IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2022 005792**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | AUDREY JAMIESON, Coroner |
| Deceased: | Arto Aaro Bohm |
| Date of birth: | 1 January 1948 |
| Date of death: | 9 October 2022 |
| Cause of death: | 1a: Sepsis secondary to infected pressure wounds (necrotising fasciitis) in a man with multiple medical co-morbidities |
| Place of death: | Sunshine Hospital Furlong Road, St Albans, Victoria, 3021 |
| Keywords: | Residential aged care facility, pressure injury, pressure wound, bed sores, dignity of risk, refusal of treatment |

## INTRODUCTION

1. On 9 October 2022, Arto Aaro Bohm (**Arto**) was 74 years old when he died in hospital. At the time of his death, Arto lived at Doutta Galla Footscray Aged Care Home in Footscray, Victoria.

2. Arto was born in Finland to Waro Kullervo Bohm and Tynne Liinatainen. In 1960, Arto immigrated to Australia and worked as a mechanical engineer, including for the National Service. He was a creative individual and his hobbies included knitting, sewing, photography and repairing cars.

Transfer to Doutta Galla

3. Arto previously lived with his mother in Bendigo until her death in June 2021. He continued to live alone and received formal support at home.

4. On 7 October 2021, the Victorian Civil and Administrative Tribunal (**VCAT**) appointed a Public Advocate as Guardian for Arto. VCAT gave the Public Advocate authority to determine where he lived, and whether any services were needed and if so which ones.

5. The order was made in light of Arto's multiple medical comorbidities and '*history of not accepting medical and nursing interventions including non-attendance to Outpatient Wound clinic for wound dressing and management'.* His desire to enter a residential aged care facility fluctuated. He appealed VCAT's decision but was unsuccessful.

6. On 2 February 2022, Trish Amore (**Ms Amore**) of the Office of the Public Advocate (**OPA**) was appointed as Arto's guardian. Ms Amore was granted power regarding Arto's accommodation and financial matters, but not his medical treatment.

7. On 22 February 2022, Arto was placed at the Doutta Galla Aged Care facility (**Doutta Galla**) in Footscray for an initial respite period of 40 days. On 23 March 2022, the Residential Services Manager of Doutta Galla contacted Ms Amore to advise that Arto's care needs were too complex, and he was not suitable for the facility. Several other aged care facilities were contacted but none were able to accommodate him, and so Arto remained at Doutta Galla.

8. Arto had sporadic contact with his sister, Aira Kemister, and nephew, Benjamin Kemister. However, they were not involved with care or associated decision making.

Medical History

9. Arto had several medical conditions including Type 2 Diabetes Mellitus, urinary and faecal incontinence, obesity, chronic lower back pain, chronic wounds/ulcers and lymphoedema to his lower limbs, Type 2 respiratory failure, bipolar affective disorder and schizoaffective disorder. He required assistance for all daily tasks.

10. Arto experienced reduced mobility and used a wheelchair to self-propel. He often insisted on sleeping in his wheelchair overnight. According to Doutta Galla, this arrangement *'exacerbated his wound issues and made treatment difficult'*.

11. By all accounts, Arto was a difficult resident and was *'often physically aggressive and verbally abusive towards staff and others'*. Such behaviours often arose when Doutta Galla staff attempted to initiate care, leading to Arto frequently refusing assistance with his daily living including personal hygiene, medication, transfer to bed and wound care. These difficulties were well documented by Doutta Galla staff, clinicians and Arto's Public Advocate, Ms Amore.

12. Between April and October 2022, Arto was admitted to Footscray Hospital on eight occasions. The admissions ranged between three and 17 days in duration and were most often associated with his respiratory failure. In June and July 2022, Arto's admissions were also due to a bleeding left leg ulcer and pressure wound, respectively.

## THE CORONIAL INVESTIGATION

13. Arto'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.

14. 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.

15. 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.

16. This finding draws on the totality of the coronial investigation into the death of Arto Aaro Bohm. 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.[1]

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

### Circumstances in which the death occurred

17. On 7 July 2022, an enrolled nurse at Doutta Galla identified a pressure wound on Arto's right buttock. The wound was *'broken with low bloody discharge'*, it was cleaned, and a dressing was applied. A wound chart was commenced.

18. On 9 July 2022, a general medical practitioner (**GP**) reviewed Arto and noted the pressure wound to his buttock, and pre-existing wounds. The GP advised to proceed with *'pressure sore management per nursing home'* and to *'review as required'.*

19. From 11 to 21 July 2022, Arto was hospitalised with respiratory failure and for management of his pressure wounds. In the discharge summary, Western Health noted that Arto was at *'very high risk of pressure injury'* and advised Doutta Galla to *'tilt patient from side to side every hour'*. Clinicians also provided directions for topical treatment of the wounds.

20. On 25 July 2022, Arto's buttock wound was re-assessed and was *'healing well'*. The wound chart was closed and completed. However, there remained several wounds to both of his legs (upper and lower) and left heel. According to Doutta Galla's wound chart, these wounds often featured macerated skin, heavy exudate and an offensive smell.

21. On 12 September 2022, due to Arto's worsening lower leg wounds, Doutta Galla's Clinical Care Coordinator referred him to his GP and a Registered Nurse wound specialist.

22. On 15 September 2022, the Behavioural and Specialist Intervention Consultation Services (**BASICS**) of Western Health consulted with Arto for ongoing psychiatric assessment.

[1] 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.

BASICS clinicians assisted Doutta Galla staff by suggesting measures to manage Arto's defiant behaviour and mental health diagnoses. The BASICS staff also told Doutta Galla staff that Arto required *'specialist equipment'* including a specialised wheelchair, bariatric bed and pressure mattress in order to assist in the management of his pressure injuries.

23. On 19 September 2022, the wound specialist reviewed Arto. The wound specialist recorded the wounds to Arto's lower legs had *'pus/odour/redness/swelling ++++++++'* and had a *'high chance of infection'*. The wound on Arto's left heel was categorised as a stage 3 pressure wound, which was also infected. He also identified a wound to Arto's sacrum – on the right buttock. It demonstrated *'active bleeding'* and *'maceration and excoriation'* and it was red and irritated and possibly infected. The wound specialist outlined care plans for each of the wounds, featuring a varying mix of cleaning, exfoliation, topical products and dressings. A follow-up appointment was scheduled for two weeks' time, however, this did not occur as Arto was hospitalised at that time.

24. During the following days, from 20 to 25 September 2022, Arto demonstrated defiant behaviours. He refused to take his medication, let staff clean him after episodes of incontinence or apply wound care. In some instances, staff were able to persuade him to comply, though at other times, they were unable to do so.

25. Staff continued to monitor Arto's leg and heel wounds. However, it was not until six days after the wound specialist assessment, on 25 September 2022, that an Initial Wound Assessment was completed regarding his sacral wound. It was an additional four days later, on 29 September 2022, that a wound chart was commenced. By this time, Arto's sacral wound was unstageable and, according to an entry by a registered nurse, had a *'foul smell like dead flesh'*.

26. Over the following days, Arto continued to sleep in his wheelchair most nights. Arto's sacral wound was checked at 4:30pm on 30 September 2022, and at 1:00pm on 1 October 2022 – minimal notes were recorded on these occasions. His other wounds were also checked. His heel appeared black, with macerated skin[2] and an offensive odour. The wounds on Arto's legs were red in appearance, with purulent or haemoserous exudate, an offensive odour and similarly macerated edges.

[2] Defined in the wound chart to refer to *'softening breakdown of the skin'*.

27. From 1 to 2 October 2022, Arto slept in his wheelchair overnight and throughout the day, demonstrated defiant behaviour. Eventually, staff were able to give Arto a sponge bath and transferred him to bed.

28. On 3 October 2022, staff contacted Arto's GP. Arto had consumed little food over the weekend, had poor vital signs and his hands and feet were cold to the touch with a purple colour. The GP advised Doutta Galla staff to contact emergency services. At approximately 5pm, an ambulance arrived and transported Arto to Sunshine Hospital.

29. In the emergency department, clinicians noted that Arto had decreased oral intake over several days, functional decline and remained resistant to care. He had lost weight and was bed-bound. They observed the pressure wound on his sacrum was *'large'* and *'necrotising'* with *'sloughy edges'*. His leg wounds were bandaged and oozing.

30. Clinicians determined it was appropriate to transition him to palliative care. On 9 October 2022, Arto was declared deceased.

**Identity of the deceased**

31. On 12 October 2022, Arto Aaro Bohm, born 1 January 1948, was visually identified by his sister, Aira Kemister, who completed a Statement of Identification.

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

**Medical cause of death**

33. Forensic Pathologist Dr Judith Fronczek (**Dr Fronczek**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Arto Bohm. Dr Fronczek considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan, e-Medical Deposition Form completed by Western Health and notes from the Doutta Galla aged care facility and provided a written report of her findings dated 19 October 2022.

34. The post-mortem CT demonstrated a skin defect of the right buttock, with subcutaneous emphysema of the right buttock, both upper legs (predominantly the right), and the scrotum. The post-mortem examination was consistent with the CT findings. Dr Fronczek identified extensive necrotising pressure sores of the right buttock, extending to the right side of the perineum/scrotum and right groin. There were also necrotising pressure sores on both heels.

35. There was no radiological evidence of osteomyelitis.

36. Dr Fronczek provided an opinion that the medical cause of death natural causes, due to 1(a) SEPSIS SECONDARY TO INFECTED PRESSURE WOUNDS (NECROTISING FASCIITIS) IN A MAN WITH MULTIPLE MEDICAL CO-MORBIDITIES.

## DOUTTA GALLA'S MANAGEMENT OF ARTO'S WOUNDS

37. The Court sought a statement from Doutta Galla regarding the treatment provided to Arto during his residence, with particular focus on their management of his wounds, and of their broader policies regarding the same. Statements were provided by Fiona Fisher (**Ms Fisher**), General Manager of Extended Care Services and by Jacquelene O'Brien (**Ms O'Brien**), Executive Manager of Strategy, Quality and Innovation.

Pressure Wound Risk Assessments

38. Doutta Galla's *'Wound Management Policy and Procedure'* addresses skin risk assessments and states, *'a skin assessment is conducted using the Waterlow Pressure Ulcer Risk Scale'* and that a *'skin integrity assessment'* should also be completed. The policy outlines that the results of these assessments is to inform the care provided to residents. However, it does not state when these assessments should occur.

39. Records from Doutta Galla indicate that staff performed a Waterlow risk assessment on 27 June 2022. Risk factors included that Arto was obese, elderly, had peripheral vascular disease, was immobile and occasionally incontinent. The assessment gave a score above 20 indicating a *'very high risk of pressure ulcer'.*

40. On 27 September 2022, the Waterlow risk assessment was repeated. Arto's risk factors had increased – such as from *'occasionally incontinent'* to *'doubly incontinent'* – and he again scored over 20.

41. Arto's increased risk of pressure wounds was also identified by Western Health staff in July 2022. In the corresponding discharge summary, clinicians wrote he was *'very high risk of pressure injury'.*

Preventative measures adopted

42. According to Doutta Galla's wound management policy, Arto's high risk scores on the Waterlow risk assessment indicated four hourly position changes, such as from lying to sitting (and vice versa) and the use of pressure reliving pillows. Ms Fisher also stated that Arto *'required positional changes every four to six hours from staff'*.

43. However, this contradicts directions from Western Health clinicians. In a discharge summary dated 21 July 2022, clinicians directed Doutta Galla staff to *'tilt patient from side to side every hour'.* There is no indication in Doutta Galla records that the frequency of Arto's position changes increased in response to the discharge summary.

44. According to Doutta Galla's wound management policy, residents who score above 10 on the Waterlow risk assessment are to receive an overlay or specialist pressure reliving device, such as a foam mattress, heel boot or roho cushion. There should be a 10cm foam cushion for their seating. Scores above 15 indicate alternating pressure inlays, mattresses and bed systems as well as a specialist gel and/or foam cushion for seating. Scores above 20 indicate bed systems such as a fluidised, bead, low air loss or alternating pressure mattress, and a seating cushion capable of being adjusted to suit individual residents.

45. The BASICS team also encouraged the use of equipment – specially a bariatric bed and bariatric wheelchair – to assist with pressure injury management. Progress notes indicate that Doutta Galla staff were able to obtain a bariatric wheelchair which Arto was *'seem[ed] happy with'.*

46. Ms Fisher and Ms O'Brien's statements do not address whether such measures were implemented. Doutta Galla's progress notes do not refer to any pressure injury prevention equipment – such as a cushion on Arto's wheelchair – being implemented to preserve his skin integrity.[3]

Treatment of Arto's sacral wound once it had developed

47. Records from the wound specialist appointment indicate that Arto had developed the sacral pressure wound as early as 19 September 2022. Indeed, by this time it was already macerated

[3] I note that in an entry by an osteopath on 9 June 2022, Arto is recorded as having refused an air cushion on his wheelchair. However, the cushion was intended as a method of post-acute care following Arto's fall the day prior, and not as a means to prevent the development of pressure injuries.

and potentially infected. There is no indication that Doutta Galla staff were aware of the wound prior to this appointment.

48. On 19 September 2022, at 5:50pm, the wound specialist entered his observations and care instructions into Arto's progress notes, able to be accessed by Doutta Galla staff.

49. On 22 September 2022, an endorsed enrolled nurse made a progress note which read, *'no dressing to be stuck on buttock wound according to wound specialist'* - indicating an acknowledgment by Doutta Galla staff of both the existence of Arto's sacral wound and of the wound specialist's instructions.

50. According to Doutta Galla's wound management policy, when a new wound is identified, staff should commence *'initial and ongoing comprehensive documentation'* which includes a wound chart and an entry in the resident's progress notes.

51. It was not until six days after the wound specialist appointment, on 25 September 2022, that an initial wound assessment was made. It took a further four days, on 29 September 2022, for staff to commence a wound chart.

52. The policy states that the wound chart is to capture various points of information: type of wound, aetiology, anatomical location, dimensions, clinical characteristics, wound edge and surrounding skin characteristics, exudate, phase of healing, signs and symptoms of infection, photos and associated pain.

53. On 29 September 2022, the wound chart was commenced and captured minimal information. For example, it did not record the size of the wound, the appearance of the wound's edges or surrounding skin, signs or symptoms of infection or associated pain. The wound chart entries on 30 September and 1 October 2022 contain similarly sparse information.

Treatment of Arto's other wounds

54. Wound charts were also kept for the wounds to Arto's left heel, back of his left leg, inner aspect of his right leg, right calf and the back of his upper right leg. During nurse reviews[4] of the wounds, various details were often not recorded – most often the dimensions of the wound and the pressure injury classification were left blank. Instead, subjective fields such as the appearance of the wound and surrounding skin, amount of exudate and odour were often documented. There were apparent inconsistencies in these subjective fields. For example, on

[4] The chart consisted of 'dressing checks' and 'RN/EN reviews'.

30 September 2022, the wound on Arto's left heel was recorded as *'black'* in colour, however, on 2 October 2022, it was recorded as *'green'* even though photographs captured on these dates demonstrate the wound was largely identical.

55. Records demonstrate that Doutta Galla staff were otherwise consistent in attending to the wounds on Arto's legs and heel, and in applying care and dressings as instructed.

56. On 12, 22 and 28 September 2022, Doutta Galla staff contacted Arto's GP due to his worsening lower leg wounds and significant weight loss (15kg). A statement provided by Arto's GP, Suren Haripersad (**Dr Haripersad**), did not discuss the advice he gave to Doutta Galla staff regarding Arto's management.

57. Ms O'Brien addressed Dr Haripersad's role in Arto's care. Dr Haripersad attended Doutta Galla weekly and spoke with the available senior staff member,[5] reviewed referrals for the resident and commenced his assessments and/or treatment. According to Ms O'Brien, Dr Haripersad *'often did not enter any information into the progress notes despite reviewing Arto'*.

## ARTO'S CAPACITY TO REFUSE MEDICAL TREATMENT

58. At the time of his death, Arto did not have an advanced care directive or substitute medical decision maker. Ms Amore, Arto's guardian, did not possess power to make medical treatment decisions on his behalf.

59. By all accounts, Arto was a difficult resident to manage. He often became physically violent and verbally abusive. There are several entries in the progress notes in which Arto refused treatment – including dressing changes and hygiene assistance – and yelled and swore at staff.

*60.* Throughout his residence at Doutta Galla, staff maintained that Arto had capacity to refuse medical treatment, including relating to his wounds. This conclusion was echoed by BASICS staff. Ms Fisher cited the facility's *'Dignity of Risk Policy'* and stated that *'staff respected Arto's independent decisions with respect to his care'*. According to Ms Fisher, *'residents have the right to make decisions that others feel are unwise or disagree with, they have the right to have a different tolerance for the risks associated with a decision and the right to fail after making a decision'*.

[5] The Clinical Care Coordinator, registered nurse or the Clinical Care Supervisor.

61. As a consequence, staff often obliged when Arto refused treatment. While they were occasionally able to persuade him into compliance, there are several documented occasions in which incontinence pads, daily hygiene, skin checks or wound dressings could not be tended to because of Arto's *'decision'*. By way of illustration, on 29 September 2022, at 1:34pm, staff recorded a progress note that Arto had been incontinent. Arto refused to engage with the staff member to change his pants, so it was not done. In a progress note that night, at 9:53pm, staff recorded that Arto remained in urine *'soaked'* clothes with an *'offensive smell'* that bothered other residents. It appears from these progress notes, that staff upheld Arto's decision with the consequence that he remained in urine-soaked clothing for several hours. In another instance, Arto was left for an unknown period of time with faeces on his hands because he refused to let staff wash them.

62. There is evidence which contradicts the position that Arto possessed capacity for medical decision making. Ms Fisher acknowledged that Arto's *'awareness with respect to the importance of care declined over time'* and Ms O'Brien similarly stated that Arto's *'capacity with respect to his decision-making fluctuated from day-to-day'*.

63. On 26 October 2021, Nurse Unit Manager Clinical Neuropsychologist and General Psychologist, Susan Lloyd (**Ms Lloyd**) wrote a report following an assessment with Arto. Ms Lloyd wrote that he had *'reduced capacity to fully comprehend the extent of his physical condition and cognitive limitations'* and concluded she *'[had] concerns about [Arto's] ability to make fully informed and reasoned decisions'.* This report pre-dates Arto's residence at Doutta Galla, accordingly, it is unclear whether they were aware of Ms Lloyd's conclusion.

64. In a statement provided by Western Health geriatrician, Kalyani Tharmarajah (**Dr Tharmarajah**), she recalled a medical assessment with Arto, which occurred on 31 August 2022. Dr Tharmarajah found that Arto had *'very limited insight into his medical conditions and their management and the consequences of suboptimal care.'* In the context of Arto's respiratory failure, she concluded that Arto *'*did *not appear to have capacity to make decisions about non-invasive ventilation therapy as he could not understand why it is given and its risks and benefits'.* She continued that Arto *'had limited understanding as to what constituted "an emergency" and was in the habit of refusing life-prolonging treatment even in dire circumstances'*.

65. Following her assessment, Dr Tharmarajah referred Arto to the BASICS team to *'ascertain mental state contributing to refusal of care'.* On 7 September 2022, a BASICS mental health

key clinician assessed Arto. The clinician concluded that Arto had capacity. He was re-reviewed on 15 September 2022, during which the BASICS team provided Doutta Galla with strategies to manage his difficult behaviour.

Escalation to a substitute medical decision maker

66. Ms O'Brien stated that *'in the absence of a doctor or mental health professional to involve a substitute decision-maker, Doutta Galla seeks to respect the choices of residents'.* Doutta Galla referred Arto to his GP on multiple occasions. However, due to poor record keeping during these visits, it is unclear whether Dr Haripersand turned his mind to consider whether Arto maintained capacity and would have benefitted from a substitute medical treatment maker. His statement does not address this point.

67. Doutta Galla did not inform Arto's guardian, Ms Amore, that he was refusing care. Since the OPA did not have decision making capacity regarding Arto's medical treatment, it was not within Ms Amore's powers to inquire into, monitor or explore Arto's medical treatment or advanced care wishes.

68. Michelle Long (**Ms Long**), of the OPA, explained what would have occurred had the OPA been advised of Arto's refusal of treatment:

> *'Where any issues of concern are raised by, or about, represented persons for whom the Public Advocate is guardian, it would be standard practice and in keeping with s 16 of the [Guardian Administration Act] 2019 for a guardian to provide advocacy around these issues to promote the person's interests and human rights'.*

69. And,

> 'Further, should a guardian be made aware that there are concerns the represented person may not have capacity to make decisions regarding nursing care and medical treatment, education would also be provided regarding alternative pathways for substituted consent to medical treatment'.

70. On 22 July 2022, a clinical nurse consultant from the Western Health Aged Care Liaison Service reviewed Arto. According to Dr Tharmarajah, the clinical nurse consultant confirmed that Arto did not have an advanced care directive in place. Dr Tharmarajah suggested *'that this be reviewed in conjunction with his GP and Office of the Public Advocate Guardian, Trish Amore'.* It is unclear whether this review occurred.

## ACTIONS TAKEN BY DOUTTA GALLA SINCE ARTO'S DEATH

71. Doutta Galla did not review Arto's death. According to Ms Fisher, this was *because 'he was in the care of Western Health'* at the time.

*72.* It was only when the Court requested statements from Doutta Galla that they *'immediately commenced a review of the clinical care'.* Ms Fisher stated the outcome of that review was that *'Arto was supported to live his best life and make day to day decisions about his care'.*

*73.* Nonetheless, Doutta Galla identified that there was an opportunity to *'initiate earlier mental health support intervention for Arto'.* The facility has refined its assessment process to have a greater focus on resident mental health and the recognition that *'continuous refusal of care, while it is a resident's choice, can impact on the resident and requires timely assessment referral to the GP for any additional action they may see as appropriate'.*

74. Importantly, staff were provided updated training on the *'early identification of pressure injury and reporting to the [Registered Nurse] in charge'* and attended a workshop targeted towards *'understanding the skin, frailty in aged care, clinical relevance, skin assessment, factors affecting wound healing, wound assessment, wound infection and the use of wound products'.*

75. As discussed, Ms O'Brien stated that poor record keeping by Arto's GP arose in the duration of his care. She stated that *'the lack of detailed, recorded GP notes in resident progress notes was identified as an issue by the new Clinical Care Coordinator, and attending GPs have been reminded to complete the Doutta Galla progress notes for patients after every visit'.*

76. Doutta Galla further informed the Court of wider changes they have made to the organisation to improve clinical care and governance.

77. The members of the current executive leadership team are Registered Nurses with relevant sector experience. In January 2025 they established a dedicated Clinical Services Division, which has clear reporting lines to ensure accountability and rapid escalation of concerns.

78. Four Clinical Nurse Specialist roles have been introduced at the organisational level, each providing high-level advisory, education, and quality improvement functions in their respective domains: Wound & Ostomy Management; Diabetes Management; Dementia & Mental Health Wellbeing; and Palliative Care. These roles support frontline teams, guide clinical best practice, and drive ongoing professional development.

79. Moreover, deployment of a comprehensive suite of updated policies and procedures is currently underway, with key enhancements including standardised incident reporting workflows, strengthened escalation pathways, unified care assessment and planning and consolidated clinical audit schedules.

80. Doutta Galla stated that *'the changes made in relation to clinician governance and care are such that it is confident that, had [Arto] been admitted to care at any of Doutta Galla's aged care facilities today, there would have been earlier identification, escalation and management of its care needs.'*

**DISCUSSION**

81. My investigation into Arto's death has revealed the intersection of several, complicating factors. Arto was an elderly man, who wished to maintain his independence and suffered from several physical and mental health conditions. As a result, he was a difficult patient and resident for all who were responsible for his care.

82. At the outset, I seek to acknowledge the difficult position that many Doutta Galla staff found themselves in, particularly when Arto refused necessary care – often becoming violent and aggressive. This is not, by any standard, behaviour which care staff should be subject to.

83. There is no indication that Doutta Galla staff implemented pressure wound prevention equipment indicated by their own policy. Doutta Gatta implemented only two preventative measures – a bariatric wheelchair and four-hourly position changes. However, four hourly position changes fell short of the hourly position changes which Western Health clinicians recommended as early as July 2022. Given that Arto was recognised as being at high risk for the development of pressure wounds, I conclude that Doutta Galla's preventative efforts, or lack thereof, fell short of the expected standard outlined in their own policies.

84. Regarding wound charts maintained by Doutta Galla, I have not been able to identify a plausible explanation for the delay in commencing documentation regarding Arto's sacral pressure wound following the appointment with the wound specialist. Additionally, wound charts often lacked important information. Objective fields including measurements of the wound and pressure injury categorisation were frequently left blank. Instead, subjective fields regarding the appearance and quality of the wound were more often recorded. The inherent problem with relying on subjective assessments is the variability between individual perceptions. As evidenced in this finding, descriptions of a wound fluctuated despite

photographs demonstrating it to be in largely the same condition. In the absence of objective and empirical standards from which to compare, I find that staff's ability to accurately monitor and assess the healing or worsening of Arto's pressure injuries was compromised. While education has been provided to staff on wounds and skin health, it is important this be paired with a reminder to record all observations for the most accurate tracking of residents' injuries.

85. Having acknowledged that Arto was a difficult resident to manage, I note that staff not infrequently complied with his refusal and withheld treatment or assistance with the effect of potentially worsening his existing pressure wounds and hastening the development of new ones. The examples which I outlined above, during which Arto was left in urine-soaked clothing for over eight hours, and was left with faeces on his hands for an unknown amount of time, constitutes treatment that I consider is at best suboptimal, and at worst, void of dignity. It is not treatment which, as Ms Fisher put it, allowed Arto to *'live his best life'*.

86. I consider that there were missed opportunities to escalate Arto's care. On 23 March 2022, Doutta Galla staff informed Arto's guardian that his care needs were too complex, and he was not suitable for their facility. Across the following six months, Arto's cognitive function and health declined, however, there is no indication that Doutta Galla made any repeated attempts to contact Ms Amore and transition Arto to higher-level care. Doutta Galla should have pursued alternate accommodation options through the OPA particularly as his care needs continued to increase and his decision-making capacity in respect of the same declined.

87. The weight of the evidence indicates that there were lost opportunities to have improved Arto's care, related to his pressure wounds and more generally. However, I am unable to extend this contemplation to make a finding that his death could have been prevented.

**COMMENTS**

Pursuant to section 67(3) of the Act, I make the following comments connected with Arto's death:

1. The circumstances of Arto's death highlights some of the difficulties faced by nursing staff in the aged care sector when managing patients with complex needs. In patients such as Arto, who have several diagnoses which may complicate their treatment, it can be difficult to strike a balance between providing care and respecting a patient's dignity of risk. However, Doutta Galla's deference to that dignity of risk – particularly in those situations where he was left in unhygienic conditions due to his refusal of care – compromised his wellbeing, compromised

the ability of staff to undertake their duties, and compromised the wellbeing of other residents who may have been subject to the smell of his incontinence.

2. There is a dilemma encountered by nursing staff when patient's decisions about their care or refusal of the same, impacts their clinical management. As in this instance, Arto demonstrated difficult behaviours and lived, in large part, in his wheelchair. These factors reduced the capacity of nursing staff to attend to his wounds and provide care.

3. In 2021, the final report of the Royal Commission into Aged Care Quality and Safety (**RCACQS**) was handed down. They commented:

> *'People at the end of their lives should be treated with care and respect. Their pain must be minimised, their dignity maintained, and their wishes respected. Their families should be supported and informed. However, throughout our inquiry we heard examples where the care provided to people in their last weeks and days of life was severely lacking and fell well short of community expectations."*[6]

4. As part of their final report, the RCACQS made several recommendations including *'Recommendation 19: Urgent review of the Aged Care Quality Standards'* which required that the Commissioner of Safety and Quality in Health and Aged Care make amendments, as necessary, to Aged Care Quality Standards regarding several fields including pressure injury prevention and wound management.[7]

5. In response to these recommendations the Federal Government's Aged Care Quality and Safety Commission (**the Commission**) reviewed the existing Aged Care Quality Standards and are updating the same, to come into effect with the new Aged Care Act on 1 November 2025. The Commission will also implement the Stronger Standards, Better Aged Care Program in order to provide better patient care.

6. Under the new standards, the Commission addresses residents' independence and dignity of risk: *'dignity of risk is about the right of consumers to make their own decisions about their care and services, as well as their right to take risks'*. However, the standards make clear that staff must still exercise professional discretion and intervene if a patient's decision may lead to an increased risk of harm. The Commission advises that if the resident makes a choice *'that*

[6] 'Final Report - Executive Summary' of the Royal Commission into Aged Care Quality and Safety, page 69. Accessible at: https://www.royalcommission.gov.au/system/files/2021-03/final-report-executive-summary.pdf.
[7] 'Final Report – List of Recommendations' of the of the Royal Commission into Aged Care Quality and Safety, page 223. Accessible at: Aged Care Royal Commission Final Report: Recommendations.

*is possibly harmful to them, then the organisation is expected to help the consumer understand the risk and how it could be managed. Together, they should look for solutions that are tailored to help the consumer to live the way they choose'.*

7. Since late 2022, the Commission has published articles intended to provide support and assistance to aged care residential facility staff. These articles include, *'wound management',*[8] *'Avoiding common wound management mistakes'*[9] and *'incontinence associated dermatitis and pressure injury'.*[10]

8. In these articles, the Commission identified common wound management mistakes include failing to adequately document the wound assessment such as *'missing essential information'* and failing to update treatment plans and documentation. The Commission also emphasises the need for clinicians to distinguish between incontinence associated dermatitis and pressure injuries in order to *'improve consumer health outcomes'.*

9. These resources, and the updated Aged Care Quality Standards, are a promising step to strengthening the care provided to older Victorians, including to effectively treat pressure injuries and wound management while balancing a patient's dignity of risk.

## 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 Arto Aaro Bohm, born 1 January 1948;

   b) the death occurred on 9 October 2022 at Sunshine Hospital, Furlong Road, St Albans, Victoria, 3021;

   c) I accept and adopt the medical cause of death ascribed by Dr Judith Fronczek and I find that Arto Aaro Bohm, a man with multiple medical comorbidities, died from sepsis secondary to infected pressure wounds;

[8] *'Wound management'* Aged Care Quality and Safety Commission. Accessible at: Wound management | Aged Care Quality and Safety Commission.
[9] *'Avoiding common wound management mistakes'* Aged Care Quality and Safety Commission, published 23 August 2024. Accessible at: Avoiding common wound management mistakes | Aged Care Quality and Safety Commission.
[10] *'Incontinence associated dermatitis and pressure injury'* Aged Care Quality and Safety Commission, published on 20 October 2022. Accessible at: Incontinence associated dermatitis and pressure injury | Aged Care Quality and Safety Commission.

2. AND I find that Doutta Galla fell short of its own policy by failing to adequately implement pressure wound prevention strategies or equipment, despite having recognised that Arto Aaro Bohm was at a markedly elevated risk of developing pressure wounds.

3. AND I find that the poor record keeping, particularly as it relates to the tracking of Arto Aaro Bohm's wounds, reduced staff's ability to effectively monitor the development of his pressure injuries and act accordingly at the earliest possible opportunity.

4. AND having commented on the difficulties faced by staff when managing Arto Aaro Bohm, I find that there was a missed opportunity to contact the Office of the Public Advocate to explore options to help facilitate his treatment.

5. AND noting Arto Aaro Bohm's pre-existing medical comorbidities and the rapidity with which his sacral wound worsened, I am unable to definitively conclude that earlier hospitalisation would have prevented Arto Aaro Bohm's death.

6. AND FURTHER I acknowledge the extensive restorative and preventative measures implemented by Doutta Galla since Arto Aaro Bohm's death and I accept that they have been undertaken with the aim of preventing like deaths.

I convey my sincere condolences to Arto's family for their loss.

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:

Ms Aira Kemister, Senior Next of Kin

Doutta Galla, c/- Lander and Rogers

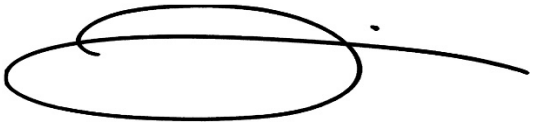
Western Health

Aged Care Quality and Safety Commission

Office of the Public Advocate

First Constable Catherine Nichols, Coronial Investigator

Signature:




AUDREY JAMIESON

CORONER

Date: 15 September 2025

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.