IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 003678

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Margaret Alice Cook
Date of birth:	23 December 1928
Date of death:	28 July 2017
Cause of death:	1(a) Complications of a stage 3 sacral pressure ulcer in a woman with dementia
Place of death:	Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152
Keywords:	Supported residential services, Dementia, Pressure ulcer, Advance care planning

INTRODUCTION

1. On 28 July 2017, Margaret Alice Cook was 88 years old when she died from complications of a stage 3 sacral pressure ulcer at the Palliative Care Inpatient Unit (**PCIU**) of Wantirna Health. At the time, Ms Cook was diagnosed with end-stage dementia and resided at Crofton House Supported Residential Services (**SRS**) ("Crofton House") in Blackburn.

THE CORONIAL INVESTIGATION

2. Ms Cook's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* ("the Act"). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. 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.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. As part of the coronial investigation, several statements were obtained from Crofton House, treating clinicians, Eastern Health, the Office of the Public Advocate and the Department of Health and Human Services[1] (**DHHS**). The Coroners Prevention Unit[2] (**CPU**) was also requested to review the nursing and medical response in relation to Ms Cook's nutritional status and pressure area care given the advanced nature of her pressure ulcer[3].

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[1] Currently the Department of Fairness, Families and Housing (**DFFH**) following the Department of Health and Human Services (**DHHS**) dissolution 1 February 2021. All references to the DFFH will remain as DHHS, given it was the Department that was responsible to regulate and oversee the operations of all Supported Residential Services (**SRS**) at the time of Ms Cook's death.

[2] 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.

[3] Also known as a bed sore.

6. This finding draws on the totality of the coronial investigation into the death of Margaret Alice Cook. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [4]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

Background

7. Ms Cook did not marry and had no surviving relatives. She previously lived with her only brother (deceased). The State Trustees, as her Enduring Power of Attorney (**EPOA**) had managed her financial affairs since January 2013.[5] She did not have an appointed medical treatment decision-maker. Neither did Ms Cook make an advanced care directive. She had a close friend, Glenys Tarrant, who visited her weekly at Crofton House and as such, was the point of contact between Crofton House and State Trustees.

8. Ms Cook's medical history also included hypertension, rheumatoid arthritis, ischaemic heart disease. Her general practitioner (**GP**) at Crofton House, at least in the last two years of her stay, was Dr Hossain Islam.

9. In February 2013, Ms Cook moved to Crofton House for respite care after having been discharged from Epworth Hospital due to fracturing her left shoulder.[6] She weighed 47 kilograms (**kg**) at the time.[7] Despite her shoulder fracture, she could initially ambulate with the aid of a four wheeled walker and manage her self-care independently.

10. During her stay at Crofton House, Ms Cook's cognitive capacity gradually declined in that she became forgetful and susceptible to falls. However, it is unclear when the decline became advanced as dementia was not formally diagnosed until the end of her life. She suffered six occasions of falls and unresponsive episodes in the last two years of her life, following which she was transferred and reviewed at the Emergency Department (**ED**) of Box Hill Hospital (**BHH**). She was also admitted as an inpatient during two of the six occasions. Medical notes

[4] 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.
[5] See paragraph 75
[6] Court File (**CF**), Statement of Dr Hossain Islam dated 28 June 2018.
[7] CF, Statement of Dr Peteris Darzins dated 2 January 2019.

detail that some of these falls were precipitated by a loss of consciousness, with an eventual diagnosis of an electrical heart conduction disorder[8] in April 2017.

11. On 16 December 2016, Ms Cook presented to the BHH ED following a fall. During the ED presentation, ED physicians noted that Ms Cook resided in a SRS. They questioned her suitability for care in an SRS, given she was incontinent and unable to ambulate independently after her recent fall.

12. On the same afternoon, Ms Cook was transferred to the general ward where she remained an inpatient for two weeks. Upon admission, treating clinicians observed her skin in the sacral region was reddened but intact and identified her as high risk of developing pressure ulcers.

13. On 19 December 2016, a BHH physiotherapist noted Ms Cook's high needs and risks and questioned the appropriateness of her residence at a SRS. The physiotherapist contacted Crofton House to check their ability to meet her functional needs. Despite the vague details provided by Crofton House staff, the physiotherapist ascertained that Ms Cook had developed significant functional and cognitive deterioration.[9] The physiotherapist recorded further that they were not reassured by Crofton House's response about supporting Ms Cook's functional needs and considered her *"not safe for discharge to a SRS currently"*. It appears the physiotherapist also raised the possibility of consulting Ms Cook's medical power of attorney (**MPOA**), recording - *"need to f/u [follow up] patient [Ms Cook's] MPOA"*. [10]

14. On 21 December 2016, a hospital occupational therapist (**OT**) completed an assessment and review. The OT noted that Ms Cook had *"a functional + cognitive decline since October [2016]"* and later contacted Crofton House regarding the status of her care.[11] The then Crofton House manager, Kim, reassured the OT about its willingness and ability to manage Ms Cook's high needs with an air mattress, diffuser cushion and transfer hoist.[12] The OT later recommended a complete assessment and review of Ms Cook's cognitive, functional and mood decline by a geriatrician and noted "appropriate for return to SRS from OT perspective".

[8] A trifasicular heart block was diagnosed in April 2017 and an explanation on the condition to Ms Cook ensued. The condition required no further investigation given her current functional decline.
[9] CF, Eastern Health Medical Records – Total Care Progress Notes, page 580.
[10] Ibid.
[11] Ibid, page 588.
[12] Ibid, page 590.

15. Later on the same day, a different physiotherapist reviewed Ms Cook and made a note stating Crofton House *"could take patient back as high level care or palliative care mode"*, but unsuitable for discharge secondary to reduced mobility. [13]

16. During that admission, Ms Cook's estimated weight was 37 kg, with an estimated BMI of 14.4 kg/m² and prompted a referral for reviews by an in-house dietician and Eastern Health community-based dietician after her discharge.[14]

17. On 23 December 2016, Ms Cook was assessed by a hospital dietician. The dietician found Ms Cook to be severely malnourished, experiencing swallowing difficulties and commenced her on a high protein supplemental drink, Resource.

18. On 30 December 2016, Ms Cook was discharged from BHH back to Crofton House and into the care of Dr Islam. A handover document by BHH noted Ms Cook's risk of developing pressure injury and further details of a follow-up by a community rehabilitation centre dietician were provided to Crofton House.[15]

19. In the early hours of 13 January 2017, Ms Cook had an unwitnessed fall and was found on the floor by care staff. She was presented to the BHH ED. Ms Cook denied any pain, headache or neck pain but only complained of discomfort in her left hip. She was discharged on the same evening.

20. Prior to Ms Cook discharge to Crofton House, the BHH medical records indicated a physician, Dr Caleb Lim, contacted Crofton House, to ascertain whether Crofton House could provide support to Ms Cook's baseline function. Dr Lim's notes also recorded *"nursing home [Crofton House] states able to cope with her care needs, able to provide palliative care as well"*.[16]

21. On 19 January 2017, Dr Islam reviewed Ms Cook and drafted a GP Mental Health Care Plan for "ongoing counselling with a psychologist" and included a plan of "on palliative approach as per hospital". There was also no record on file of blood tests being performed per BHH's request or any referral from Dr Islam for a palliative care service.

22. On 30 January 2017, Paula Howell, a community-based dietician at Peter James Centre, attended Ms Cook and found her unsuitable for rehabilitation at the centre. Crofton House

[13] CF, Eastern Health Medical Records – Total Care Progress Notes, page 595.
[14] CF, Statement of Dr Peteris Darzins dated 2 January 2019.
[15] Ibid.
[16] CF, ED Electronic Notes, page 5.

staff also informed the dietician that Ms Cook was unable to feed herself and required feeding and her food cut up.

23. The progression notes record that over the next few months, Ms Cook began to refuse food and fluids including Resource, as she seemingly disliked the supplemental drink and was experiencing an inability to swallow.[17]

24. On 14 February 2017, Dr Islam attended Ms Cook and noted that she was *"eating better than before and sleeping well"*. He observed that she had cellulitis on her lower right leg and identified it as "from [a] skin tear". Dr Islam noted his instruction for personal care assistants (**PCAs**) to provide Ms Cook with fresh dressings and commenced her on flucloxacillin.[18]

25. Subsequently, Ms Cook's health appeared to have rapidly declined. According to Dr Islam, she had been bed-bound since March 2017 and while she remained bed-bound, pressure injury prevention and management were implemented. Dr Islam recorded in the progress notes that Ms Cook was provided a "doughnut cushion" to sit on during the day and repositioned in bed four times overnight.[19]

26. On 27 April 2017, Dr Islam was informed by Crofton House staff of an infected pressure ulcer on the back and sacral area. The available evidence indicates that Dr Islam did not subsequently attend Ms Cook personally but directed care staff to administer flucloxacillin 500mg for five days and switched the betadine wound dressing to a Mepilex dressing.[20] No referrals were made to a wound specialist or a visiting registered nurse.

27. On 25 May 2017, Dr Islam attended Ms Cook personally and noted the bedsore was "getting dry". Prior to this attendance, Dr Islam saw Ms Cook on three occasions in which he noted she had possibly developed "mixed musculoskeletal and neuropathic pain". Dr Islam commenced her on pain relief medications.

28. On 13 June 2017, Dr Islam observed Ms Cook was deteriorating. He noted she was passing green urine, apyrexial and had lower abdomen discomfort. He prescribed 500 milligrams of Keflex[21] with an instruction to be administered three times a day.

[17] Eating problems such as difficulty swallowing are one of the signs of the final stages of Alzheimer's disease.
[18] An antibiotic used to treat skin infections.
[19] CF, Statement of Dr Hossain Islam dated 28 June 2018.
[20] To prevent further bed sores or bed sores in other skin areas.
[21] An antibiotic used to treat bacterial infections.

29. On 29 June 2017, Dr Islam attended Ms Cook and noted she was "quite frail". Given her condition, it appeared Dr Islam intended to commence Ms Cook on a "palliative care approach" which he recorded should be "comfortable and pain-free".

Events proximate to death

30. Between 1 July 2017 to 22 July 2017, Dr Islam was on leave and several locum GPs were relied upon to attend to Ms Cook.

31. On 6 July 2017, locum GP Dr Isaac Khoo attended to Ms Cook and examined her pressure ulcer. Dr Khoo recorded that she had developed a "Grade 2 (or stage 2) pressure sore" and that the ulcer had become necrotic. He commenced her on topical metronidazole cream to be applied twice daily for a week and instructed staff to change Ms Cook's position in bed regularly.

32. On 14 July 2017, locum GP Dr Shashi Mishra attended to Ms Cook and noted she was *"emaciated and frail"* but afebrile. On examination of her pressure ulcer, Dr Mishra recorded that the pressure sore on the sacrum was large and was presented with *"some weeping"*. Dr Mishra ordered treatment of "another week of metronidazole cream" and resumed regularly repositioning Ms Cook. Dr Mishra also indicated that the wound appeared such that it "may require debridement".[22]

33. On 18 July 2017, locum GP Dr Navid Afsharipour reviewed Ms Cook and arranged for a transfer to a hospital, given the pressure ulcer had become "deep and infected". Dr Afsharipour further detailed that the pressure ulcer had persisted for "2-3 weeks" and the deep wound was "size~8cm" with *"erythema around and smelly pus on top and [was] oozing"*.[23]

34. Ms Cook was conveyed to BHH, where she arrived at the ED at 8.31pm. On admission to the ED, she weighed 36 kg with urinary and faecal incontinence. Her stage 2 pressure ulcer had developed to stage 3 and was measured at 5 centimetres. It was described as necrotic, purulent and foul-smelling. There was also a large erythema to the right scapula without broken skin or signs of ulcers. Moreover, ED treating clinicians recorded that Ms Cook was dehydrated and "very cachectic".[24]

[22] Debridement is the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue. Removal may be surgical, mechanical, chemical, autolytic, and by maggot therapy.
[23] CF, Burwood Rise Family Clinic Medical Records.
[24] CF, Burwood Rise Family Clinic Medical Records.

35. Given Ms Cook's presentation, an ED physician, Dr Nicholas Johnson, contacted Crofton House. The contact entry was recorded as follows:

> *"As per staff member no nursing staff present at home, PCAs only. NH [Crofton House] has been struggling to manage to look after Margaret. No bed hoists, no inflatable mattresses. Feel [patient] would be better suited in high level care facility. Unfortunately no family members to arrange this. Concerned that ulcers getting worse [sic]".*[25]

36. Dr Johnson later contacted Ms Tarrant, who was listed as Ms Cook's "Next of Kin" and advised her that Ms Cook's wound condition was not suitable for surgical intervention or debridement. Dr Johnson noted a subsequent plan *"will need Gen Med admission to [arrange] placement into high level care"*. A State Trustees representative was notified of Ms Cook's admission to BHH and provided with an update on her condition.

37. On 19 July 2017, at 9.31am, Ms Cook was discharged from the ED and admitted to the general medical ward for wound dressings. She was also commenced on intravenous fluids, antibiotics as well as analgesics.

38. Given her poor prognosis, Ms Cook's treating clinician decided to focus her care on comfort care. On 20 July 2017, she was transferred to Eastern Health Wantirna Palliative Care Inpatient Unit, and dementia was formally diagnosed.

39. Ms Cook's condition deteriorated, and she eventually ceased all oral intake. She became less responsive over the course of the week and passed away on 28 July 2017.

Identity of the deceased

40. On 28 July 2017, Margaret Alice Cook, born 23 December 1928, was visually identified by her friend, Glenys Tarrant.

41. Identity is not in dispute and requires no further investigation.

Medical cause of death

42. On 31 July 2017, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of Margaret Alice

[25] CF, Eastern Health - ED Electronic Notes EH 290132, page 3.

Cook. Dr Francis also reviewed the computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83) and E-Medical Deposition Form. Dr Francis provided a written report of her findings dated 4 August 2017.

43. At examination, Dr Francis noted Ms Cook had a body mass index (**BMI**)[26] of 12 kg/m² and a pressure ulcer over the sacrum but none identified over the heels.

44. The post-mortem CT scan revealed evidence of severe emaciation with cardiomegaly and coronary artery calcification, as well as cerebral atrophy.

45. Dr Francis ascribed the medical cause of death to 1(a) complications of a stage 3 sacral pressure ulcer in a woman with dementia.

FURTHER INVESTIGATIONS

Response by Crofton House

46. On 11 April 2018, the Court received a statement from one of Crofton House's Managing Directors, Craig Baker, in response to a previous request for further information. Mr Baker advised that he had recently taken over Crofton House's ownership in October 2017 and provided his statement based on records held at the facility.

47. Mr Baker reported that the care provided to Ms Cook appeared diligent and carried out consistently. He confirmed staffing levels at the time adhered to the relevant ratio and all PCAs were accredited with Certificate III in Personal Care and First Aid.

48. Mr Baker outlined that Ms Cook had *"declined rapidly after the succession of falls, both physically and mentally"* and explained that she was admitted to BHH for further treatment and care. Other than noting that Ms Cook's food was required to be cut up as part of her ongoing support plan in March 2017, Mr Baker did not address if at any point of her falls, her care plan was markedly reconsidered or updated. He noted that the ongoing care plans were entered "sporadically and out of chronological order at times"

[26] Body Mass Index is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²). According to the World Health Organisation, the normal range is 18.5 to 24.99 kg/m². 14 kg/m² is classified as underweight.

49. Moreover, when asked about the pressure injury prevention that Crofton House had implemented, Mr Baker stated Ms Cook was provided a doughnut cushion, and her ongoing care plan recorded that PCAs were instructed to reposition her from right to left side. Mr Baker indicated that he could not find details of any specialist wound care and management service being engaged.

50. Mr Baxter provided further that he *"cannot comment if there was a consideration of the need to transfer [Ms] Cook to a residential aged care facility"* in light of her increased level of care as he could not locate any relevant information about such consideration.

Response by Dr Islam

51. As mentioned, Dr Islam, who was Ms Cook's primary GP, was also requested to provide a statement in response to his care and management. At the time of Ms Cook's death, Dr Islam practised as a GP in a skin care clinic. He attended Crofton House as well as other local RACF. He began attending Crofton House following a request by Crofton House's then care manager to see several residents in September 2015. Dr Islam did not detail the method(s) of request or the frequency of his visits. From the available evidence, it appeared that Dr Islam's requests were mainly by facsimile. He did not have a fixed day for visits and appeared to attend Ms Cook monthly and very rarely weekly.

52. When asked about Ms Cook's overall functional and cognitive ability decline when under his care, Dr Islam noted that Ms Cook had *"quite a number of falls"* as early as the time she commenced living at Crofton House. He also outlined that Ms Cook's *"frailty and [her] general decline continued with increased cognitive impairment, increasing depression and decreased mobility"*.[27]

53. According to Dr Islam, Ms Cook developed a bed sore on the back and sacral area in April 2017. Apart from noting that Crofton House staff advised him of an infected bed sore on 27 April 2017, Dr Islam did not detail when the bed sore was very first observed but outlined that the bed sore was eventually "resolved" *"with good care, frequent turnovers, do[ugh]nut cushion management and diligent wound care management"* under his instructions throughout April to May 2017. His progress notes recorded the bed sore was healed by the time he attended Ms Cook on 25 May 2017.

[27] CF, Statement of Dr Hossain Islam dated 28 June 2018.

54. Dr Islam explained further that the major contributing factors to Ms Cook's subsequent pressure ulcer were her immobility and malnutrition. He considered that in addition to those risk factors, her dementia and "lack of interest in food caused her condition to be irreversible and medical care unable to be improved".

CPU Review

55. As part of its review, the CPU considered the Court File, which consisted of, *inter alia,* Ms Cook's medical records, the VIFM forensic pathology report and statements from treating clinicians and carers.

56. The CPU considered there was an overall apparent lack of planning of Ms Cook's care in light of her increased needs and care due of her declining cognitive capability.

57. Prior to moving to Crofton House in January 2013, Ms Cook was assessed by an Aged Care Assessment Service (**ACAS**) as suitable for low-level residential aged care. There is no evidence to support that further ACAS assessments to reassess Ms Cook's suitability to reside in a low-level care facility were conducted, as well as when Crofton House was informed that Ms Cook required high-level care in January 2017.

58. The CPU advised that it is unable to determine whether Crofton House had adequately met her care needs, given the level of care provided to Ms Cook lacked sufficient detail in terms on the level and skill set of the staff.

59. Similarly, the CPU cannot determine whether there could have been any particular intervention(s) to change Ms Cook's outcome as there was no precise dementia diagnosis until Ms Cook was at the end of her life.

60. Despite that, the CPU considered there were some missed opportunities to improve Ms Cook's quality of life, particularly, her end-of-life-care, which could have been done by initiating advance care plannings when she had the capacity to do so.

61. The CPU noted Ms Cook was at risk of developing a pressure injury due to her age, malnourishment, (urinary and faecal) incontinence and long periods of immobility that occurred secondary to her fall and fractured left shoulder. The CPU also noted that given Ms Cook's risk factors, the wound care and management would ideally have been managed by a nurse in consultation with Dr Islam.

62. The CPU advised it could not to pinpoint to what degree and extent each factor had contributed to her pressure ulcer, as it is difficult to determine the time it takes for a pressure ulcer to develop. Medical literature reveals that a pressure ulcer can develop within hours to days which is important for continued vigilance, especially when a person is immobile.

63. While the evidence gathered in the coronial investigation indicated that Dr Islam had provided PCAs instructions to manage her pressure ulcer, the CPU considered Dr Islam's monthly attendance sub-optimal and that he was too optimistic in relying on Crofton House PCAs to manage and care for Ms Cook, especially given she was of high risk in developing pressure ulcers.

FURTHER RESPONSES

Department of Health and Human Services

64. In light of the ambiguity of evidence from Crofton House and the different service that each SRS may provide[28], I determined to seek further clarification directly from the DHHS. The DHHS were asked whether they had a framework in place for escalating medical care when the needs of an SRS resident change. Specifically, whether there is an expectation on SRS staff to identify when a resident's needs evolve from low-care to high-care and whether the onus is on SRS staff to facilitate changes to the resident's care.

65. The DHHS responded by detailing that SRS are private businesses that provide accommodation and personal support for people with varying support needs and are regulated by the Secretary to the DHHS. The DHHS is responsible for the registration and regulation of SRS to ensure that the services provided for the care and wellbeing of residents are in compliance with the statutory requirements as set out in the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) ("SRS Act") and *Supported Residential Services (Private Proprietors) Regulations 2012* ("SRS Regulations"). The DHHS also meets its responsibilities by providing guidance and advice to SRS proprietors.

66. The DHHS referenced the SRS Act and SRS regulations and advised that these legislative frameworks set out the obligations of SRS proprietors to respond appropriately to the deterioration in a resident's health. Notably, Sections 60(1) and 61(1) of the SRS Act provide that *if a proprietor is, or ought reasonably to be, aware that a resident is in need of more*

[28] At the time of Ms Cook's death, the DHHS' website outlined SRS facilities were privately operated businesses that provided accommodation and support for people requiring assistance with daily living activities, with the proprietors themselves to determine the service offered and fees structure.

health care or personal support than can be provided by their facility, the proprietor must take all reasonable steps to ensure appropriate health care or personal support[29] *is provided to the resident*. A failure to comply with these obligations is an offence.

67. Moreover, if the proprietor is unsuccessful in securing the provision of appropriate health care or personal support for a resident after taking all reasonable steps, the proprietor must notify the DHHS without delaying the resident's needs.

68. The DHHS further detailed that if they received notification from a proprietor outlining that their facility has not been able to ensure appropriate health care or personal support, the DHHS will first make enquiries and assess how the resident's needs may best be met.[30] Following this assessment, the DHHS must take steps to refer the resident to appropriate healthcare professionals and make arrangements to relocate the resident.

69. The DHHS stated that while it is expected all SRS meet statutory obligations, they stated that "an analysis of regulatory practice data identified that staff working in SRS and providing personal support to residents may lack the knowledge and skills to support the early identification of health deterioration in a resident".

70. In order to address the identified risk, at the time of their response, the DHHS advised that they had allocated funds for education and additional training for the SRS sector, including modifying the delivery of the SRS training package at La Trobe University. The training package, "*Recognising and reporting changes in residents' health",* was developed by Australian Centre for Evidence Based Aged Care to support Personal Care Workers and Personal Care Assistants in recognising changes in a resident health status and reporting changes to the appropriate person in a care facility.[31]

71. When asked about whether it was an expectation that SRS staff would manage wound care for a pressure ulcer, in the absence of a registered nurse, the DHHS advised that "SRS are accommodation settings which provide some personal support services" and as such, SRS

[29] Personal support is defined under the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) ("SRS Act") to include a range of supports such as assistance with personal hygiene, support to seek out and maintain contact with health professionals and assistance with or supervision in administering medication.

[30] Section 62 of the SRS Act.

[31] La Trobe University, *Recognising and reporting changes in residents' health: an education and training package for aged care facility staff* (webpage) <https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care/workshops-and-training-packages/recognising-and-reporting-changes-in-residents-health>.

facilities are not a clinical environment. This is also because majority of SRS do not employ staff with clinical backgrounds.

72. Nonetheless, if a resident developed a wound from a pressure area, the DHHS explained that the expectation of the Department would be upon the SRS proprietor to arrange a review from an appropriate healthcare professional and nursing services to attend the SRS for ongoing wound management, as well as facilitate access to any other recommended healthcare services.

73. The DHHS advised that the SRS Act outlines a list of relevant requirements on proprietors relating to the provision of health and personal support to SRS residents. A failure to comply with the requirements is also an offence under the SRS Act.[32]

State Trustees

74. As mentioned, given the State Trustees were Ms Cook's EPOA, I requested the State Trustees to clarify whether they have an expectation to be informed of her increasing healthcare requirements and deteriorating health.

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[32] SRS Act (n 31) s 57.

(1) Within 28 days after a person becomes a resident, the proprietor, in consultation with the resident and, if appropriate, the person nominated, must cause the resident's interim support plan to be reviewed and expanded into a written document to be called the resident's on-going support plan that includes—
(a) the on-going health and personal support needs of the resident; and
(b) the services to be provided to the resident to assist with those needs.
…
(2) The proprietor must cause a resident's on-going support plan to be reviewed and updated at least once every 6 months.
…
(3) If the resident's health and personal support needs change, the proprietor must ensure that the on-going support plan is reviewed and changed as necessary to meet those changed needs of the resident.
…
(4) The proprietor must ensure that any change to a resident's on-going support plan is prepared in consultation with the resident and, if appropriate, the person nominated.
…
(5) The proprietor must ensure that consultation occurs with the resident's health service providers in the preparation of—
(a) a resident's on-going support plan; and
(b) any changes made to that plan.
…
(6) The proprietor must ensure that a resident's on-going support plan is carried out in accordance with that plan as prepared.
…
(7) When requested, the proprietor must cause a resident's support plan and any changes made to it to be made available to—
(a) the resident;
(b) the person nominated;
(c) the resident's health service providers.
…

75. State Trustees responded by providing that Ms Cook became a client of State Trustees on 31 January 2013 when she instructed them to prepare EPOA and named them her sole attorney. State Trustees advised that the EPOA allows them to only make financial and property-related decisions on Ms Cook's behalf. They have no authority under that EPOA to make medical, lifestyle or personal matter decisions.

76. Furthermore, State Trustees explained that when Ms Cook's healthcare requirements increased due to deteriorating health, their role limits to applying her funds towards additional or increasing healthcare-related expenses.

77. State Trustees were also asked if they would have expected to play a role in appointing a Public Advocate for Ms Cook once she ceased to have the capacity to make decisions about her medical treatment. State Trustees advised that they are only expected to play such a role when a client has no other relevant support, or when they are alerted to a manifest need for such an appointment, as anyone can make an application to the Victorian Civil and Administrative Tribunal (**VCAT**) for appointment of a guardian.

78. State Trustees explained that generally, family, friends, medical practitioners, carers, accommodation providers or other support persons would be first considered to initiate the application. Moreover, State Trustees advised that when a client has regular attention from a medical practitioner, they would not be expected to play an active role in initiating contact with VCAT to appoint a guardian with the power to make medical treatment decisions.

Office of the Public Advocate

79. As part of my further investigations, several lines of inquiry were explored relating to the absence of a legal guardian and who, if anyone, was responsible for ensuring Ms Cook was adequately represented in relation to decisions pertaining to her medical care.

80. The Office of the Public Advocate (**OPA**) was requested to clarify what were the expectations of the OPA in relation to the responsibility of State Trustees, medical practitioners or any other person to notify the OPA of someone in need of their services.

81. OPA later responded with a letter dated 2 October 2018. OPA advised that if the provision of medical or other treatment related to consent as then defined in Part 4A of *Guardianship and Administration Act 1986* (Vic)[33] ("the G&A Act"), OPA would have expected to receive a

[33] Authorised Version incorporating amendments as of 1 November 2017

notice under section 42K[34] of the same Act. OPA explained that its formal responsibility was to accept the notice if the treatment met the criteria set out in that section.

82. Additionally, OPA's role in assessing the criteria would be contacting the person submitting the form and then would have inquired about a person's circumstances. However, if the medical treatment relates to the administration of pharmaceutical drugs for any condition, OPA will not be expected to be contacted.

83. OPA noted Ms Cook lacked the capacity to make medical treatment decisions and thus, the relevant and applicable legislative framework at the time would empower a *"person responsible"* [35] to consent in the person's best interests to undergo any medical or dental treatment.[36]

84. When there was no person responsible available, there was an authorisation process set out in section 42K of the G&A Act, which provided a registered practitioner *"may carry out, or supervise the carrying out of, medical or dental treatment under this section without the consent of the person responsible if they had made reasonable efforts to identify a person responsible"* and *"if the practitioner ascertains who the person responsible is, to contact that person to obtain his or her consent to the proposed treatment".*

85. However, in the event that a person requires medical or dental treatment[37] and the registered practitioner has been unable to ascertain whether there is a person responsible or who that person is or to contact that person, the registered practitioner with the reasonable belief that the proposed treatment is in the person's best interest, was required to give notice to the Public Advocate before carrying out or supervising the relevant medical or dental procedure.[38]

86. OPA advised that their office did not receive any section 42K notices relating to Ms Cook.

87. In terms of the OPA's expectation concerning State Trustees' responsibilities, the OPA advised that State Trustees would only liaise with their office if they have identified concerns

[34] Medical or dental treatment without the consent of person responsible.
[35] Part 4A of the *Guardianship and Administration Act 1986* ("the G&A Act") provides a hierarchical list of persons available, willing and able to consent as a means of defining a *person responsible*. The G&A Act and part specifically 4A has subsequently been repealed by the *Medical Treatment Planning and Decision Act 2016.*
[36] Ibid s 3, definition of medical or dental treatment.
[37] As defined in the G&A Act.
[38] G&A Act (n 36) s 42K(1) and 42K(2).

about the care and support of a client. If such concerns are verified, a Public Advocate may initiate an investigation into whether a person is in need of guardianship.[39]

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. While an expert was not commissioned to provide an opinion on the care and management Ms Cook received from Crofton House, I have the benefit of utilising senior medical specialist in Geriatric Medicine, Professor Joseph Ibrahim's expert report provided to a similar coronial matter. The matter was previously investigated by Victorian Coroner Jacqui Hawkins, where a 86-year-old woman, Adele Di Quinzio, who was also a SRS resident died as a result of pressure ulcer related complications.[40] I am mindful that the expert report was specifically tailored to the circumstances of that matter. I aim to highlight and discuss Dr Ibrahim's report from a general viewpoint concerning pressure ulcer care and management in SRS facilities.

2. Professor Ibrahim highlighted that although the DHHS *"use a range of activities to monitor a SRS [facility's] compliance with the SRS Act and SRS regulations"*, a detailed description of what the standards entail, particularly standards pertaining to a SRS resident returning to a facility following a hospital admission, including the assessment, prevention and management of pressure injury are not detailed in the relevant legislation. Therefore, the responsibility of instituting relevant management policies and procedures, and resources to manage residents' health conditions ultimately lies with the management and executive.

3. I am unable to discern from the available evidence the appropriate number and skills of staff rostered to work on any given shift during the period when Ms Cook required wound care and management. I am also unable to discern the relevant policies or procedures employed by Crofton House about pressure area monitoring and management when Ms Cook developed a bed sore. As a result, I cannot be satisfied that every precise element of wound care as promised by Crofton House and the geriatric care identified by the BHH OT were delivered.

4. Crofton House's inconsistent representations about their capabilities to accommodate Ms Cook's care needs upon her discharge should be balanced against the reliability of the evidence given by Mr Baker and the overall capacity of Crofton House in managing a complex

[39] G&A Act (n 36) s 16(1)(h).
[40] Coroners Court of Victoria (**CCOV**), *Finding into the Death of Adele Di Quinzio Without Inquest*, COR 2016 4948 (Webpage, 30 January 2020) < https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=adele+di+quinzio>.

care resident like Ms Cook. It is evident that from the available evidence that Crofton House was not equipped with the necessary pressure injury prevention equipment as represented by its then manager, Kim. Crofton House staff conceded they had been struggling to manage and care for Ms Cook, and there were no bed hoists and inflatable mattress available at the facility. This was the very reason that staff eventually decided to escalate Ms Cook's wound care and management when her pressure ulcer developed to stage three.

5. In view of the above, I intend to distribute this Finding to the Department of Families, Fairness and Housing, the Department currently responsible for Victorian Supported Residential Service to inform their regulatory activities and consider auditing Crofton House in relation to its compliance with the relevant statutory requirements.

6. I make no adverse comment about the role of the State Trustee who was under the impression that Ms Cook was appropriately supported by Dr Islam and Crofton House. Similarly, the Office of the Public Advocate did not receive a section 42K notification which would have been enabled them to intervene and likely escalate Ms Cook's care.

7. I also accept that Dr Islam was not required by law to make a section 42K notification to the Office of Public Advocate when he commenced Ms Cook on a "palliative care approach"[41]. The *Medical Treatment Act 1988* defined palliative care as the *provision of reasonable medical procedures for the relief of pain, suffering and discomfort*[42]; and the definition of medical or dental treatment in the *Guardianship and Administration Act 1986* did not include *the administration of a pharmaceutical drug*[43]. The available evidence did not suggest Dr Islam undertook a medical procedure when he commenced Ms Cook on palliative care.

8. Dr Islam's palliative care approach appears to have been compliant with the law however, I am less confident that all of Dr Islam's decisions about Ms Cook's medical treatment were in her best interests and/or whether they were made at the time when she still had the capacity to consent to the same. On the evidence available to me, it appears that Dr Islam had a limited understanding in terms of facilitating coordination and continuity of patient care. A more robust understanding would have ensured Ms Cook's rights and dignity were respected.

9. These unfortunate circumstances equate to a missed opportunity to bring Ms Cook's circumstances to the Public Advocate's attention.

[41] See paragraph 29.
[42] Section 3 of the *Medical Treatment Act 1988.*
[43] G&A Act (n 36) s 3, definition of medical or dental treatment, subsection (g).

Advance care planning / Current legislative requirement

10. In a time where many people live into advanced old age with multiple comorbidities, making care goals and decisions are essential to balance quality of life. Importantly, amongst all the desirable outcomes, the making of an advance care directive (also known as advance care plan), can lead to the appointment of a medical treatment decision maker. Section 26(2)(a) of the *Medical Treatment Planning and Decisions Act 2016* now provides that *an appointment as an appointed medical treatment decision maker may be made at the same time as an advance care directive is given.*

11. The process of advance care planning should ideally be initiated before a person requires community (or residential) aged care services[44], at a time when they have the capacity, rather than leaving it to the point that may be infeasible, as in the case Ms Cook. What also complicated her medical treatment was that she had no surviving relatives or an appointed medical decision maker. The relevant legislations[45] in force at the time required the person responsible, a spouse or domestic partner, primary carer or nearest relative included, to be appointed in writing. I note that the relevant sections of those legislations have been subsequently repealed. Section 55 of the *Medical Treatment Planning and Decisions Act 2016* now provides that when a patient does not have an appointed medical treatment decision maker and a guardian appointed by the Victorian Civil and Administrative Tribunal, a patient's spouse or domestic partner, primary carer[46], adult child, parent or adult sibling may make medical treatment decision(s) if he or she is reasonably available and willing to make the decision(s).

12. My investigation further highlights the unique and integral roles of general practitioners in promoting and facilitating advance care planning, especially in Ms Cook's circumstances. A general practitioner, such as Dr Islam is well placed to initiate advance care planning at an

[44] Advance Care Planning Australia, *Advance care planning and aged care*, (webpage) <https://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-areas/advance-care-planning-and-aged-care>.

[45] G&A Act (n 36) s 37; *Medical Treatment Act* (n 42) s 5A.

[46] According to section 3 of the *Medical Treatment Planning and Decisions Act 2016*, "primary carer" of a person means an adult who—

(a) is in a care relationship with the person; and

(b) has principal responsibility for the person's care.

opportune and early time by virtue of their long-term relationship and intimate knowledge of their patients.

13. I acknowledge and commend the continuous efforts of the Royal Australian College of General Practitioners (**RACGP**) in advocating the importance of incorporating advanced care planning into routine general practice. However, in considering Ms Cook's circumstances and the additional utility of making an advance care directive as mentioned above, it is desirable that general practitioners should be reminded of the same.

14. Accordingly, making a Recommendation is appropriate in the circumstances.

Previous Recommendations

15. I endorse Coroner Hawkins' Recommendations, notably, Recommendations 3 and 4, made as a result of the investigation into the death of Mrs Di Quinzio.

> *Recommendation 3: I recommend that Ms Kym Peake, Secretary of Department of Health and Human Services develop and distribute education material to Supported Residential Services with the aim to inform them about the importance of the prevention, identification and management of pressure injuries in their residents.*
>
> *Recommendation 4: I recommend that Chief Executive Officer of Eastern Health, Maroondah Hospital arrange to provide refresher training to staff responsible for admitting and discharging patients to ensure that they are aware of the differences in types of agreed care facilities; such as the difference between a nursing home and Supported Residential Services and their respective levels of care.*

16. Given Eastern Health and Department of Fairness, Families and Housing's responses to Coroner Hawkins' Recommendations, I am satisfied that the preventative issues in this matter were adequately addressed. I determine to not make further Recommendations to Eastern Health[47] and the Department of Fairness, Families and Housing.[48]

[47] Mrs Di Quinzio was discharged from Maroondah Hospital before her death. Maroondah Hospital is also a member of Eastern Health.
[48] CCOV (n 41).

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation:

1. In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Royal Australian College of General Practitioners consider using Margaret Alice Cook's matter as a case study to highlight the utility of the making of an advance health directive as part of general practice education and general practitioners' obligations under the *Medical Treatment Planning and Decisions Act 2016*.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Margaret Alice Cook, born 23 December 1928;

   b) the death occurred on 28 July 2017 at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152;

   c) I accept and adopt the medical cause of death ascribed by Dr Victoria Francis, and I find that Margaret Alice Cook, a woman with a medical history of dementia, died as a result of complications of a stage 3 sacral pressure ulcer.

2. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explication.[49] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

3. While there is cogent evidence of suboptimal wound care and management provided by Crofton House, there is no doubt Margaret Alice Cook's pre-existing physical vulnerabilities all played a part in the development of her pressure ulcer and her subsequent death. The

[49] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".

Coroners Prevention Unit informed me no single causative factor led to the occurrence and development of a pressure ulcer.

4. Consequently, I am unable to find how different clinical courses would have changed the approach taken and whether they might be outcome changing for Margaret Alice Cook had her pressure ulcer been treated more promptly or had her nutritional status been managed more appropriately. The answer to this question is complex and multifactorial. I am also unable to find whether her death was preventable.

5. The available evidence, however, supports a Finding that Crofton House failed at the earliest opportunity to escalate Margaret Alice Cook's complex and increasing care. Escalation did not occur until she required palliation, and this represents an opportunity lost to improve her quality of care.

6. The weight of the available evidence also supports a Finding that Crofton House misrepresented its capabilities and as such failed to provide the necessary pressure ulcer prevention equipment.

7. AND FURTHER, I am satisfied that Crofton House has been given reasonable notice of the content and scope of my adverse comments and Findings and was afforded a reasonable opportunity to respond timeously to mitigate my adverse comments and Findings.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Glenys Tarrant

Crofton House

Dr Hossain Islam

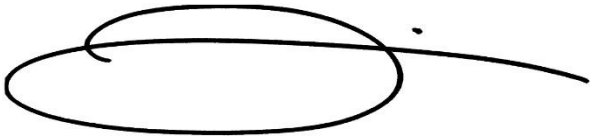
Department of Families, Fairness and Housing

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Royal Australian College of General Practitioners

State Trustees Limited

Signature:



AUDREY JAMIESON

CORONER

Date: 22 March 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.