ikunu sejrin, jekk ikunu bil-karozza ghandu jittiehed in-numru tal-vettura u jkun ir-registrat.

Meta s-Security jigu biex jinbidlu ghandhom jinbidlu wiehed ma wiehed.

Dawn il-proceduri jibqaw fis-sehh sakemm tinhareg ordni ohra.

RC 9 1

harles Said

rincipal Security Officer SVPR

ppja ; Dr Josianne Cutajar Chief Executive Officer SVPR

Ms Audrey Anne Bugeja Support Services Manager SVPR

Sur Carlo Baldacchino Security Officer Xift B

Sur Mario Farrugia Security Officer Xift D

Sur Angelo Abela Security Guard Xift A & C

NIGHT DETAIL

S.V.P.R. SECURITY SECTION. DATE / /

SECURITY OFFICER NO;_____. NAME IN BLOCK LETTERS;_____.

DUTIES AT S.V.P.R.	19.00PM TO 01.00AM	01.00AM TO 07.00AM	REMARKS
S.O. SHIFT_____.			
KEYS			
MAIN GATE			
PATROL GENERAL			
SEARCHING			
WARDS			
NEW GATE			

MAIN GATE WILL BE CLOSED BETWEEN 23.00 P.M. TO 05.15 A.M.

ELDERLY HOMES;	S.G. DUTY.	REPLACED BY S.G.	REMARKS
FLORIANA HOME;			
MOSTA HOME;			
MSIDA HOME;			
MTARFA HOME;			

SECURITY GUARDS ON V/L;

SECURITY GUARDS ON TOIL;

SECURITY GUARDS ON SICK LEAVE;

SECURITY GUARDS ON TIL OR OVERTIME;

SECURITY REPORTING BACK FROM SICK LEAVE;

CHANGE OF DUTY

SG DUTY TODAY / / . INSTEAD OF / / .

SG DUTY TODAY / / . INSTEAD OF / / .

SG WAS DUTY ON / / . INSTEAD OF TODAY / / .

SG WAS DUTY ON / / . INSTEAD OF TODAY / / .

REMARKS;

SIGNATURE SEC.OFFICER:_____ NO_____

ST. VINCENT DE PAUL RESIDENCE

Keeping residents at the heart of our services

Security Section

Standard Operating Procedures

1. Security duties at SVPR
   - Main Gate 24 hour surveillance
   - Inspection at the workshops including the boiler
   - Attending to the mortuary
   - Doctor's parking till m9.00am
   - Kitchen inspection at 11am and 4,30pm
   - Inspection of external yards and ring road
   - Visits in wards

2. Shift arrangements and staff complements
   - DNRO shift
   - Day complement 1 Security Officer and 5 security guards
   - Night complement 1 Security officer and 4 security guards
   - One Principal Security Officer in administration

3. Staff allocation
   - The Security Officer is responsible for the daily staff allocation of his /her personnel
   - The daily staff allocation must cover all surveillance duties described above
   - This allocation must be recorded on the provided form/template.
   - Copies of the daily allocation to be hang on the notice board at the main gate guard room
   - An electronic copy to be submitted early in the morning to the CEO office
   - There will be 2 security guards at the main gate in any given time

4. Documentation of all inspections and surveillance visits
   - Security guards must fill in and sign their log book which is available in all wards and sections
   - Major incidents to be reported immediately to the head of their section

5. Main gate barricade
   - The barricade will always be closed except for an hour duration during changing of main shifts at 07.00hrs and 19.00hrs.

6. Audit process
   - This SOP will be audited by the quality assurance unit and a quarterly report submitted to CEO office

04.06.13

ANNEX 6

Temporary leave of absence by SVDP-LTC residents 2022

Saint Vincent De Paul
long term care facility

SOP No: 06 / 2022	**Version:** 01
Issue date: 01/06/2022	**Review Date: 30/05/2025**
Department: Geriatrics	

TEMPORARY LEAVE of ABSENCE by SVP-LTC RESIDENTS.		
Written by:	Dr Ronald Fiorentino MD	Medical Director
	Ms Karen Muscat	Assistant Director LTC
	Ms Mary Grace Dalli	Chief Nursing Manager
Reviewed by:	Senior Management Team	Name Surname
		Name Surname

Approved by:	Dr Josianne Cutajar	Chief Executive Officer

Change History

Version Number	Revision Date	Change Description
01	N/A	Original – No changes
Version No	Date	Description
Version No	Date	Description
Version No	Date	Description

This document is not valid without all the number of pages specified: 5

1. Purpose

1. Establishing a Standard Operating Procedure for the assessment and release of residents to be able to leave temporarily from the Facility unaccompanied

2. Scope

2.1. Ensure that when a client is admitted to SVP-LTC and wishes to be able to leave the residence unaccompanied for any outing, such a wish can be sustained.

2.2. Ensures that the resident is cognitively and physically capable of performing such an endeavour.

2.3. Ensures that the client is assessed by a multi-disciplinary team to confirm the resident's capability of such an event, AND Form SVP 190 is duly filled and signed.

2.4. Ensures that the Resident is capable of understanding Risk and that he / she would be bearing such a risk and any other consequences.

2.5. Provides safety measures in case the resident would be out of the residence and facilitate easy location of said resident.

2.6. The client must fill in the disclaimer form

3. Terms & Definitions

3.1. SVP – Saint Vincent de Paul long-term care facility

3.2. LTC – Long-Term Care

3.3. Resident – any person who would be living permanently at St. Vincent de Paul Long-term Care Facility

3.4. Premises – St. Vincent de Paul Long-term Care Facility

3.5. Temporary leave – refers to any time spent unaccompanied by SVP officers, outside the facility or out of the ward.

3.6. AAU – Active Ageing Unit.

4. Reference Documents

4.1. N/A

5. Responsibilities

5.1. The resident will be made aware that he / she can temporarily leave the residence unaccompanied at the Welcome encounter and given this choice.

5.2. Charge Nurse will be responsible to start the assessment process once a request is received from the Resident.

5.3. Multi-disciplinary Team will assess and deem fitness for purpose of the Resident

5.4. The Telecare-on-the Move equipment will be supplied by an officer of the Active Ageing Unit.

5.5. The Resident will bear FULL and SOLE responsibility for any incidents / accidents provoked or received

6. Safety Issues

6.1. If Resident uses a Battery-operated wheelchair, the resident MUST ensure that the battery has full capacity for the duration of his / her sojourn outside SVP-LTC.

6.2. The resident must ensure that any equipment or mobility aides and any such other items necessary required by the resident during his temporary leave, including any monies, will be carried by the said resident.

6.3. If the resident becomes aware or encounter any difficulties, the resident MUST request assistance before the outing.

7. Method

7.1. During the welcome encounter, the resident MUST indicate his / her wish to be able to leave the premises unaccompanied.

7.2. Such a request will be recorded in the welcome encounter and made accessible to all authorised staff.

7.3. Once the Charge Nurse or Nurse-in-Charge is aware of such request, a multi-disciplinary team assessment of the resident MUST be requested.

7.4. The assessment is based on two (2) main components – PHYSICAL and COGNITIVE.

7.5. PHYSICAL ASSESSMENT.

7.3.1. If the resident is found to be physically impaired and considered as at High Risk of accident, the request of the Resident WILL be REFUSED

7.3.2. If the resident is NOT physically impaired and considered INDEPENDENT and the Resident understands RISK , the Resident's request to leave the premises UNACCOMPANIED is GRANTED.

7.3.3. If the resident is WHEELCHAIR INDEPENDENT, and

a. Manually-operated – the Resident will be issued with a limited permit and must make their own arrangements for transport.

b. Battery-operated – A Risk assessment MUST be performed on the Resident and if the person understands risk, the REQUEST is APPROVED.

7.6. COGNITIVE ASSESSMENT

7.3.1. If the Resident is Cognitively IMPAIRED, the REQUEST will be REFUSED.

7.3.2. If the Resident is COGNITVELY INTACT, then it must be determined whether the Resident has the capacity to understand risk and what such a permit will entail and if in the AFFIRMATIVE, the request will be APPROVED.

7.7. For an APPROVAL of the request to temporarily leave the premises unaccompanied, BOTH COGNITIVE AND PHYSICAL ASSESSMENTS MUST NOT BE IMPAIRED.

7.8. The Resident and the Multi-disciplinary Team MUST sign the Declaration Form SVP 190.

7.9. Any resident who expresses a wish to be able to leave the premises MUST inform the Nurse-in-Charge at least twenty-four (24) hours before the event,

7.10. If the wish to leave the premises is made to any other member of staff, they are OBLIGED to inform the Charge Nurse or Nurse-in-Charge of such a request.

7.11. Once the resident would be allowed to temporarily leave the premises unaccompanied, the nurse will inform AAU.

7.12. The AAU Officer will provide the pendant to the Resident.

7.13. The resident is to sign on receipt of the pendant.

7.14. This equipment would have to be worn / kept in the resident's possession and functional throughout the residents' absence from the Facility. This will be returned to AAU, as soon as possible after the outing.

7.15. The Resident is allowed to leave the residence not earlier than 7.30am and return by not later than 7.30pm. Should resident require to return to the residence later than 7.30pm, permission is to be authorised by management.

7.16. All pendants in use at SVP will be numbered and stored at AAU.

7.17. Should the resident not return within the stipulated time, nurse in charge is to call as per below schedule to locate the resident.

- **Monday to Friday 8am till 4pm** **21424949**
- **Monday to Friday 4pm to 8am** **79827101**
- **Saturday, Sunday, and Public Holidays all day** **79827101**

7.18. Service provider will be provided with SVP contact numbers should the resident require any assistance throughout the outing.

- **Nursing Administration** **22912292**
- **Operators** **21224461**
- **Security** **22912348**

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8. Records

8.1 The assessments and request MUST be kept in the resident's medical file for ease of reference.

8.2 The Declaration Form SVP190 MUST be kept at a Safe place for medico-legal purposes.

9. Appendices

N/A.

ANNEX 7

SVDP Prganisation Chart

ANNEX 8

Previous SVDP incidents

Saint Vincent De Paul

6th July 2022

Since 2013 there were only two other circumstances similar to this episode. The first occurred on the 6th December 2014 when Mr Joseph Cassar, resident in JP2, went missing from the ward and was later found in the vicinity of Marsa Race Track. The incident was investigated, and disciplinary action was taken. JP2 is a closed ward and cares for patients with dementia. Following this incident SOPs were put in a place to improve the safety and operations within closed wards.

The second incident occurred on the 27th June 2015, when Mr Louis Florian resident at SJ8, a closed ward, went missing from the ward and was found by police officers in the area of Hal Farrug. He was brought back safely to SVP. Disciplinary action was taken against the three employees involved in the incident. Following this episode, further measures were taken to ensure safety of residents and the main doors of dementia wards were changed to fire doors, complete with intercom, access cards and an alarm, should the door be left open or forced.

From data collected prior to 2013 there were three other incidents involving residents with dementia. One incident occurred in 2007 when Mr Joseph Bongailas left the facility unauthorised and was found later in the evening at Valletta police station.

The other occurred in 2010 where a resident, Mr Ernest Gaffiero, went missing from ward PP2. His son phoned SVP to inform them that Mr Gaffiero was at his house and brought him back to SVP soon after.

The third incident occurred in 2011 involving resident, Mr Alfred Meilaq who was unaccounted for in his ward and was found later at Sliema Police Station. He was brought back safely to SVP.

ANNEX 9

Telecare on the move – MDT Declaration

Saint Vincent De Paul
long-term care facility

St. Vincent de Paul Long-term Care Facility
Florence Nightingale Street
Luqa LQA 3301
Tel: 21224461
22912400
ronald.fiorentino@gov.mt

SVP 190

TELECARE ON THE MOVE – MULTIDISCIPLINARY TEAM DECLARATION.

_____

The hereunder signatories, forming the multi-disciplinary team, declare that we have examined

Mr / Mrs /Ms_____, currently a resident at ward _____,

St. Vincent de Paul Long-term Care Facility and found him / her physically and cognitively fit to be able to leave the Facility on his / her own.

The team also informed the resident about the rules subject to this permission and agree that should the resident fail to abide with these regulations, management may decide to withdraw the permission to leave on his/her own.

_____	_____	_____
Consultant Geriatrician	Charge Nurse	Resident
_____	_____	_____
Physiotherapist	Occupational Therapist	Social Worker

Saint Vincent De Paul
long-term care facility

St. Vincent de Paul Long-term Care Facility
Florence Nightingale Street
Luqa LQA 3301
Tel: 21224461
22912400
ronald.fiorentino@gov.mt

SVP 190

RELEVANT DATA TO SUPPORT DECISION.

Name:	**ID Number:**	**Ward**
	Result	
Physical Health Condition		
Stable	**Yes**	**No**
Hearing		
Vision		
Cognition	**Not impaired**	**Impaired**
MMSE		
RUDAS		
Barthel Score		
Mobility	Independent	
	Using	Frame
		Wheelchair / Normal
		Electrical

This permit is vlid for a period of three (3) months unless there would be a suspicion or evidence of a change or deterioration in cognitive or physical function of the resident.