IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001323

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Brent Andrew Newman

Delivered On:	17 June 2022
Delivered At:	Melbourne
Hearing Dates:	9 June 2022
Findings of:	Coroner Simon McGregor
Police Coronial Support Unit:	LSC Dani Lord 34438

THE CORONIAL INVESTIGATION

1. Brent'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

2. 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.

3. 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.

4. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brent's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

5. This finding draws on the totality of the coronial investigation into the death of Brent Andrew Newman including evidence contained in the coronial brief. 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]

[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.

BACKGROUND CIRCUMSTANCES

6. Brent Andrew Newman was born on 26 March 1961 in Blenheim, New Zealand to parents Kevin and Glenis Newman. He was the second child of four, having an older sister Sheryl, and two younger brothers, who were born two and four years after Brent.[2]

7. Brent was born with Down Syndrome (despite there being no family history) and grew up attending a regular primary school in his early years despite his disability. Brent was very intelligent and was often a leader for his younger brothers and was able to participate in all the activities that they did. He also participated in Boys Brigade and in numerous activities with disability support groups and friends. At aged seven, Brent began attending a special school in Blenheim and around this time Brent's parents also separated.[3]

8. After the separation, Glenis and the children moved to Christchurch and Brent was in the full-time care of his mother when he wasn't in school. As he grew older, Brent functioned at a higher level than some persons with Down Syndrome and he was able to develop many friendships and eventually was able to enter the workforce. Brent was fascinated with computers, had a love of typing, and was able to reliably complete tasks set for him. His skills enabled him to work in many administrative roles during his adult life and his sister Sheryl recalled Brent enjoyed working so much that he even disliked taking any days off.[4]

9. In his 20s, Brent continued to work, and his health was quite good, although he reportedly didn't look after himself particularly well, eating only a basic diet, without much exercise. His sister described him having regular coughs and chest infections, said to be common to people with Down Syndrome.[5] He continued to enjoy social activities with groups of others living with disabilities, travelled overseas, and Brent enjoyed a relationship with a long-term girlfriend Tina, remaining together for five years until she unfortunately passed away. Tina's death was particularly distressing for Brent.[6]

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[2] Sheryl Newman statement, 010 [2]-[3].
[3] Ibid [4].
[4] Ibid [5]-[6].
[5] Ibid [8].
[6] Ibid [15].

10. In approximately 2003, Brent moved to Australia with his mother and her new partner George.[7] Brent's sister Sheryl had moved to Australia some ten years prior and so they joined her in Melbourne, after Brent's girlfriend Tina had passed away and to pursue work opportunities.

11. Brent was still largely reliant on his family but was able to re-enter the workforce in Melbourne, obtaining a position with a job seeking agency for persons with a disability. Here he performed administrative tasks and odd jobs.[8] Brent was able to catch public transport to and from work, and he continued to socialise with disability support groups who would pick him up for activities. His days were well structured, and he had a good routine that suited Brent.[9]

12. In 2012, Glenis noticed that Brent's memory was starting to decline, and that he couldn't remember certain things. This was apparent in his forgetting to purchase a TV guide on a Monday morning, something he had done routinely for a long time. When his mother questioned him, Brent didn't recall it being something that he did. Glenis became worried and spoke to Brent's GP[10], and eventually in 2013 Brent was diagnosed with Early Onset Dementia. He was 52 at the time.[11]

13. The following year, Brent's mother Glenis passed away leaving Glenis' partner George and Brent on their own in the family home. As Glenis had been Brent's primary carer, a decision was made for sister Sheryl and her daughter to move in with them to care for and support Brent. Brent handled his mother's passing well, accepting it as part of life, however his memory was becoming more and more effected, and the next few years would see his mental and physical health decline.[12]

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[7] Newman indicates that this move occurred in approximately 2006, however medical records of Dr Ellen Sadauskas (Medical Centre Frankston) show a first appointment with Brent on 3 October 2003 (Exhibit 4 – page 17), suggesting that the move may have occurred earlier than Ms Newman's recollection.
[8] Newman 011 [12].
[9] Ibid [12]-[13].
[10] Exhibit 4 – page 31 – notes of GP Dr Sadauskas on 1 March 2012, recording observations by Newman of Brent's cognitive decline.
[11] Newman [14].
[12] Ibid [15].

14. Between 2014-2019, Sheryl cared for Brent, and the effects of Brent's dementia became more apparent. He began forgetting how to do tasks and would fall asleep faster, but Brent was still able to work for some time. He did however have to rely more on the National Disability Insurance Scheme (**NDIS**) for private transport and organised social activities as he was more and more forgetful, and unable to catch public transport on his own.

15. Around 2019 a decision was made to transition Brent to a partial care facility so that he could live with other people and to enable Sheryl to take a break from her role as fulltime carer. A position was located at a facility in Carrum Downs however funding delays with NDIS meant that Brent never got to move to this house. At around this time Brent also had to retire from his work, as he continued to decline mentally, and his health meant that he was neglecting his duties and not able to function at a level where he could maintain employment.[13] After retiring from his job, Sheryl described Brent as starting to 'lose his purpose in life'.

16. Planning continued to transition Brent to supported accommodation, and the NDIS assisted with finding a facility in Narre Warren run by The Australia Foundation for Disability (**AFFORD**). Eventually Brent was able to move into this facility however just prior to moving he suffered a fall which affected his confidence in his mobility and independent movement. Brent's family provided a walking frame to enable him to feel more secure, but while living at the home he continued to have hip and shoulder issues that caused pain.[14] He also had other issues with chest infections, skin complaints, seizures, and regular falls.

17. After a fall on 21 August 2019 Brent was taken to Casey Hospital in Berwick, and diagnosed with a Urinary Tract Infection (**UTI**) and several other medical conditions. Due to his serious condition Brent was moved to the Intensive Care Unit (**ICU**) at Dandenong Hospital (Monash Health) and was also diagnosed with pneumonia, respiratory failure (**T1RF**), septic shock, constipation, and urinary retention. After some time in ICU, Brent was moved to a ward where he stayed for approximately three more weeks.

[13] Ibid [17]-[18].
[14] Ibid [19].

18. While in hospital Brent sustaining three unwitnessed falls and on 6 September 2019, Brent had an indwelling catheter (**IDC**) inserted, and plans were made to transfer him to rehabilitation to enable him to recover before returning home.[15] Brent stayed in Hospital for a total of 23 days.

19. During Brent's hospital stay, Dr Ellen Sadauskas (Brent's regular GP), spoke with Sheryl and raised concerns about Brent and the ability of staff at the AFFORD accommodation to provide the ongoing level of medical care Brent would require after leaving hospital. Dr Sadauskas suggested that Brent needed to be moved somewhere permanently where he could be provided with greater medical care. Brent also expressed to Sheryl his concerns about communication with staff at AFFORD, and that he felt he was being misunderstood or ignored. He told her that this was exacerbated by language barriers between him and the staff, and by his hearing issues, and not always having access to the hearing aids he wore.[16]

20. Brent was discharged from Hospital on 13 September 2019 and moved to the Kingston Rehabilitation Centre (**Monash Health**). His physical health had significantly declined since his stay in ICU and Brent struggled to walk and perform basic movements including eating. His physical issues and his efforts to rehabilitate proved difficult and were complicated by the constant requirements for his catheter and hearing aids and Sheryl stated that she never noticed any improvements in Brent's physical health over the weeks he was at the facility.[17]

21. During his stay at the Kingston facility, Brent had further unwitnessed falls, and a seizure, the cause of which was not apparent despite CT scans and tests following the falls.[18] Brent also continued to have urinary issues and a decision was made to have a long-term indwelling catheter placed on 24 September 2019.

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[15] Exhibit 4 – page 421-422 – Discharge summary Dandenong Hospital 21 August 2019.
[16] Newman 013 [23].
[17] Ibid [24].
[18] Exhibit 4 – page 458-459 – 2 x CT Brain without Contrast performed at Monash Imaging on 10 and 11 September 2019.

22. This was reinserted on 25 October 2019 when Brent developed further issues and urology follow up was recommended in 4-6 weeks' time.[19]

23. Sheryl located permanent accommodation for Brent at the Regis Aged Care Facility (**RACF**) in Frankston and Brent was discharged from hospital and transferred to that facility on 7 November 2019.

CIRCUMSTANCES OF DEATH

24. On arrival at RACF, Brent was assessed and several plans for his care were prepared. In addition to his medical conditions, Brent was noted as a high falls risk, and had significant deconditioning, fatigue, gait, and mobility issues that required full physical assistance from staff. Several preventative strategies were also highlighted for staff to reduce risk including hip protectors, removing environmental hazards, non-slip footwear, monitoring and assistance to Brent during the day, and reinforcing the need for him to wait for assistance.[20]

25. It was noted that Brent's skin was at a high risk of sustaining pressure injuries due to prolonged sitting and that staff were to undertake regular repositioning, monitor of risk areas and report any concerns. Staff were to check Brent's feet daily for any signs of wounds, trauma, or infection during personal hygiene checks and to document and report any change.[21]

26. Several recommended interventions were noted in relation to Brent's continence, with staff required to report any signs and symptoms of a UTI, increased confusion, increased frequency of urination, pain on urination, and macroscopic blood in urine.[22] Brent also had a Catheter Care Plan[23] specifying actions that staff should take to monitor the IDC, the steps to maintain hygiene, the required tube and bag changes, and records to be kept relating to its use.

[19] Exhibit 4 – page 430-431 – Discharge summary Kingston Rehabilitation Centre 7 November 2019.
[20] Exhibit 4 – page 484, 490, 500-501 – Regis Aged Care Facility Medical Records.
[21] Exhibit 4 – page 486 & 542-543 – Regis Aged Care Facility Medical Records.
[22] Exhibit 4 – page 493 – Regis Aged Care Facility Medical Records.
[23] Alyson Sparkes statement (Attachment 13 – Catheter Care Plan), 168.

27. Early in his time in care at RACF, Brent had several issues relating to his mobility with him trying to get out of bed without assistance to walk. Brent's mobility had declined so far that he now required a wheelchair, and these attempts to walk unassisted resulted in unrecorded incidents and unwitnessed falls in his first two months at Regis.[24]

28. Brent continued to need assistance with toileting and monitoring of his catheter, and several occasions were recorded where there were issues with Brent's IDC.

29. In December 2019, Brent was recorded on various dates to have had mild bleeding from the catheter site and pain caused by pulling of the catheter, redness and excoriation of the penis tip, and an incident where Brent woke staff in the middle of the night, crying in pain holding his groin due to the catheter tube being pulled from the insertion site, and the thigh strap not being secure.[25] Intermittent bleeding was said to have been observed by staff from the catheter site again on 21 December. On 26 December, staff again observed bleeding from the IDC site and scrotal and penile redness. Due to the public holiday, a GP review by Dr Sadauskas was not completed until the following day, when cortisone and antifungal cream were prescribed for one week.[26]

30. During January 2020, Brent continued to have issues with his IDC and presented to staff as agitated, unsettled and confused, with ongoing behavioural issues during nights. Urine samples were obtained to ascertain if he had a UTI, however a test on 6 January was not indicative of Brent requiring antibiotics. On 15 January Brent's IDC was changed as scheduled and staff noted some swelling, a small split in the urethra near the tip of his penis and blood spotting on his continence pad. This was assessed by GP Dr Dolezal attending for review, as a 'phymosis from IDC traction'. Staff were to ensure that the IDC not have any tension on it and to ensure the IDC was taped loosely to Brent's leg to avoid tension. It was also recommended that in time Brent may require a suprapubic catheter.[27]

[24] Sparkes, 019-021 (7 & 8 November 2019, 2,12 & 16 December 2019).
[25] Sparkes, 020; Sparkes (Attachment 12 – Case Notes) 135 & 138.
[26] Sparkes (Attachment 12 – Case Notes) 122 & 127.
[27] Sparkes, 022; Sparkes (Attachment 12 – Case Notes) 107 & 115.

31. On 24 January 2020 a urine test was suggested by Dr Sadauskas to exclude a UTI, as Brent continued to exhibit agitation and intermittent abdominal pain. She prescribed a one-week course of antibiotics and Hiprex for 3 months as a UTI preventative measure. Staff were advised by a GP on 30 January that Brent did have a UTI but there is no record of Brent being reviewed again until 7 February, when it is noted that his symptoms had settled and Hiprex was to continue.[28]

32. On 12 February 2020, Brent developed a cough and temperature of 38 degrees, and a further GP review was conducted by Dr Dolezal. Urinalysis was ordered and Brent was prescribed Keflex 500 three times daily (**TDS**). The next day (13 February), staff observed Brent was 'not himself', and extremely sleepy and that same day staff observed Brent to have pressure injuries to both heels and a blister on his right foot. These injuries were recorded on two incident reports and monitored in the following days by staff, and his treatment recorded via wound management charts.[29] On 18 February, a further pressure injury to Brent's right bunion was recorded, and a further blister to his right ankle noted on 24 February. These were also recorded via incident reports and wound management charts.[30]

33. On 19 February staff were advised that Brent urinalysis had diagnosed a pseudomonas UTI. Dr Dolezal continued to monitor Brent in the following days, and he was notably sleepier, ate little food, and recorded elevated temperatures. Brent remained in bed or seated in a Broda chair due to his lack of mobility. Staff recorded that they treated and monitored Brent's pressure injuries and reposition him every two hours to try to keep him comfortable.

34. Staff consulted Brent's sister, Sheryl, about family wishes should his condition worsen, and it was agreed that if he deteriorated further, he should be conveyed to hospital. Sheryl reported in her statement to the court that staff seemed hesitant to act on occasions, and that she felt they showed a lack of decisiveness which she believed was a risk to her brother.

[28] Sparkes, 022; Sparkes (Attachment 12 – Case Notes) 108, 110 & 114.
[29] Sparkes, 022; Sparkes (Attachments 4, 8, & 9 – Incident Report and 2 x Wound Management Charts) 043, 059, 068.
[30] Sparkes, 022; Sparkes (Attachments 5, 6, 10 & 11 – 2 x Incident Reports and 2 x Wound Management Charts) 048, 053, 077, 086.

35. An infection notification form was recorded on 26 February listing Brent as having a multi resistant e-coli in his last urinalysis. He was prescribed antibiotics to treat his chest symptoms and UTI.[31]

36. On 27 February, Brent developed further symptoms of chest congestion, and his oxygen saturation dropped to 85% on room air. Brent was administered oxygen and non-urgent transport was called to take him to hospital. As Brent was becoming more ill, non-urgent transport was not suitable and an ambulance was called. Brent was conveyed to the Frankston Hospital Emergency Department at 2.15pm by paramedics.[32]

37. On admission to Frankston Hospital, Brent was diagnosed with sepsis, aspiration pneumonia and a UTI. It was noted that the long-term placement of Brent's IDC was causing erosion of the urethral meatus and the ventral aspect of the urethra (traumatic hypospadias[33]). Hospital staff questioned the care provided to Brent at RACF.[34] Brent's sepsis and pressure wounds were treated in hospital, and his condition did begin to improve enough for him to be moved from the emergency department to a ward bed. Discussions were also held about the placement of a suprapubic catheter, to replace the IDC, and to allow for easier care by staff when he returned to RACF if Brent was well enough.

38. Given the conditions that Brent had presented with and Sheryl's ongoing concerns of care by staff at RACF, Peninsula Health's Hospital Admissions Risk Program (**HARP**) staff met with RACF Critical Care Coordinator on 3 March 2020. Nurse Janette Fox and Dr Albert Rudock attended, and they expressed concerns in relation to Brent's condition and the apparent lack of staff training and education about care for pressure wounds and IDCs. They offered to provide in-service training to RACF staff, and the approach from HARP was said to be well received. The outcome of the meeting was discussed with Sheryl to

[31] Exhibit 4 – page 946 – Regis Aged Care Facility Medical Records; Alyson Sparkes (Attachment 7 – Infection Notification Form) 058.
[32] Sparkes, 023-024; Sparkes (Attachment 12 – Case Notes) 097- 098.
[33] CPU review of this condition comments on the records of Peninsula Health and the examination of Brent by the VIFM ME Dr Bedford. Dr Bedford describes the condition as a 'mid-urethral catheter' and does not speculate as to the causation (traumatic). Dr Margaret Bird (CPU) comments that while hypospadias may be congenital, Brent had previously been examined by a Urologist where this abnormality was not detected.
[34] Exhibit 4 – page 1070 – Peninsula Health Medical Records.

enable her to consider whether she was comfortable with Brent returning to care at RACF.[35] Sheryl was extremely hesitant about Brent returning and wasn't confident that staff would be able to care for Brent sufficiently given his current hospital admission.

39. Sheryl's daughter told her that she had overheard Brent speaking to nursing staff in hospital, refusing to let them care for his feet. She had heard him saying that he didn't want them treated, and that he was "busy trying to die". Brent had also been declining food, and this led the family to consider comfort measures rather than further medical intervention. Sheryl recalls Brent having apparently given up 'bettering his own situation', and that medical staff had indicated that his blood test results, and his significant ongoing pain would mean that pain relief and palliative care would be a reasonable path to consider.[36]

40. Brent was moved to a palliative care bed on 6 March, given pain relief, and a decision made that there would be no attempts at resuscitation. Brent died surrounded by his family in the afternoon on 8 March 2020. He was 58 years of age at the time of his death.

MEDICAL OF DEATH

41. After his death, Brent was conveyed to the Victorian Institute of Forensic Medicine (VIFM), and on 10 March 2020 his body was inspected by Dr Paul Bedford, a specialist forensic pathologist.[37]

42. Dr Bedford formulated a cause of death as **Pneumonia and Urosepsis, with contributing factor being Down Syndrome.**[38] He is of the opinion that Brent's death was due to natural causes,[39] and I accept that opinion.

[35] Exhibit 4 – page 1067 – Peninsula Health Medical Records; Newman 014-015 [31]-[33]
[36] Newman 015 [34]-[36]
[37] Dr Paul Bedford, Medical Examiner's Report, 006.
[38] Bedford 007, Cause of Death.
[39] Bedford 008, Comments [2].

INVESTIGATIONS AND REVIEWS

43. Upon receiving the report of Brent's death, I commenced this investigation, and the Medical Examiner's Report was released to Sheryl, as the Senior Next-of-Kin. Sheryl then contacted the Court on 19 May 2020 via email raising concern with the content of that report, and her significant concerns in relation to the care provided by the Regis Aged Care Facility. She also indicated that she had had contact with the Aged Care Quality and Safety Commission (**ACQSC**), who had investigated Brent's case.[40]

44. Sheryl later provided a formal statement to the court where she described during the times visiting Brent, she had become concerned about Brent treatment at the Regis facility. She felt that staff did not monitor Brent in relation to his falls risk, felt that Brent was "simply put in front of the television all day" and had concerns with the level of care provided and training of staff. She felt that she had to repeat herself when conveying issues Brent was having, and that information was not being relayed to staff on the change of shifts or included in Brent's file. She also raised concerns over the care of Brent's catheter, his skin and pressure injuries, and his decline in the last weeks of his life. She also questioned the timeliness of decisions made by staff around his care.[41]

45. In response to an enquiry from the court, Alison Sparkes, Senior Quality and Compliance Manager for Regis Aged Care provided answers to several questions posed by me. Her response detailed Brent's care and made a number of concessions in relation to training, staff actions and provided documentation in relation to new policy and the development of a Plan for Continuous Improvement (PCI).[42]

[40] Email from Sheryl Newman, 009.
[41] Newman 014 [26]-[29].
[42] Sparkes 027-028, Respiratory Symptoms, Indwelling Catheter, Wound Management

46. In her response Ms Sparkes makes the following concessions in relation to three areas:

a) Respiratory symptoms – Despite GP review and treatment for Brent's ongoing respiratory symptoms, it was acknowledged that staff clinical assessment of his decline was limited and improvement in monitoring vital signs and assessing acute illness and ensuring care plans were accurate and reflected care needs - was an area for improvement.

b) Indwelling catheter – Brent was said to have had a number of incidents of physical and verbal aggression and resistive behaviours towards staff during care and pulling at his own catheter making it difficult for staff to maintain a clean and infection free site. It was conceded however that staff did not associate resistive behaviour with the potential for pain in Brent and that monitoring of penile care and catheter support were areas for improvement. Catheter care information was included in clinical meetings and all resident's care plans were reviewed for accuracy and sufficiency of information.

c) Wound management – It was conceded that it was clear that the strategies for management of pressure injuries were not being monitored and improvements have been identified for staff in wound assessment, staging documentation, monitoring of pressure relieving strategies and clinical review. Education and upskilling were to be conducted and wound specialists engaged for review and guidance of management.

47. It was noted by Ms Sparkes that improvement in monitoring of condition and vital observations regularly may have been beneficial in Brent's case. Improved knowledge in the management of clinical decline and acute illness with comprehensive clinical assessment would be a necessary area of improvement for Regis nursing staff. The above topics and relevant action items were all added to the Plan for Continuous Improvement.[43] The RACF Wound Management Policy was also updated on 22 October 2020.[44]

[43]Sparkes 028; Sparkes (Attachment 17 – Plan for Continuous Improvement) 246.
[44] Sparkes 028; Sparkes (Attachment 19 – Wound Management Policy) 253.

48. On 15 April 2020, Ms Jacqueline Rodrigues, delegate of the Commissioner, ACQSC, provided a copy of their investigation findings to Sheryl Newman in response to her complaint about Brent's care. The documentation sets out ACQSC findings as per the issues raised of respiratory symptoms, indwelling catheter care, pressure injuries and additionally, pain management.[45]

49. The investigation concluded that there was a failure to complete basic assessments regularly and for senior nursing staff to consider Brent's overall clinical presentation in respect of his respiratory symptoms. They comment that closer monitoring of his symptoms and temperature may have enabled nursing staff to keep the treating doctors more accurately informed. Staff did not appear to consider holistically signs that Brent was becoming unwell, despite family noting his changed condition and requesting escalation.

50. In respect of Brent's indwelling catheter, ACQSC considered that despite a comprehensive catheter care plan containing specific instruction, the care provided to Brent contributed to the injury observed at Frankston Hospital on 27 February 2020. They suggest that this was indicative of a systematic problem, highlighting a deficit of knowledge around care of IDCs, and that this posed a risk to other residents at the facility.

51. The Commission further concluded that despite preventative measures listed as being in place for Brent in relation to pressure injuries, the management of same had been inadequate. There was limited information to support regular 'formal assessments' of his skin. They found that wound charting appeared inaccurate and that there were clear failings in assessment of skin integrity, and that higher-level skin protection options should have been considered.

52. Additionally, the Commission considered Brent's pain management in so far as it was associated with Brents pressure injuries and catheter care. Their view was that given Brent's cognitive impairment and ability to verbalise the degree of pain he was in, behavioural signs demonstrated by Brent were likely indicative of the level of pain he felt.

[45] Exhibit 1 268-273 – Review of Care, Regis Aged Care Frankston.

53. The Commission also noted that there appeared to be no indication that staff considered pain was the potential cause of Brent's behavioural signs, and that there was no consideration to providing pain relief before or after dressing changes.

54. In all these areas, the Commission acknowledged the Plan for Continuous Improvement (**PCI**) implemented by Regis Aged Care, and their response and undertakings for quality improvement within their facility. The Commission deemed them as being suitable to address the identified gaps in care and training.

55. To finalise the investigation, I requested a review of the case by the Coroner's Prevention Unit (**CPU**)[46] at the Coroners Court of Victoria. This review was conducted by Dr Margaret Bird and utilised the documents that now form the Coronial Brief. Dr Bird is a consultant physician in geriatric medicine with clinical expertise in continence management.

56. Dr Bird assessed whether unreasonable delay recognising and responding to Brent's final septic illness had affected the outcome; considered the failure to complete basic regular assessments of Brent's overall clinical presentation; and the failure to escalate to a doctor or complete respiratory assessment. Dr Bird noted the investigation already conducted by ACQSC and acknowledged that Brent was seen on several occasions by a covering GP and was diagnosed with a multi-resistant[47] UTI. Oral antibiotics had been commenced and during his final admission to hospital, Brent did receive intravenous antibiotics. Although he initially improved, Brent declined soon after and Dr Bird considered that given this was Brent's second severe sepsis within six months, it would be unlikely that the outcome would have significantly changed with earlier escalation to hospital level care.

[46] 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.

[47] Pseudomonas aeruginosa resistant to most of the commonly used antibiotics

57. In considering if there was neglect of care leading to Brents pressure and urethral injuries, Dr Bird again referenced the ACQSC findings of multiple deficiencies in care particularly in relation to catheter care, recording of treatment and follow up, and deficiency of knowledge around care of the IDC. She also acknowledged the ACQSC findings of failings in skin integrity assessment and wound care documentation and concluded that it was evident that the progression from irritation to ulceration occurred in the weeks prior to Brent's hospital admission. This would have been a cause of considerable distress and was not recognised or managed appropriately by the staff at RACF.

58. 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 explications.[48] 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.

FINDINGS AND COMMENT

59. Brent had multiple life limiting conditions including sepsis from pneumonia, neurogenic bladder, and urinary infections as well as Alzheimer's disease in the setting of down syndrome. From the perspective of immediate cause of death being from recurrent and overwhelming infection, Brent's death was from natural causes and was not preventable.

60. However, Brent's high-level care needs were not met at Regis Frankston, with a failure to adequately manage his risk of pressure injury and urethral trauma due to his indwelling catheter. As multiple improvements have been reportedly put in place at Regis Frankston, and these have satisfied ACQSC, I make no further adverse comment.

[48] *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…'.

61. Additionally, within the response to the ACQSC, Regis Frankston had offered a meeting with the senior next of kin to allow for an apology and to describe the quality improvements now in place.

62. Lastly, given the public interest in ensuring the welfare of persons living in care, it is recommended that there would be significant value in publication of the findings in this matter.

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

    a) the identity of the deceased was Brent Andrew Newman, born 26 March 1961;

    b) the death occurred on 08 March 2020 at Peninsula Health, Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199, from *pneumonia and urosepsis*; and

    c) the death occurred in the circumstances described above.

64. I make the following comment(s) connected with the death under section 67(3) of the Act:

    The continued reference to the Aged Care Royal Commission final report[49] provides ongoing guidance and benchmarking about prevention opportunities. In this case I was particularly assisted by reviewing the following areas:

    d) Ensuring quality and safety – the imperative: Recommendation 3, 90 and 92

    e) Righting a wrong – services for older people with disability: Recommendation 2, 8, 30 and Chapter 10.

    f) A workforce to deliver quality, safe care: Recommendation 75

[49] Aged Care Royal Commission Final Report: Summary

Pursuant to section 73(1B) 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:

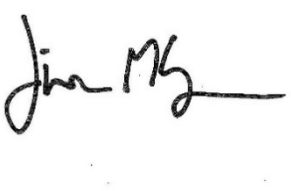
Sheryl Newman, Senior Next of Kin

Regis Aged Care

Peninsula Health

Leading Senior Constable Dani Lord, Victoria Police, Coroners Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 17 June 2022

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 inquest. 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.