IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 4087

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of KATHLEEN SCHLEIBS

without holding an inquest:

find that the identity of the deceased was KATHLEEN SCHLEIBS

born 21 December 1927

and the death occurred on 28 August 2016

at Chatsworth Terrace Supported Residential Service, 430 Main Road, Lower Plenty, Victoria 3093

from:

1 (a) SEPSIS COMPLICATED BY MULTIPLE ORGAN FAILURE IN A WOMAN WITH COMORBIDITIES IN THE SETTING OF RECENT SHOULDER SURGERY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Kathleen Schleibs was 88 years of age and had resided in Chatsworth Terrace, a Supported Residential Service (SRS),[1] for only a few days at the time of her death. She had previously lived with her daughter Antoinette Harry. Mrs Schleibs also had a son, David Schleibs. Mrs Schleibs' medical history included hypertension, supraventricular tachycardia[2], retinal surgery[3], anxiety and depression, gastroesophageal reflux and gastric ulcers, mild aortic stenosis[4], sleep apnoea, diverticulitis, peripheral vascular disease[5], osteoporosis with kyphosis[6], anaemia[7] and deafness.

2. On 26 August 2016, Mrs Schleibs was discharged from Warringal Private Hospital where she had been treated for a fractured humerus sustained in a fall. She was transferred to Chatsworth Terrace SRS as Mrs Harry was concerned about her ongoing ability to care for her mother. On that day, Mrs Schleibs was seen by a local medical practitioner who noted that she had right-sided chest pain, which was attributed to an area of bruising. There were crepitations[8] heard at the base of Mrs Schleibs' lungs and she appeared sweaty. Her pain medication was increased in response to her symptoms.

3. On 28 August 2016, Mrs Schleibs had been feeling unwell since midday with abdominal and back pain, shortness of breath and diarrhoea. Mrs Schleibs' daughter raised the issues with the SRS staff who assured Mrs Harry that a local medical officer would be informed when their manager arrived at 5.00pm. At approximately 7.00pm, Mrs Schleibs suddenly deteriorated and became pale, sweaty and short-of-breath.

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[1] Supported Residential Services (SRS) are privately operated businesses that provide accommodation and support for Victorians who need help with everyday activities. Each SRS determines the services it offers and its fee structure. The Department of Health and Human Services administers the *Supported Residential Services (Private Proprietors) Act 2010* (Vic), and monitors SRS compliance with this Act and its regulations: <https://www2.health.vic.gov.au/ageing-and-aged-care/supported-residential-services>.

[2] Irregular fast heart beat than cause palpitations and dizziness.

[3] The retina is part of the eye responsible for vision.

[4] A narrowing of the aortic valve of the hear common in older persons.

[5] Impaired circulation to the lower legs due to atherosclerotic disease of arteries

[6] Deformity of the spine.

[7] Low blood count.

[8] A crackling or rattling sound.

At approximately 7.20pm, ambulance paramedics attended, and, despite resuscitative efforts, Mrs Schleibs died shortly thereafter.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Clare Elizabeth Grace Hampson, Forensic Pathology Registrar working under the supervision of Forensic Pathologist Dr Heinrich Bouwer at the Victorian Institute of Forensic Medicine (VIFM), performed an autopsy upon the body of Kathleen Schleibs, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

5. Dr Hampson identified severely disordered blood clotting affecting the heart lungs and adrenal glands. She stated that there was evidence of multiple microinfarcts which may lead to cardiac arrhythmia or cardiac failure. The latter was seen in Mrs Schleibs' case in the form of pulmonary oedema and pleural effusions. Dr Hampson stated that damage to Mrs Schleibs' adrenal glands may also have contributed to her death by causing adrenal crisis which, in turn, causes severe hypotension and hypoglycaemia if left untreated.

6. Dr Hampson explained that disordered blood clotting can occur in the setting of infection (septicaemia), auto-immune disease or severe metabolic derangement. In Mrs Schleibs' case, it was most likely due to sepsis as: she had evidence of an elevated marker of inflammation (C-reactive protein) on bio-chemistry, Escherichia coli bacteria was cultured from her blood and there was histological evidence of inflammation of the bladder (cystitis). Dr Hampson stated that these findings are in-keeping with sepsis due to a urinary tract infection.

7. Toxicological analysis of Mrs Schleibs' post mortem blood detected analgesics fentanyl (~ 2ng/mL),[9] tramadol (~ 0.2 mg/L)[10] and paracetamol (~ 13 mg/L).[11] Analysis also

[9] Fentanyl is a narcotic (opioid analgesic) used as a perioperative analgesic and as an adjunct to surgical anaesthesia.

[10] Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain.

[11] Paracetamol is an analgesic drug available in many proprietary products, either by itself or in combination with other drugs such as codeine and propoxyphene.

detected her regular prescription medications duloxetine (~ 0.3 mg/L)[12] and verapamil (~ 0.7 mg/L),[13] as well as pholcodine (~ 0.2 mg/L).[14] Dr Hampson commented that the level of duloxetine was higher than the established therapeutic dose, however, this drug is subject to post-mortem redistribution and therefore the toxicology results are difficult to interpret. The verapamil level was also higher than expected, however, Dr Hampson stated that there is high individual variability in response to this medication.

8. Dr Hampson formulated the medical cause of Mrs Schleibs' death as sepsis complicated by multiple organ failure in a woman with comorbidities in the setting of recent shoulder surgery.

Police investigation

9. Leading Senior Constable (LSC) Gary Steele was the nominated Coroner's investigator.[15] At my direction, LSC Steele prepared the coronial brief for this matter. The coronial brief contained, *inter alia*, statements made by: Orthopaedic Surgeon Mr Trung Nguyen who saw Mrs Schleibs at Warringal Private Hospital, Warringal Private Hospital General Physician Dr Jibin Thomas, Director of Clinical Services at Warringal Private Hospital Leanne Rowlands, Director of Chatsworth Terrace SRS Rosie Bai and General Practitioner Dr Christine Taylor who saw Mrs Schleibs at Chatsworth Terrace SRS. Appendices to the coronial brief included:

    a. Family Concerns outlined by Mrs Harry;

    b. Warringal Private Hospital *Transfer Form and Discharge Summary*;

    c. Chatsworth Terrace *Resident Transfer Information, Admission paperwork and Interim Care Plan*;

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[12] Duloxetine is a synthetic serotonin and norepinephrine reuptake inhibitor used in the treatment of depressive disorders.

[13] Verapamil is a drug used to treat high blood pressure, angina and irregular heart beat (arrhythmias).

[14] Pholcodine is an opioid chemically related to morphine and is an over-the-counter cough suppressant medication with a mild sedative effect.

[15] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

d. Chatsworth Terrace *Police and Procedure for Admission for a New Resident* [sic], and

e. Chatsworth Terrace *Policies and Protocols for Transfer a Resident to Hospital or Vacate the Facility* [sic].

10. During the investigation, LSC Steele ascertained that Mrs Schleibs fell whilst shopping on 15 August 2016. Subsequently, she was transported by ambulance to the Austin Hospital Emergency Department (ED) with severe pain in her right shoulder. An x-ray diagnosed a communicated fracture involving the right humeral neck with angulation at the fracture site and some displacement of the humeral head and involving the articular surface. A collar and cuff was prescribed and an admission sought at Warringal Private Hospital as Mrs Schleibs had a Department of Veterans Affairs (DVA) entitlement for private health care.

11. On 16 August 2016, Mrs Schleibs was transferred to Warringal Private Hospital after waiting on bed availability. She was admitted under the care of physician Dr Jibin Thomas. Nursing notes documented the following: extensive bruising on Mrs Schleibs' right upper limb, she suffered 10/10 pain, she was confused and having visual hallucinations.

12. On 17 August 2016, Mrs Schleibs complained of bladder fullness and being unable to void. Subsequently a bladder scan was conducted and identified almost one litre of retained urine[16]. An indwelling catheter was subsequently placed, and a specimen of urine sent for microbiological examination. There was no infection identified at that time. Mrs Schleibs was subsequently examined by Dr Thomas who noted acute kidney injury and recommended pain management.

13. On 18 August 2016, Mrs Schleibs was referred to the orthopaedic surgeon Mr Nguyen who recommended a reversed total shoulder replacement. On 19 August 2016, Mrs Schleibs underwent surgery for the total shoulder replacement. Postoperatively, Mrs Schleibs' suffered confusion, continued poor pain control and she became hypoxic. After further investigation, it was found that Mrs Schleibs had a normal white cell count with a urine culture and a chest x-ray showing minor changes. Her pain

[16] Incomplete bladder emptying leads to retained urine and will cause discomfort and a nidus for infection.

medication was altered from oral Targin[17] to a fentanyl[18] patch which was worn continuously delivering 25mcg fentanyl per hour transdermally. She also received a blood transfusion.

14. On 20 August 2016, a urine sample was sterile but showed minor raised leucocytes and increased red blood cells[19]. Blood cultures showed no growth[20]. There was no record of a C-reactive protein[21] (CRP) test.

15. Over the ensuing days, Mrs Schleibs was intermittently confused, anxious and complained of pain. Mrs Schleibs required daily morphine injections and extra (as required) doses of tramadol[22] in addition to the fentanyl patch and oral Targin.

16. Warringal Private Hospital staff had discussions with Mrs Harry who felt that her mother's care-needs were too high to continue to care for her at home. Mrs Harry was especially concerned that her mother could not be independently mobile as she usually used a walking frame, but her arm was in a sling. She was also concerned about the challenges in managing her mother's confusion and pain.

17. On 23 August 2016, Mrs Schleibs had a successful trial of passing urine. No further urine specimens were collected.

18. At 12.10am on 25 August 2016, Mrs Schleibs was given a morphine 5mg injection and a further 100mg tramadol at 1.20pm for pain, in addition to the analgesia provided by the fentanyl patch.

19. On 25 August 2016 Mrs Schleibs was reviewed by Dr Thomas. He documented that Mrs Schleibs was improved but still mildly confused and that she was suitable for discharge into DVA funded 'convalescence' at a supported residential service (SRS)[23] as arranged by the social worker. In his statement, Dr Thomas wrote

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[17] A slow release opioid analgesic containing oxycodone.

[18] An alternative opioid based analgesic.

[19] Examination of the urine under microscopy demonstrated a low number of inflammatory cells, however no microorganisms were grown after culture.

[20] This suggests low likelihood of infection.

[21] A blood test were a raised value is indicative of infection or inflammation.

[22] Synthetic opioid medication.

[23] Convalescence care is a service paid for the DVA upon request to allow veterans to recuperate in a supportive environment where assistance is provided for domestic and personal tasks. Private hospitals frequently have agreements to fund a special residential service to provide this case for a contracted fee.

Mrs Schleibs had intermittent episodes of confusion, especially at night, but she made a good progress post-operatively. I reviewed her on 25 August 2016 and she appeared to be oriented and was hemodynamically stable. Her renal function was back to normal.[24]

20. At 12.30am on 26 August 2016, the last set of nursing observations were taken, and these were within normal limits. At 9.35am, Mrs Schleibs was given an extra dose of tramadol (50mg) for pain. Pain scores on the nursing bedside chart were rated between 4 and 5 out of 10 at this time. During this day, Mr Nguyen reportedly reviewed Mrs Schleibs but he did not document this in the medical records.

21. At 2.00pm on Friday 26 August 2016, Mrs Schleibs was transferred to Chatsworth Terrace SRS. Director of Clinical Services at Warringal Hospital Leanne Rowlands stated that Mrs Schleibs went to Chatsworth Terrace unaccompanied, in a DVA funded taxi, wearing only a nightie and dressing gown with her arm in a sling.

22. Chatsworth Terrace SRS staff assessed Mrs Schleibs upon her arrival and developed a care plan to administer medications, assist with showering, dressing, toileting and mobilisation with a four-wheel frame. Staff also arranged for visiting General Practitioner Dr Christine Taylor to review Mrs Schleibs.

23. Dr Taylor reviewed Mrs Schleibs and noted that she had pain over her right chest. Dr Taylor was concerned that Mrs Schleibs exhibited signs of delirium related to opioid use and possibly some withdrawal effects of opiates as she was requiring subcutaneous morphine until the day prior to discharge. In her notes, Dr Taylor wrote *'ring if worried'* to staff.

24. During the weekend of Saturday 27 August or Sunday 28 August 2016, Mrs Schleibs became acutely unwell. On the multiple occasions that they visited, Mrs Schleibs' visiting family members saw that she was *'still disorientated and in immense pain and could not complete basic tasks for herself'*.[25]

25. In her statement, the Director of Chatsworth Terrace SRS Rosie Bai stated that Mrs Schleibs became unwell with diarrhoea at 3.50pm on 28 August 2016. At 5.30pm, Chatsworth Terrace SRS staff rang Dr Taylor to request her attendance on Mrs Schleibs

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[24] Coronial Brief, *Signed Statement of Dr Jibin Thomas dated 31 October 2017*, page 25-26.

[25] Coronial Brief, *Family Complaint by Antoinette Harry*, page 40-42.

who had not improved. Ms Bai stated that Mrs Schleibs was *'feeling tired'* at 6.30pm and at 7.05pm was *'looking unwell, not responding and quite pale'*.[26] This prompted staff to call for an ambulance which attended at 7.20pm.

26. Mrs Schleibs medical record from Chatsworth Terrace SRS includes a number of observations that were taken with a blood pressure ranging from 165/80 to 98/60, and a respiratory rate of 36. There is no time stamp recorded but these observations were presumably made during the afternoon of 28 August 2016.

27. According to the notes of attending Victoria Police officers, paramedics arrived at 7.20pm and immediately requested a MICA attendance. Mrs Schleibs was treated in the ambulance however went into cardiac arrest upon arrival of the MICA at 7.40pm. CPR was continued for approximately 30 minutes, but Mrs Schleibs could not be revived.

Family concerns

28. Mrs Harry provided the Court written concerns in relation to many aspects of the medical care provided following her mother's fall, including: poor communication regarding the nature of the orthopaedic injury; the poor access to DVA transport requiring Mrs Schleibs to be transported from Austin Health to Warringal Private Hospital in a private car, despite her painful fracture; her perceived inappropriate discharge to a low care residential service whilst in *'immense pain'* and without adequate medical and nursing support; the perceived lack of care by the Warringal Private Hospital staff in arranging Mrs Schleibs to take a taxi transport to Chatsworth Terrace unaccompanied, wearing night attire, and with delirium, significant pain and her arm in a sling; and the perceived failure by Chatsworth Terrace SRS staff to act on Mrs Schleibs' deterioration over the weekend of 27 and 28 August 2016.

Coroners Prevention Unit

29. In light of the family's concerns, I had a meeting with the Coroners Prevention Unit (CPU)[27] on 6 February 2017 to discuss the circumstances of Mrs Schleibs' death.

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[26] Coronial Brief, *Signed Statement of Rosie Bai dated 8 May 2017*, page 34-36.

[27] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Subsequently, I requested a review of Mrs Schleibs' medical management, including the examination of statements from the treating doctors at Warringal Private Hospital.

Urinary Sepsis

30. Mrs Schleibs had an untreated urinary infection that was undiagnosed prior to the development of septic shock on 28 August 2016. The urinary catheter represents the most likely portal of entry of the infection. Whilst there were two *'sterile'* urine samples collected at Warringal Hospital, the last specimen was reported on 20 August 2016 and there was no urine sample checked after removal of the urinary catheter on 23 August 2016. However, it would not be standard practice to culture urine after removal of a urinary catheter unless there was clinical suspicion of infection.

Investigation of Delirium

31. Older persons are prone to confusion (delirium) in the setting of pain, opioid medication and infections. The initial delirium screen performed incorporated a septic work-up, including blood and urine cultures which were negative for infection. However, there was no record of a CRP being requested at any time during Mrs Schleibs' admission. If a CRP had been completed, the CPU opined that it would be likely to have been raised indicating underlying sepsis. In turn, a raised CRP may have prompted requesting a further urine sample to be collected after the removal of the urinary catheter. Whilst this omission may represent a missed opportunity for earlier diagnosis of sepsis, the CPU informed me that it was not unreasonable for medical staff to conclude that the persistent delirium was related to pain, anxiety and opioid medications.

Was Mrs Schleibs stable for transfer to a low care residential facility?

32. There were no nursing observations recorded after midnight on 26 August 2016, and, whilst Mr Nguyen visited that morning, he did not make any notes and represents the only medical review provided on the day of Mrs Schleibs discharge from Warringal Private Hospital. However, the CPU stated that it was reasonable to presume her vital signs were stable as they had been within normal limits for several days prior to discharge.

33. On the day of her discharge from Warringal Private Hospital, it was evident that Mrs Schleibs had significant pain which was difficult to control. Mrs Schleibs had regular pain medication in the form of a fentanyl patch and oral Targin. She also

required additional medication in the form of morphine injections and oral tramadol. Dr Taylor correctly identified that Mrs Schleibs suffered poor pain control and effects of opioid toxicity (delirium) on 26 August 2016.

34. A 'low care' SRS is only required to provide personal assistance, meals and medication supervision to their residents, and is not required to provide medical and nursing support. Therefore, Mrs Schleibs' acute pain management was inappropriate for management in a low care facility.

35. The CPU noted that Warringal Private Hospital displayed a want of compassionate care when Mrs Schleibs was discharged unaccompanied, in a taxi, in her nightwear. However, the Hospital had acknowledged their error and issued an apology to Mrs Schleibs' family in relation to this incident. The error also led to a hospital-wide education program, updating nursing staff on optimal transfer processes.

Did Chatsworth Terrace SRS provide reasonable care?

36. Chatsworth Terrace provided personal care, domestic assistance and arranged a locum medical practitioner visit on the day of Mrs Schleibs' admission. However, Chatsworth Terrace is not staffed to provide complex pain management or frequent vital signs observations. The concern that Mrs Schleibs' care needs could not be managed at Chatsworth Terrace was identified by her family members, and also in a statement from Rosie Bai. Ms Bai stated she was told *'she* (Mrs Schleibs) *might need to go to the hospital'* by either a staff member or a family member; it is not clear from Ms Bai's statement who said that.

37. On Sunday 28 August 2016, there seems to be a delay of some hours between staff identifying that Mrs Schleibs had deteriorated and requesting ambulance attendance. The documentation of the events within the progress notes at Chatsworth Terrace is scant and Ms Bai's statements describe a number of reasons for the delay including that Ms Bai was off site, that Mrs Schleibs was in the toilet and then declined medical attention when Ms Bai arrived, and that the call was initially requested for the locum doctor to attend rather than the ambulance.

Discussion of contributing factors

38. Urinary sepsis is a readily treatable condition. Septic shock can be survivable but requires early recognition and aggressive treatment. If Mrs Schleibs had remained an inpatient at Warringal Private Hospital and had not been discharged on

Friday 26 August 2016, the availability of a more rapid medical response may have changed the outcome. The key area for consideration is therefore whether Mrs Schleibs was medically stable for discharge and, in particular, whether Mrs Schleibs' ongoing delirium should have prompted a further septic screen and ordering of either a CRP or urine sample. However, given the chronicity of the delirium and the normal range of her vital signs, the decision not to investigate further does not appear unreasonable in isolation.

39. Mrs Schleibs' relatively high doses of opioid medication with frequent "breakthrough" doses administered evinces that Mrs Schleibs' pain was higher than estimated by Dr Thomas. The screening process for accepting patients for transfer for "convalescence care" relies on discharge planners within the acute hospital who contract with the Department of Veterans Affairs to fund approved residential care facilities for a defined period. The use of 'convalescent care' provides veterans and war widows extra 'recovery' time after an acute hospitalisation.

40. The CPU opined that Mrs Schleibs was not fit for discharge on Friday afternoon 26 August 2016 due to her unstable and high pain management requirements, especially given that medical availability is lower over weekends. If Mrs Schleibs had not been discharged, the development of septic shock in the acute care setting (rather than an SRS) may have prompted a more rapid escalation of medical care and an improved chance of survival.

41. The CPU stated that the family had valid concerns and complaints regarding Warringal Private Hospital's poor pain management, inappropriate transport arrangements and discharging Mrs Schleibs into a low care residential service which could not provide the care she required.

42. The CPU noted the apparent delay by Chatsworth Terrace staff to escalate Mrs Schleibs' medical care and subsequently contact an ambulance during the weekend of 27 and 28 August 2016. However, the CPU informed me that it was difficult to be critical of the delay given that the facility is low care, has largely personal (non-nursing) care staff working over a weekend, and Mrs Schleibs was not familiar to them.

MENTION HEARING

43. In light of the issues identified by the CPU, I held a Mention Hearing into the death of Kathleen Schleibs on 15 June 2018. Prior to the Mention Hearing, the interested parties were provided a copy of the coronial brief subject to non-publication conditions pursuant to section 115 of the *Coroners Act 2008* (Vic). The parties were also informed that the following issues had arisen during the course of the investigation:

    a. The manner in which Mrs Schleibs was transported from Warringal Private Hospital to Chatsworth Terrace.

    b. The non-identification of Mrs Schleibs' urinary infection by Warringal Private Hospital.

    c. The appropriateness of Mrs Schleibs' discharge from Warringal Private Hospital to Chatsworth Terrace.

    d. The appropriateness of Chatsworth Terrace staff's actions in response to Mrs Schleibs' health deterioration on the weekend of 27 and 28 August 2016.

44. Warringal Private Hospital, Mr Nguyen, and Dr Thomas were legally represented at the Mention Hearing. Chatsworth Terrace SRS was not legally represented and did not attend. Acting Sergeant (AS) Gary Steele appeared to assist me during the Hearing. AS Steele read out a summary of the circumstances of Mrs Schleibs' death and an outline of the issues identified during the course of the investigation.

45. In relation to issue (a), AS Steele submitted that the issue required no further investigation as Warringal Private Hospital had made a concession and apology directly to Mrs Schleibs' family, as well as significant efforts to educate staff on appropriate transfer practices.[28]

46. In relation to issue (b), AS Steele submitted that the issue required no further investigation as the CPU had already identified that Mrs Schleibs' delirium could be reasonably attributed to a number of factors.[29]

47. AS Steele submitted that issues (c) and (d) would appropriately form part of any ongoing and continuing inquiry into Mrs Schleibs' death.[30]

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[28] Investigation into the death of Kathleen Schleibs, *Mention Hearing Transcript 15 June 2018*, pages 5-6.

[29] Ibid, page 6.

[30] Ibid, page 8.

48. During the Mention Hearing the representative for Warringal Private Hospital submitted that the treating clinicians determine where a patient is transferred after discharge, and that the Hospital has no input in this decision.[31] There were no further submissions.

49. At the close of the Mention Hearing, Interested Parties were granted approximately four weeks to provide further written submissions. Chatsworth Terrace SRS were informed of the outcome of the proceedings and provided with a written copy of the Court's Mention Hearing transcript. I informed the parties that I did not anticipate the need to proceed to a full Inquest, if the submissions adequately covered the highlighted issues. A transcript of the proceedings was also provided to Mrs Schleibs' family.

FURTHER INVESTIGATION

Further family concerns

50. On 14 July 2018, David Schleibs sent an email to the Court which contained information provided by Mrs Harry. The email further outlined their concerns in relation to their mother's care and treatment from 23 August 2016 to 28 August 2016.

51. Mrs Harry said that she had been advised by an employee of the Department of Veteran's Affairs (DVA) who worked at Warringal Private Hospital to send her mother to Chatsworth Terrace SRS as she was in too much pain to return home. Mrs Harry provided more detail in relation to her visits to the SRS on 23 and 26 August 2016. She wrote of her distress at seeing her mother's condition and the apparent inability of the staff to provide Mrs Schleibs with the care she required. Upon Mrs Schleibs' arrival at the SRS, Mrs Harry stated that her mother was in immense pain, clammy and entirely disoriented.

52. Mrs Harry expanded on her interaction with Chatsworth Terrace SRS staff on the date of her mother's death. On 28 August 2016, Mrs Harry stated that she found her mother in poor condition; she had soiled herself, had explosive diarrhoea and was immense pain. Mrs Harry said that she asked to see the registered nurse who was not available. She said that she asked if her mother could be seen by a doctor, be seen by a nurse through the DVA, or be taken by ambulance to hospital. Mrs Harry was informed by

[31] Above n 28, pages 11-12.

the staff member that they did not have the authority to make those arrangements but that the requests would be passed on when the appropriate person arrived at the facility.

Further written submissions

53. Subsequent to the Mention Hearing, I received additional material in the form of statements from Ms Bai, Mr Nguyen, Dr Thomas and Ms Rowlands. I will examine those submissions in the context of the relevant issues addressed.

Medical Stability

54. Dr Thomas and Mr Nguyen were satisfied that Mrs Schleibs was medically stable with respect to her post-operative recovery, vital signs and blood tests. Both doctors also reported that the pain management regime on the day of discharge was appropriate for a safe discharge. Mr Nguyen did write that if ongoing morphine injections were being used, this would represent an indication that discharge should not have gone ahead. Mr Nguyen's and Dr Thomas' both stated there was an indication that Mrs Schleibs' pain was controlled as a morphine injection was not used in the 36 hours prior to discharge.

55. Ms Rowlands statement did not specifically address whether nursing staff determined whether pain levels were adequately controlled prior to Mrs Schleibs' discharge, except to comment that the decision to proceed with discharge requires the consent of the treating doctor. The Warringal Private Hospital medication record shows that "breakthrough" pain relief was provided on 25 August 2016 at 1.10am (5mg subcutaneous morphine), at 1.20pm (100mg tramadol) and 26 August 2016 at 9.35pm (50mg tramadol).

Functional stability

56. Mrs Schleibs had a shoulder joint replacement where post-operative pain would be expected. The post-operative orders were for "non-weight bearing" (through the arm) and restraint of the arm in a collar and cuff for four weeks. In his statement, Mr Nguyen wrote:

> *It is to be noted that Mrs Schleibs used a walker pre-operatively but was unable to use same due to immobilisation of her upper limb and thus required care over that provided pre-operatively by Mrs Schleibs' daughter.*

57. Ms Rowlands referred to Mrs Schleibs' increased care requirements due to her non-weight bearing status. However, the Hospital medical records document that Mrs Schleibs was using a four-wheel frame to ambulate with assistance of nursing staff.

58. The transfer form (to Chatsworth Terrace) describes Mrs Schleibs' functional care needs as "assistance required" for dressing, hygiene, nutrition and mobility with the use of a four-wheel frame.[32] As four-wheel frames require two guiding hands for effective use, it is unclear how Mrs Schleibs could be ambulating using a four-wheel frame maintaining a non-weight bearing status through her affected limb. The Warringal Private Hospital nursing record documents that Mrs Schleibs required assistance in walking, toileting, feeding and dressing in addition to the care required for pain management and anxiety/delirium especially overnight.

Determination of the discharge destination

59. Ms Rowlands stated that Mrs Schleibs' discharge destination was collectively decided by her case manager, social worker, family members, Mr Nguyen, Dr Thomas and physiotherapist. Ms Rowlands said that the social worker suggested SRS convalescent admission as an appropriate alternative to Mrs Schleibs' daughter providing care, as Mrs Harry had indicated the provision of care was now beyond her means.

60. Ms Rowlands stated that Mrs Schleibs' care needs were discussed with Chatsworth Terrace SRS. There is no supportive documentation of what was communicated to Chatsworth Terrace regarding the functional care needs that Mrs Schleibs required. However, Ms Bai stated that Chatsworth Terrace SRS received a phone call from Warringal Private Hospital prior to discharge. She stated that the phone call conveyed that Mrs Schleibs: was alert and orientated; was able to walk with a frame; needed assistance with showering, dressing and toileting.

61. Ms Bai confirmed in her statement that an SRS provides meals, cleaning and personal care to residents, and does not provide medical services such as measuring resident's vital signs, unless instructed by a doctor or if there is an emergency. Ms Bai said that most Chatsworth Terrace SRS staff had a Certificate 3 in Personal Care and that there is no requirement for registered nurses to be employed in an SRS.

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[32] Coronial Brief Appendix, *Chatsworth Terrace Resident Transfer Information*, page 55.

Response of Chatsworth Terrace SRS to Mrs Schleibs' deterioration

62. The recollection of Mrs Schleibs' condition provided by Ms Bai varies from that provided by the family who visited on multiple occasions over the weekend of 26 August 2016 to 28 August 2016. Ms Bai stated that she had no urgent concerns in relation to Mrs Schleibs' presentation on 28 August 2016, until 7.05pm when she rapidly deteriorated.

63. Ms Bai stated that Chatsworth Terrace SRS has changed its policy to arrange immediate hospital transfer if family so request. Ms Bai reflected that family have superior knowledge of the resident, especially those residents who are newly admitted to the facility.

Further CPU advice

64. The CPU reviewed the additional information provided to me by the interested parties and informed me that it is unlikely Mrs Schleibs suddenly developed septic shock at 7.05pm on 28 August 2016, as described by Ms Bai. It would have been more likely that signs of illness would have been present for at least several hours prior to her death.

65. The CPU stated that the DVA convalescence program can be utilised successfully when a period of recuperation in a supportive environment is provided especially for those who are socially isolated. In Mrs Schleibs' case, her daughter had been a live-in carer and Mrs Harry accurately assessment that Mrs Schleibs' care needs were too high for her to manage. However, discharge to the Chatsworth Terrace SRS did not provide a higher level of care for Mrs Schleibs than her daughter had been able to provide.

66. Private hospitals do have access to the publicly funded inpatient Rehabilitation, Geriatric Evaluation and Management (GEM) and Transitional Care Programs. Mrs Schleibs was not referred to any of these or referred for an assessment by a private geriatrician. Whilst these programs do have wait times for admission as well as prioritized waiting lists for admissions skewed toward public hospitals, there was a missed opportunity for the case managers to refer for these services.

67. Consequent upon the information provided by interested parties and the subsequent review by the CPU, I determined that my investigation could be completed without the need to proceed to an Inquest.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. My investigation has highlighted to me that there are limitations to the level of care that an SRS can provide. It appears that this is not generally well-understood, and that the limitations of SRS care were not well-articulated to Mrs Schleibs' daughter who believed that her mother was going to be provided with a higher level of care than Mrs Harry could provide herself, in her own home.

2. The available evidence indicates that there were deficiencies of clinical assessments and decision making provided by attending staff at Warringal Private Hospital in determining whether Mrs Schleibs was medically or functionally appropriate for discharge to a low care facility. This is evinced by poor pain control, lack of clarity regarding the use of a four-wheel frame for ambulation and the need for supervised mobility, feeding and overnight physical assistance, all of which were beyond that of reasonable care that could be provided by a low care SRS.

3. The CPU have informed me that it was more likely that Mrs Schleibs was evidently and increasingly unwell over several hours prior to her death. On this point, the evidence of Mrs Harry is preferred to the evidence of Ms Bai. Consequently, there was a missed opportunity to ring for emergency assistance earlier as Mrs Schleibs' daughter recalls she had asked staff to do during the afternoon of 28 August 2016. I note that Chatsworth Terrace SRS has now amended its policies and procedures to contact emergency services at the first request by a resident's family.

4. I acknowledge the distress evidently caused to Mrs Schleibs' family by the circumstances of her death. I also acknowledge the additional pain that a prolonged coronial investigation may cause and thank Mrs Schleibs' family for their involvement and contribution.

FINDINGS

On the weight of the evidence available to me, I find that Kathleen Schleibs was inappropriately discharged to a low-care Supported Residential Service due to apparent shortcomings in clinical assessment and decision making. Furthermore, I find that Chatsworth Terrace SRS missed an opportunity to contact emergency services at an earlier time on the date of Mrs Schleibs' death.

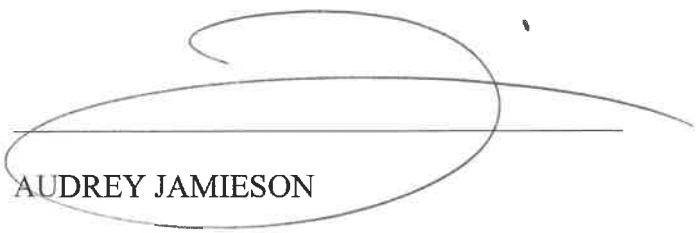
I accept and adopt the cause of death formulated by Dr Clare Hampson, and I find that Kathleen Schleibs, a woman with comorbidities and who had recent shoulder surgery, died from sepsis complicated by multiple organ failure.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

David Schleibs & Antoinette Harry
Dr Jibin Thomas
Dr Trung Nyugen
Warringal Private Hospital
Chatsworth Terrace SRS
Austin Health
Department of Veterans Affairs
The Honourable Richard Tracey AM RFD QC and Ms Lynelle Briggs AO,
Royal Commissioners in the Royal Commission into Aged Care Quality and Safety
Helen Dickson Supported Residential Service Regulation at the Department of Health and Human Services

Signature:



AUDREY JAMIESON

CORONER

Date: **21 February 2019**