IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5110

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the Coroners Act 2008*

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| Findings of: | Caitlin English, Acting State Coroner |
| Deceased: | Hong Tay |
| Date of birth: | 4 January 1953 |
| Date of death: | 27 October 2016 |
| Cause of death: | I(a) Sepsis in a man with complicated peripheral vascular disease |
| Place of death: | Regis Inala Lodge, 220 Middleborough Road, Blackburn South, Victoria |

## INTRODUCTION

1. Hong Tay was a 63-year-old man who lived in Blackburn South at Regis Inala Lodge, a residential aged care facility, at the time of his death.

2. Mr Tay died at the facility on 27 October 2016.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Tay's death was reported to the Coroner as it appeared to be unexpected or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Tay, treating clinicians and investigating officers.

6. I have based this finding on the evidence contained in the coronial brief, as well as medical records, statements from Patricia Fairman, General Manager Quality and Compliance at Regis Aged Care and Jan Rice, wound nurse consultant and advice from the Coroners Prevention Unit[1]. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

## IDENTITY

7. On 31 October 2016, Gary Tay visually identified his brother Hong Tay, born 4 January 1953. Identity is not in dispute and requires no further investigation.

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[1] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[2] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

## BACKGROUND

8. Mr Tay was born in Cambodia. He first emigrated to Australia in the 1980s, and later again in the early 2000s after returning to Cambodia for a period of time to see his family. Mr Tay was divorced, with three children with whom he had limited contact. He maintained a close relationship with his brother, Gary Tay.[3]

9. Mr Tay had an extensive medical history including type 2 non-insulin-dependent diabetes mellitus, hyperlipidaemia, depression, osteoarthritis and a right cerebrovascular event (stroke) in 2007 resulting in left sided weakness.[4] He also suffered from severe peripheral vascular disease[5], which had necessitated a right below knee amputation in July 2015, amputation of his left first to third toes and a left femoral-popliteal bypass of his left lower leg in November 2015, and a debridement of wound and resection to the first metatarsal head of his left foot in February 2016.[6] He had very slow progress of the wound healing of his right below knee and left toe amputations and required ongoing regular vascular outpatient review at Box Hill Hospital.[7]

10. Mr Tay was admitted to Regis Inala Lodge, a residential aged care facility operated by Regis Aged Care ('**the facility**') in September 2015 after his right below knee amputation.[8] He mobilised using a wheelchair and was visited by Gary Tay every day.[9] Mr Tay had ceased smoking following medical advice. However, approximately three to four months before his death, Mr Tay re-commenced smoking to *'release the stress'*.[10]

## CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 8 September 2016, Mr Tay suffered an unexpected fall at the facility.[11] He was found in the entrance to the smoking area by nursing staff at approximately 6.45pm, appearing to have fallen off his wheelchair. He had a lump on his head, with abrasions to his forehead, left side, left cheek and left knee. He was assisted by nursing staff to his bed via a lifting machine. Nursing staff requested an ambulance and conducted three sets of neurological

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3 Statement of Gary Tay dated 28 December 2016, Coronial Brief.
4 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.
5 Peripheral vascular disease is caused by narrowing of the blood vessels that supply parts of the body with blood and oxygen. This usually occurs by accumulation of cholesterol within the walls of these vessels. As a result, limbs become prone to poor wound healing or eventual ulceration and tissue death.
6 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief; Statement of Gary Tay dated 28 December 2016, Coronial Brief.
7 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.
8 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.
9 Statement of Gary Tay dated 28 December 2016, Coronial Brief.
10 Statement of Gary Tay dated 28 December 2016, Coronial Brief.
11 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.

observations until ambulance paramedics arrived at about 7.08pm and took over management of Mr Tay's care.[12]

12. Mr Tay was taken to Monash Medical Centre by ambulance, where a computed tomography (CT) scan confirmed a fracture of his C4 vertebrae resulting in incomplete quadriplegia with reduced sensation. Mr Tay was reviewed by the neurosurgical team, but due to his poor health, a decision was made to treat his condition conservatively and he was referred for palliative care. He was discharged back to the facility the following day for ongoing high-level care and comfort measures with ongoing symptomatic treatment of his right stump and neck pain.[13]

13. Over the following six weeks, Mr Tay was regularly reviewed by his general practitioner Dr Mark Weng. He was also reviewed by wound nurse consultant Jan Rice, palliative care service Eastern Palliative Care[14] (EPC), locum general practitioner Dr Wan (Jennifer) Lau and the Eastern Health InReach palliative care team. He was treated for right stump wound necrosis, sacral pressure sores and a urinary tract infection, as well as increased drowsiness related to an adverse effect of his Durogesic[15] patches.[16]

14. On 24 October 2016, nursing staff completed a comprehensive review of Mr Tay and found he was in significant pain when turned or having his wound care attended. His sacral wound had deteriorated further, and the clinical manager found that his current pain relief appeared to be inadequate. Nursing staff attempted to arrange a medication and wound review by his general practitioner Dr Weng the following day, but he was unavailable. After consulting with Gary Tay, the facility contacted Eastern Health's InReach palliative care service to arrange review by a specialist palliative care clinician.

15. On 25 October 2016, Mr Tay was examined by InReach consultant geriatrician Dr William Browne. Dr Browne found that Mr Tay appeared pale and unwell, with a reduced oxygen saturation, low blood pressure and low body temperature. He noted that Mr Tay's sacral and right stump wounds were extensively necrotic. Dr Browne considered Mr Tay's poor vital signs were indicative of evolving sepsis, likely originating from the sacral or right stump

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[12] Statement of Helen Spellman, Facility Manager Inala Lodge dated 19 January 2017, Coronial Brief.

[13] Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.

[14] Eastern Palliative Care (EPC) is a not-for-profit home-based palliative care service. Specialist palliative care nurses provide planned visits and telephone on-call, with nursing care aimed at relieving symptoms. Primary medical care is provided by the General Practitioner, but EPC also has specialist palliative care clinicians to provide consultancy.

[15] Durogesic patches contain fentanyl, an opioid used to relieve chronic or long-lasting pain.

[16] Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief; Statement of Dr William Browne dated 18 November 2016, Coronial Brief; Statement of Helen Spellman, Facility Manager Inala Lodge dated 19 January 2017, Coronial Brief; Statement of Dr Wan (Jennifer) Lau dated 9 February 2017, Coronial Brief.

wounds, and that his condition was rapidly deteriorating. He considered it was unlikely that Mr Tay would survive surgical treatment of the necrotic areas and that antibiotic treatment would be futile.[17]

16. Dr Browne spoke to Gary Tay and expressed the view that a palliative approach was likely to be the best treatment option as Mr Tay was distressed and would be highly unlikely to survive, even with aggressive medical and surgical support. Dr Browne offered the option of transfer to hospital but expressed concern that there was likely to be little that could be offered in hospital that could change the outcome and hospital admission would be unlikely to extend Mr Tay's life. Gary Tay agreed to ongoing comfort care and told Dr Browne he planned to visit his brother later that day to decide whether to pursue palliation or hospitalisation.

17. Dr Browne recommended that opiates should be administered prior to turns and other care causing pain or distress. He prescribed Mr Tay morphine for pain relief, maxolon for nausea, clonazepam for anxiety and atropine for secretions and ceased metformin, coveram and Lipitor medications.[18] Gary Tay visited his brother that evening. He found that Mr Tay was able to consume some food.[19]

18. Mr Tay's condition continued to deteriorate over the following day. Dr Weng reviewed Mr Tay on the afternoon of 26 October 2016 and found that he was not rousable and had not eaten or drunk for the preceding 24 hours.[20] Nursing staff continued to provide Mr Tay with palliative comfort care, administering morphine as necessary to alleviate pain and distress.[21]

19. Mr Tay died at approximately 4.45am on 27 October 2016.

## CAUSE OF DEATH

20. On 31 October 2016, Dr Essa Saeedi, a Forensic Pathology Registrar practising at the Victorian Institute of Forensic Medicine, conducted an autopsy and provided a written report, dated 24 March 2017. In that report, Dr Saeedi concluded that a reasonable cause of death was '*I(a) Sepsis in a man with complicated peripheral vascular disease*'.

21. Dr Saeedi commented that post mortem examination revealed multiple pressure sores and ulcers, osteomyelitis, necrotising fasciitis of sacral and right leg ulcers, multiple bruises on

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17 Statement of Dr William Browne dated 18 November 2016, Coronial Brief.
18 Statement of Dr William Browne dated 18 November 2016, Coronial Brief.
19 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.
20 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.
21 Regis Group – Note Report between 28 October 2014 to 28 October 2016, Coronial Brief.

Mr Tay's head, right hand and lower legs, bilateral bronchopneumonia, cystitis, cerebrovascular disease and nephrosclerosis. Mr Tay also had several infected wounds with spread of the infection into adjacent soft tissue and bone. There was no post mortem evidence of any other injuries of a severity which may have caused or contributed directly or indirectly to the death.

22. Toxicological analysis of post-mortem blood specimens identified the presence of fentanyl, morphine, duloxetine, metformin, metoclopramide, paracetamol, pregabalin and trimethoprim, consistent with medical treatment. Toxicological analysis of hair specimens also identified oxycodone and tapentadol. The C-reactive protein (a marker of inflammation within the body) was elevated (180.8 mg/L) in keeping with infected ulcers and sepsis. Vitreous humour biochemistry showed elevated urea and creatinine levels suggesting renal failure.

23. Post mortem microbiology detected Klebsiella pneumonia and enterococcus faecalis from blood cultures, Pseudomonas aeruginosa from the right leg stump swabs, and Enterococcus faecalis, Morganella morgagnii and Pesudomonas aeruginosa from sacral swabs. Dr Saeedi commented that these results are in keeping with infected gangrenous ulcers and resultant sepsis from these sites. A neuropathological examination did not identify any acute changes of infection or ischaemia in Mr Tay's brain.

24. Dr Saeedi explained that sepsis is an overwhelming infection that spreads through the body as a consequence of a primary infection elsewhere in the body. This causes widespread inflammation with damage to small vessels and eventual reduction in immunity which can eventually result in severe drop in blood pressure, variable immunity, reduction of the coagulative capabilities and multi-organ failure leading to death. Risk factors for sepsis include diabetes and peripheral vascular disease.

25. Dr Saeedi noted that Mr Tay had a history and post mortem evidence of severe peripheral vascular disease and uncontrolled diabetes mellitus, as well as a spinal injury which, in combination, put him at high risk of developing pressure ulcers that are prone to poor healing and infection. Infection of these wounds spread into Mr Tay's blood causing multi organ failure and death. Dr Saeedi commented that the presence of multiple pressure sores, seen on Mr Tay's left foot and upper back in combination with his infected gangrenous wounds were a complication of his existing diseases and pathological conditions, but could also have been exacerbated by problems with care provision.

26. I accept Dr Saeedi's opinion as to cause of death.

## CORONIAL INVESTIGATION AND REVIEW OF CARE

### Investigation

27. Dr Weng reported Mr Tay's death to the court on 27 October 2016. In his telephone call to the Coronial Admissions and Enquiries office, he expressed concerns regarding Mr Tay's care. He informed the coronial investigator Senior Constable Anthony Murphy that there was an issue with the administering of morphine and that Mr Tay was only to be administrated morphine as pain relief, rather than on an ongoing basis.[22] In his subsequent letter to the court, he stated that he noted that Mr Tay was given very frequent morphine which was causing Mr Tay to become drowsy and almost unconscious, and that he had ceased morphine to avoid possible overdose. He noted that Mr Tay's condition did not seem adversely affected by ceasing morphine according to nursing staff entries.[23]

28. The Court also received correspondence from Gary Tay in which he expressed concerns in relation to the circumstances of Mr Tay's fall on 8 September 2016, and the care and treatment Mr Tay had received in the days prior to his death. Gary Tay stated that on the day of Mr Tay's fall, there were *'gum nuts from the tree all on the ground'* and he believed Mr Tay had *'rolled over one that caused him to fall over'*. He also raised concern that Mr Tay's decline from 25 October 2016 to 26 October 2016 may have been related to the morphine administered for Mr Tay's pain.[24]

29. Upon review of the circumstances of Mr Tay's death, and taking into consideration the concerns raised by Dr Weng and Gary Tay, I requested that the Health and Medical Investigation Team (HMIT) of the Coroner's Prevention Unit (CPU)[25] review Mr Tay's medical care. I also requested that they provide information as to when Mr Tay's pressure areas were identified, what interventions were put in place, the appropriateness of palliative care provided to Mr Tay and whether a transfer to hospital was appropriate in light of Mr Tay's fracture and extensive pressure areas. The CPU reviewed the Victoria Police Report of Death for the Coroner, the coronial brief, the medical examiner's report and clinical

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22 Statement of Senior Constable Anthony Murphy dated 13 February 2017, Coronial Brief.
23 Statement of Dr Mark Weng dated 19 November 2016, Coronial Brief.
24 Statement of Gary Tay dated 28 December 2016, Coronial Brief.
25 The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

records from Regis Inala Lodge, Forest Hill Medical Centre and Eastern Palliative Care. The CPU also obtained a statements from Jan Rice, Wound Nurse Consultant and Patricia Fairman, General Manager Quality and Compliance at Regis Aged Care.

**Fall on 8 September 2016**

30. Mr Tay had three unwitnessed falls in 2016 prior to the fall on 8 September 2016. Nursing staff noted that he would try to get out of his bed or chair by himself and had a tendency to go out into the courtyard to smoke. He was assessed as having a high falls risk and interventions were implemented to minimise falls, as per his Falls Care Plan. This included strategies of staff approaching Mr Tay in a calm manner, interacting with him 1:1 and supervision from a distance to ensure protection of Mr Tay's privacy and dignity.[26]

31. On 8 September 2016, Mr Tay used his wheelchair to mobilise himself to the smoking area to have a cigarette without the assistance of staff. Mr Tay's fall was unwitnessed, but he was located by nursing staff on the ground with his legs in the doorway and his body facing towards the court yard.[27] Patricia Fairman, General Manager Quality and Compliance at Regis Aged Care informed me that the door to the area was a self-closing hinged door, which Mr Tay would need to physically manage in order to pass through the doorway. The smoking area was paved with no trees or shrubbery present, except for a raised garden area some distance from the entry to the smoking area.[28]

32. Helen Woods, Senior Manager Quality and Compliance, conducted an internal investigation of the incident and interviewed staff on duty at the time of the incident. Personal Care Assistant Geoffrey Tirop informed Ms Woods that Mr Hong was found lying face down in the doorway of the smoker's area with the wheelchair on top of him. His position indicated that at the time of his fall he was entering the smoker's area.[29]

33. Ms Fairman noted that as the door was a self-closing door, Mr Tay's wheelchair may have become caught on the door frame of the self-closing door, causing the chair to topple and Mr Tay to fall from the chair. She noted that Mr Tay would not have had the physical capacity to prevent the momentum of the chair toppling forward given his right below knee amputation and left foot amputations.[30]

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[26] Statement of Helen Spellman, Facility Manager Inala Lodge dated 19 January 2017, Coronial Brief.
[27] Helen Woods discussions with staff on duty at the time of the incident on 8 September 2016, Coronial Brief.
[28] Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care undated.
[29] Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care undated.
[30] Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care undated.

34. There is no evidence available to firmly establish the cause of Mr Tay's fall. However, it does not appear that the fall was caused or contributed to by the presence of gum nuts. Mr Tay had been assessed as having a high falls risk and was known to enter the smoking area without seeking assistance. It appears that for an unknown reason, Mr Tay's wheelchair overbalanced as he was entering the smoking area, causing him to fall on to the ground. I am satisfied that Regis Aged Care had appropriate falls prevention strategies and post fall management procedures in place at the time of his fall.

**Analgesic administration**

35. Mr Tay's medication charts indicate that he was prescribed Endone 5mg three times a day from 9 September 2016 to 25 October 2016 on an as required basis, as well as a topical 50mg fentanyl (Durogesic) patch applied every three days from 13 September 2016 until his death. He was also prescribed subcutaneous morphine 2.5mg by Dr Weng on 9 September 2016, on an as required basis for 'severe pain only'. Mr Tay was first administered morphine on 12 September 2016, as documented on his medication chart.[31]

36. On 12 September 2016, a registered nurse spoke to Dr Weng regarding the need to review the frequency of morphine administration. The nurse documented that Dr Weng *'stated/recommended to give as required and as prescribed...Staff encouraged to monitor and ensure safety and comfort at all times*'. Dr Weng reviewed Mr Tay again on 13 September 2016 and 15 September 2016. On 15 September 2016, Dr Weng asked nursing staff to use Mr Tay's regular analgesia first before administering morphine.[32]

37. On 22 September 2016, Mr Tay was reviewed by Dr Weng who documented that he was *'generally comfortable, intermittent pain, been given endone/morphine, both working well*'. On Dr Weng's instructions, morphine was ceased that day, but Mr Tay continued to be administered Durogesic patches every three days and Endone as required, for management of his pain relief. [33]

38. CPU reviewed Mr Tay's medication charts and noted that at times in mid-September 2016 nursing staff had administered morphine when Endone could have been used instead. However, Mr Tay had not received excessive doses of analgesics during this period. The CPU noted that given his co-morbidities Mr Tay would have been in considerable pain at certain times within the last few weeks of his life which may not have been evident when Dr

[31] Clinical records of Regis Inala Lodge, Coronial Brief.
[32] Clinical records of Regis Inala Lodge, Coronial Brief.
[33] Clinical records of Regis Inala Lodge, Coronial Brief.

Weng reviewed Mr Tay. The CPU considered that the administration of morphine at these times was not directly related to Mr Tay's death, as morphine had been ceased almost one month prior to Mr Tay's death.[34]

39. The CPU noted that Mr Tay had received frequent reviews from the clinical manager at the facility in relation to his pain levels. This included a comprehensive review on 24 October 2016, when Mr Tay was found to be in significant pain when having wound care or turning attended, despite having endone and Panadol medication on top of his regular use of the Durogesic patch. The clinical manager noted his pain relief *'now appears to be inadequate'* and organised for review of medication by his GP or palliative care team.

40. Mr Tay was re-prescribed morphine on 25 October 2016 following review by consultant geriatrician Dr Browne. The morphine was administered subcutaneously on a four-hourly basis, in line with the instruction and recommendations of Dr Browne and the palliative care team, to alleviate his pain and distress and to ensure he was made as comfortable as possible as his condition deteriorated.[35]

41. The CPU informed me of their opinion that Mr Tay had not been administered excessive doses of analgesics, and that the administration of morphine in the final days of Mr Tay's life did not lead to his death. The CPU considered Mr Tay was provided with palliative care and comfort measures in accordance with his care plan. Taking into account Mr Tay's deteriorating condition, and the opinion of CPU, I am satisfied that the administration of analgesics to Mr Tay was reasonable and appropriate in the circumstances.

**Pressure area care and wound breakdown**

42. Clinical records indicate that nursing staff first noted Mr Tay had a large sacral pressure area on 19 September 2016. An incident form was completed which documented that the pressure area was identified by nursing staff at about 3.50am as they were repositioning Mr Tay. Mr Tay's care plan was updated, and a wound assessment and management plan was implemented. The injury was treated, protective dressing was applied, and the pressure area was regularly reviewed by Dr Weng and a physiotherapist, as well as nursing staff. Despite

[34] This does not take into account the re-prescription of morphine in the two days prior to Mr Tay's death, discussed at paragraph 39 and 40.

[35] Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care, undated, Coronial Brief.

efforts of staff in monitoring, cleaning and re-dressing of the sacral pressure area, wound healing was compromised by faecal contamination and Mr Tay's poor health.[36]

43. At about 3.29pm on 19 September 2016, nursing staff found Mr Tay's air mattress had been switched off. The mattress had previously been found to be in working order at 12.22pm that day. Records confirm that the mattress was working well again at 9.28pm that day, indicating that the equipment failure was rectified relatively soon after the issue was identified.[37]

44. Despite the efforts of nursing staff to mitigate Mr Tay's risk of pressure areas through regular re-positioning and use of an air mattress, skin integrity remained an ongoing challenge for the facility.[38] On 23 September 2016 a pressure area was identified on Mr Tay's right stump and in early October 2016 a blister was found on his left heel.[39] Protective booties were applied to the left heel and right stump and a wound swab obtained from Mr Tay's right stump wound identified staphylococcus aureus.

45. Mr Tay was administered antibiotics and referred to wound nurse consultant Jan Rice on advice of Dr Weng. Ms Rice first reviewed Mr Tay on 12 October 2016. She noted he had a necrotic sacral pressure injury as well as pressure injuries to his right stump and left heel. Ms Rice noted that the injuries would not heal given Mr Tay's frail and declining condition and recommended antiseptic dressings and pressure reduction as the most conservative and appropriate management. Ms Rice completed a debridement of loose necrotic tissue on the right stump wound the following week. Antiseptic dressings continued to be administered in accordance with her advice, but the pressure areas continued to deteriorate.[40]

46. Regis Aged Care undertook a quality audit of Mr Tay's care and treatment following his death. The review identified shortfalls in Mr Tay's care, with inconsistent completion of wound documentation and pain charting. It was noted that Mr Tay's wounds had not been consistently being added to his pain assessment as a potential source of pain. In addition, the review identified that not all pressure relieving devices were monitored frequently to ensure that they were working correctly, and faulty equipment was not always notified in a timely manner. Further, 10% of staff were overdue in their required manual handling training and

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[36] Clinical records of Regis Inala Lodge, Coronial Brief; Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care undated.
[37] Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care undated.
[38] Statement of Patricia Fairman, General Manager Quality and Compliance, Regis Aged Care undated.
[39] Clinical records of Regis Inala Lodge, Coronial Brief.
[40] Statement of Jan Rice, Wound Nurse Consultant dated 26 December 2017, Coronial Brief.

Mr Tay's next of kin and General Practitioner were not consistently being notified of changes in his condition.[41]

47. Regis Aged Care implemented a corrective action plan in June 2017 in response to these shortfalls. This included a 100% Wound Review/Audit and discussion of identified issues at meetings with registered nurses and all staff, as well as review of and updating of the pain assessment and care plan. Regis Aged Care also issued a memorandum to staff to advise them of the process of reporting faulty equipment and arranged extra manual handling training for staff to ensure all staff were up to date with manual handling training.[42]

48. The CPU noted that Mr Tay's health had significantly deteriorated after he became an incomplete quadriplegic. They informed me that as a man who was immobile, with a history of significant peripheral vascular disease and poor wound healing, there was a significant potential for Mr Tay to develop pressure sores. The CPU reviewed Mr Tay's clinical records and noted that at times Mr Tay refused pressure area care which would have compounded his pressure area deterioration.

49. The CPU noted that a wound care specialist was sought just over three weeks after the initial pressure area was identified. The CPU considered that an earlier referral may have provided the staff at the facility with additional support in relation to Mr Tay's wound management. However, the CPU found that an earlier referral to a wound care specialist would not have altered Mr Tay's outcome. I accept that conclusion.

**Appropriateness of palliative care setting**

50. The CPU noted that during Mr Tay's admission to the Monash Medical Centre, a decision was made for his cervical fracture to be treated conservatively. Prior to discharge, contact was made with EPC and In-Reach for ongoing community palliative care and support. The CPU noted Mr Tay was happy to return to the facility and to receive palliative care in this setting. At the time of his discharge he did not have any significant pressure injuries.

51. EPC conducted an initial visit on 24 September 2016, with a review on 3 October 2016, and identified that Mr Tay's pain levels had improved, and advised they would continue to provide ongoing phone assessments and visits if needed. The CPU considered that Mr Tay's discharge plan was appropriate and had been discussed with both Mr Tay and his brother.

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[41] Regis Aged Care Corrective Action Plan Case No 004110/16 dated 15 June 2017, Coronial Brief.
[42] Regis Aged Care Corrective Action Plan Case No 004110/16 dated 15 June 2017, Coronial Brief.

52. The CPU commented that there appeared to be differing understanding of the meaning of the 'palliative' approach following the decision not to provide an active surgical intervention for Mr Tay's cervical fracture. It appeared that Monash Medical Centre expected Mr Tay to receive end of life or terminal care in the residential aged care facility, with the expectation that use of sedation would assist in managing his symptoms prior to his expected death. However, it appeared from the records that Dr Weng and Mr Tay's family did not consider Mr Tay in an end of life or in a terminal situation and were reluctant to prescribe opiates or sedation.

53. The CPU informed me that this situation could have been assisted with improved support from the palliative care services. The CPU noted that it would be challenging for any facility to provide effective pressure care to a man who is partially paralysed, already known to be resistive and in considerable pain. The CPU review found that the facility had provided every effort to manage this difficult situation. I accept that conclusion.

**COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT**

54. Mr Tay had a complex medical history, with severe peripheral vascular disease and ongoing difficulties with wound healing following a below knee right leg amputation in July 2015. He sustained a cervical fracture in a fall at the facility in September 2016 that resulted in incomplete quadriplegia. In view of Mr Tay's poor health, a decision was made for conservative treatment only and he was discharged back to the facility for palliative care and comfort measures. Despite being on an air mattress and frequently repositioned with allied health reviews, Mr Tay developed pressure areas which became infected. In the setting of Mr Tay's past medical history and immobility, worsening pressure areas and infection, Mr Tay rapidly deteriorated and died.

55. Mr Tay's death highlights the challenges of providing effective pressure care to residents with limited mobility and complex medical conditions. Wound care specialists can provide advice and support in the care and treatment of acute and chronic wounds. Given the importance of early recognition and monitoring of skin integrity breakdowns, residential aged care facilities should ensure staff are provided with education about the availability of wound care specialists for specialist support.

56. Whilst Mr Tay's death was not preventable, Regis Aged Care identified shortfalls in the care and treatment that had been provided to Mr Tay. I acknowledge the efforts Regis Aged Care have undertaken in identifying and implementing practice improvements in addressing these

shortfalls. I encourage Regis Aged to circulate these identified practice improvements to all residential aged care facilities operated by their organisation.

## FINDINGS AND CONCLUSION

57. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Hong Tay, born 4 January 1953, died on 27 October 2016 at Blackburn South, Victoria, from *'I(a) Sepsis in a man with complicated peripheral vascular disease'* in the circumstances described above.

58. I convey my sincere condolences to Mr Tay's family.

59. Pursuant to section 73 (1A) of the *Coroners Act 2008*, I direct this finding and comment be published on the Internet in accordance with the rules.

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

Mr Gary Tay, senior next of kin.

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Miss Roslyn Cooper, Regis Aged Care Pty Ltd

Ms Iona McNab, Legal Counsel, Regis Aged Care Pty Ltd

Dr Mark Weng, General Practitioner, Forest Hill Medical Centre

Dr William Browne, Consultant Geriatrician, Eastern Health

Eastern Palliative Care

Royal Commission into Aged Care Quality and Safety

Senior Constable Anthony Murphy, Victoria Police, Coroner's Investigator

Signature:

**CAITLIN ENGLISH**
**ACTING STATE CORONER**
Date: 31 July 2019

Coroners Court of Victoria