IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003571

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Terence Michael Brooks
Date of birth:	10 December 1942
Date of death:	7 July 2019
Cause of death:	1(a) Streptococcus pneumoniae sepsis in the setting of acute bronchopneumonia and renal failure due to obstructive uropathy in a man with dementia and ischaemic heart disease
Place of death:	TLC Marina Residential Aged Care, 385 Blackshaws Road, Altona North, Victoria, 3025
Keywords:	Streptococcus pneumoniae, acute bronchopneumonia, obstructive uropathy, urinary tract infection, TLC Marina Residential Aged Care, Westgate Nursing Home, Western Health Aged Care Liaison Service, Aged Care Quality and Safety Commission, Royal Commission in Aged Care Quality and Safety.

INTRODUCTION

1. On 7 July 2019, Terence Michael Brooks was 76 years old when he died at TLC Marina Residential Aged Care (**TLC**) in Altona North, Victoria. At the time of his death, Terence lived at TLC after having transferred into permanent high-level care following the death of his wife, Glenyce, who was in his primary carer.

2. Terence's medical history included a previous stroke with resultant left-sided hemiplegia, recurrent Major Depressive Disorder, anxiety, and visual impairment, macular degeneration and glaucoma, and Charles Bonnet syndrome.[1]

3. In 2017, Terence began seeing Dr Lorien Porter, a consultant psychiatrist, due to depressive symptoms, suicidal ideation, decreased mobility, and visual hallucinations. In November, Terence agreed to an admission to the Albert Road Clinic where he stayed for a month.[2]

4. In February 2018, Terence attended a consultation with Dr Peter Abraham, a clinical psychologist, who noted that Terence appeared unkempt. Glenyce commented that Terence had been "letting himself go" over the past 12 months.[3] Terence was admitted to Brunswick Private Hospital as a rehabilitation patient after he unintentionally lost 10 kilograms.[4]

5. In early 2019, Terence moved into high level respite care at Westgate Nursing Home (**Westgate**), Newport, as Glenyce had advanced terminal cancer and could no longer care for him. Following the move, Terence began to display symptoms of depression, grief, and adjustment issues, which was attributed to his concern for Glenyce's condition, their forced separation, the move to residential care, his loss of mobility and visual impairment.[5] He also continued to lose weight, losing almost 4.5kg in a month.[6]

THE CORONIAL INVESTIGATION

6. Terence'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.

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[1] Statement of Dr Lorien Porter dated 27 June 2017.
[2] Statement of Dr Lorien Porter dated 13 November 2017, Albert Road Discharge Summary dated 9 December 2017.
[3] Statement of Dr Peter Abraham dated 8 February 2018.
[4] Report from Brunswick Private Hospital dated 16 February 2018.
[5] Statement of Dr Elizabeth Dapiran dated 4 April 2019.
[6] Statement of Dr Sam Honigman dated 10 March 2019.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Terence'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.

10. This finding draws on the totality of the coronial investigation into the death of Terence Michael Brooks 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.[7]

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

Circumstances in which the death occurred

11. On 4 April 2019, Terence was assessed by Dr Elizabeth Dapiran, consultant geriatrician, who noted Terence's on-going depression and grief, and that he reported that he was unable to find joy in the things and had no hope for the future. Dr Dapiran recommended an extensive multi-disciplinary care plan for Terence and prescribed antidepressants and antipsychotics, as well as recommending various allied health professional reviews.[8]

[7] 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.

[8] Statement of Dr Elizabeth Dapiran dated 4 April 2019.

12. On 13 May 2019, Glenyce passed away. Terence was reviewed by Dr Dapiran on 17 May who noted that he had deteriorated since receiving the news regarding the death of his wife and the realisation that he would have to remain in care indefinitely. Dr Dapiran provided further advice regarding care strategies and recommended that he be provided with psychological counselling, however this did not eventuate.[9]

13. On 2 June 2019, Terence was transferred to the Western Health Emergency Department due to a one-week history of hip pain. There were no signs of infection, and he was eventually diagnosed with arthralgia. Terence was discharged back to Westgate with analgesia and a plan to return if any signs of infection became apparent. A review by the Western Health Aged Care Liaison Service (**WHACLS**) was also arranged.[10]

Admission to TLC

14. On 5 June 2019, Terence was transferred from Westgate to TLC for permanent residential care. He was assessed, with his weight found to be 52.5kg. Terence found the transfer particularly difficult and displayed intermittent challenging behaviours.[11]

15. Following the transfer, Terence was reviewed by Dr William Crouch, a general practitioner (**GP**), who referred him to a geriatrician, noting Terence's ongoing poor oral intake and lack of appetite. A variety of strategies were recommended to improve his oral intake.[12]

16. On 19 June 2019, Terence was reviewed by Dr Vishnu Sharma, consultant geriatrician, who noted that his presentation was "consistent with a steady decline in cognition and balance due to vascular dementia complicated by a previous mood disorder and his recent bereavement".

17. Dr Sharma recommended that Terence be encouraged to attend daily activities at the facility and increased his antidepressant medication but discouraged "significant interventions…where appropriate and in consultation with family", adding that Terence's prognosis "may be poor over the next five years in view of [his] co-morbidities".[13] A review of Terence's Care Plan Summary from Westgate shows that he was to be sent to hospital in the event of an acute deterioration but was not to receive cardiopulmonary resuscitation.[14]

[9] Statement of Dr Elizabeth Dapiran dated 4 April 2019.
[10] Western Health Discharge Summary dated 2 June 2019.
[11] TLC medical records.
[12] Ibid.
[13] Ibid.
[14] Ibid.

18. On 20 June 2019, Terence's family met with Dr Crouch who explained that he had not identified any obvious acute issues, however Terence's family advised Dr Crouch that he had been diagnosed with a urinary tract infection (**UTI**) at Westgate shortly before his departure, of which Dr Crouch had been unaware. Terence later complained of groin pain and was reviewed by Dr Crouch who noted that he was afebrile but prescribed an antibiotic for a possible UTI.[15]

19. Over the following days, further meetings were conducted with Terence's family regarding his poor oral intake (whilst noting that his weight loss appeared to have slowed), his previously untreated UTI, and his general decline. Terence later complained of nausea and intermittent vomiting which led to further refusal of food. He was reviewed by Dr Crouch and another GP who noted that Terence's abdomen and recent blood tests were unremarkable. Terence was prescribed an anti-emetic as well as further analgesia.[16]

Events of 6 - 7 July 2019

20. On 6 July 2019, Terence was reviewed by WHACLS after staff reported that he was not well and did not appear to be himself. WHACLS staff recorded Terence's vitals as unremarkable other than his oxygen saturation being 91 per cent, however this was deemed to be not concerning given his advanced age and comorbidities. WHACLS did not recommend any significant changes in his management.[17]

21. On 7 July 2019 at 6.53am, nursing staff attended Terence's room and found him to be unwell, with an unreadable blood pressure and a respiratory rate of 40. The night staff then handed his condition over to the morning staff for monitoring. A plan was also formulated to notify Dr Crouch or send Terence to hospital if required, however at 7.15am staff discovered that Terence had passed away before he could be reviewed.[18]

Identity of the deceased

22. On 11 July 2019, Terence Michael Brooks, born 10 December 1942, was visually identified by his son-in-law, Roberto Petruzzi.

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

[15] TLC Medical Records.
[16] Ibid.
[17] Ibid.
[18] Ibid.

Medical cause of death

24. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 18 July 2019 and provided a written report of his findings dated 3 September 2019.

25. The post-mortem examination revealed cachexia (Body Mass Index of 16), marked renal impairment with markedly elevated creatinine levels (226umol/L), prostatic hyperplasia with a large, distended bladder and trabeculated mucosa, hydroureter and mild hydronephrosis, and prostatic vascular plexus thromboses.

26. Right lower lung lobar pneumonia was observed, as was cardiomegaly, coronary artery atherosclerosis, and fibrotic pancreas. A clinical history of vascular dementia and cerebrovascular disease was also noted.

27. A lung swab taken at autopsy grew *Pseudomonas aeruginosa* and *Candida glabrata*. There was also evidence of *Streptococcus pneumoniae* which is most often seen in pneumonia and only rarely due to urinary tract infections. The urine culture in this case showed no bacterial growth.

28. Dr Bouwer opined that Terence's weight loss was most likely a combination of underlying chronic diseases and complications of a bladder outlet obstruction. No evidence of malignancy was identified. There was no evidence of violence or injury contributing to the death.

29. Toxicological analysis of post-mortem samples identified the presence of venlafaxine and its metabolite desmethylvenlafaxine, paracetamol, and metoclopramide.

30. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) streptococcus pneumoniae sepsis in the setting of acute bronchopneumonia and renal failure due to obstructive uropathy in a man with dementia and ischaemic heart disease.

31. Dr Bouwer opined that the death was due to natural causes.

32. I accept Dr Bouwer's opinion.

FAMILY CONCERNS

33. Terence's son, Jamie Brooks, submitted multiple concerns to the court regarding the care that his father received during his time at TLC. These related to Terence's ongoing symptoms of weight loss, stomach aches, dysphagia, and vomiting, noting that an assumption appeared to have been made that these symptoms were due to his dementia and grief, and possibly prevented timely clinical investigations.

34. Jamie also commented that information pertaining to his father's UTI diagnosis and prescribed antibiotics appeared to have been lost during his transfer from Westgate to TLC, leaving him untreated for a period of approximately one month.

Form 26 – Request for Inquest into Death

35. On 9 March 2020, the Court received a Form 26 – *Request for Inquest into Death* from Jaime. This application raised three new issues, including:

    a) Concerns regarding blood tests taken on 28 June 2019, including questions as to why Terence's family were not notified of the results of these tests;

    b) Concerns regarding the quality of assessment and diagnoses of Terence's symptoms shortly before he died; and

    c) Failures in care identified by an Aged Care Quality and Safety Commission (**ACQSC**) investigation into the care provided to Terence.

36. Following the conclusion of the ACQSC and coronial investigations, I am satisfied that these concerns have been sufficiently addressed and will be elucidated in the sections listed below.

CPU REVIEW

37. To assist with my investigation into Terence's passing, I requested that the Coroners Prevention Unit (**CPU**) [19] review the care that he received, especially in the context of his son's concerns. The CPU considered sources of evidence including Terence's court file and his records from TLC and Altona Medical Centre.

[19] 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.

Concerns regarding ongoing symptoms

38. Terence's symptoms (stomach-ache, nausea, and intermittent vomiting) were well documented in the week preceding his death. He was assessed on multiple occasions by two different GPs as well as by WHACLS who did not note any acute findings and prescribed appropriate medications. The CPU noted that Terence's reduced oral intake was a long-standing issue, and that he had been losing weight for approximately two and a half years.

39. The CPU noted that a urine test performed on 19 March 2019 was negative for bacterial growth which indicated that he was not suffering from a UTI as a possible cause of his rapid weight loss in the months prior to his death. I note that the urine culture performed at autopsy by Dr Bouwer did not demonstrate evidence of a bacterial infection.

40. The CPU concluded that it was reasonable to attribute Terence's weight loss to his advancing dementia, grief, and depression, noting in particular that a loss of appetite (and even forgetting how to chew and swallow) are well-known symptoms of advanced dementia. The CPU further noted that Terence's weight remains relatively stable during his time at TLC despite his worsening oral intake.

Concern regarding Terence's UTI

41. Whilst Terence's UTI (diagnosed on 3 June 2019) and pneumonia during the last five weeks of his life may have contributed to his increasingly poor oral intake, they did not cause significant additional weight loss. Whilst it is reasonable to say that there was a significant delay, Terence's UTI was successfully treated, and pneumonia-specific symptoms were not identified until minutes before his death.

42. Despite the delay, Terence was eventually effectively treated for his UTI. Whilst UTIs can cause a wide variety of symptoms from mild to severe, especially in the elderly, it remains unclear whether any of Mr Brooks' behavioural issues or symptoms of nausea, pain and vomiting were related to the UTI.

43. Whilst Dr Bouwer noted that streptococcal sepsis is commonly accompanied by pneumonia and only rarely by urinary tract infections, handover documents from Westgate to TLC included information regarding Terence's recent UTI diagnosis and his prescribed oral antibiotic which had been commenced on 4 June 2019. It is therefore reasonable to conclude that a breakdown in communication occurred between the residential care facilities and Terence's GPs.

Concerns regarding Terence's blood tests

44. On 28 June 2019, Terence was given a blood test. Without quoting the specific results of this test, it sufficient to note that Dr Crouch reviewed these results and, on 4 July 2019, documented that the results had been "…discussed and [were] acceptable" (it is unclear with whom Dr Crouch discussed these results with, however).

45. In the setting of Terence's comorbidities, the CPU considered Dr Crouch's assessment of the test results was acceptable, and that it would not have been possible for Dr Crouch to anticipate Terence's rapid demise based on the test results.

Concerns regarding the quality of assessment and diagnoses of Terence's symptoms

46. As noted above, Terence's blood test results (taken on 28 June 2019) were inconclusive. In the days prior to his death, Terence was reviewed on multiple occasions by his health team, including Dr Crouch and Dr Sharma (consultant geriatrician) who documented comprehensive observations which included unremarkable respiratory findings.

47. On 6 July 2019, Terence's respiratory status was assessed by a WHACLS clinical nurse consultant who noted mildly diminished oxygen saturations (91 per cent) but that all other vital signs (including his respiratory rate) were normal. Before this time, Terence's recorded vital signs showed limited indication for respiratory assessments to be performed.

48. On 24 June 2019, Terence's antibiotics were recommenced, however this was to treat a UTI that was diagnosed on a urine test, rather than any urine output-related symptoms. Given that Terence wore urinary incontinence pads, it was difficult for TLC staff to collect urinary samples for infection testing. Additionally, TLC staff did not recall Terence having dry incontinence pads in the period prior to his death.

49. Had any potential reduction in urine output been detected in the days leading up to his death, this would have likely been attributed to his reduced oral intake rather than urinary retention. Lastly, there were no clinical assessment findings that would have warranted an investigation of Terence's bladder.

Aged Care Safety and Quality Commission Investigation

50. On 24 September 2019, Terence's family contacted the Aged Care Safety and Quality Commission (**ACQSC**) to complain about the care that he received during his time at TLC. On 7 April 2020, the ACQSC concluded its investigation and provided a report of its findings to Terence's family. A copy of this report was provided to the Court on 8 October 2020 which was then reviewed by the CPU as part of its assessment of the care that Terence received.

51. The ACQSC found that, upon Terence's admission to TLC, both his new GP and the nursing staff failed to identify and/or communicate that he had recently been commenced on oral antibiotics, despite this information being included in both the medication chart and discharge summary provided by Westgate.

52. The ACQSC also noted multiple instances of insufficient documentation of nursing reviews and observations, however it was observed that every time an assessment was documented, the findings and management remained largely unchanged. It was noted that Terence's condition remained largely unchanged over the days prior to his death.

53. Despite Terence's multiple comorbidities, the CPU concluded that the cause of his death on 7 July 2019 as elucidated above was not able to be predicted by nursing staff at TLC. The issues identified by the ACQSC report (intake food intake charting, possible delay of anti-emetic medication, nursing monitoring of oral intake, as well as the intermittent symptoms noted above) were not related to the acute health changes that precipitated his death. Furthermore, it is reasonable to conclude that TLC staff were likely reassured by the repeated reviews by his medical team that did not identify any acute medical concerns.

54. Whilst WHACLS staff documented Terence's lowered oxygen saturations following their assessment on 6 July 2019, it is unclear as to whether this was verbally communicated to TLC staff. The CPU concurred with the ACQSC report that follow up monitoring and/or observations should have taken place during the evening of 6 July 2019.

55. The nurse who assessed Terence during the morning of 7 July 2019 did not appear to appreciate how unwell he was at the time of the assessment. The CPU concurred with the ACQSC findings that Terence should have been urgently transferred to hospital via ambulance, however not only is it impossible to ascertain at exactly what time Terence became unwell (due to a lack of documented overnight assessments), it cannot be concluded that such a transfer would have prevented his ultimate death.

Conclusion

56. Terence's loss of interest in food and lack of appetite pre-disposed him to infections. This is a typical progression of dementia, which was further complicated by undiagnosed urinary retention, acute renal failure, and other chronic comorbidities. It should be noted, however, that he was regularly reviewed by multiple GPs, geriatricians, and other allied health professionals in the months prior to his death who provided reasonable care.

57. The CPU concluded that the care Terence received was reasonable and appropriate, however, it was noted that information regarding his UTI and prescribed treatment appears to have not been passed on to his GPs, and the severity of his condition on the morning on 7 July 2019 was underappreciated by nursing staff. However, it is not possible to conclude his death was preventable had his illness been accurately recognised.

58. Following the publication of the ACQSC report, a Continuous Quality Improvement Plan has been actioned across all TLC aged care homes, including increased oversight, training for staff in recognising and responding to clinical deterioration, communication between staff and families, quarterly audits, updates to relevant procedures, and staff performance monitoring.

59. The CPU did not identify any prevention opportunities stemming from Terence's death.

FINDINGS AND CONCLUSION

60. 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.[20] 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.

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

    a) the identity of the deceased was Terence Michael Brooks, born 10 December 1942;

    b) the death occurred on 7 July 2019 at TLC Marina Residential Aged Care, 385 Blackshaws Road, Altona North, Victoria, 3025, from *streptococcus pneumoniae sepsis in the setting of acute bronchopneumonia and renal failure due to obstructive uropathy in a man with dementia and ischaemic heart disease*; and

    c) the death occurred in the circumstances described above.

62. After having considered the available evidence and having noted the measures taken since the handing down of the ACQSC report, I am satisfied that TLC has taken appropriate remedial actions following Terence's death. I am further satisfied that no prevention opportunities were able to be identified.

COMMENTS

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

63. Whilst I note that some of the commentary in the ACQSC report was critical of the inadequate or incomplete documentation and assessments identified in Terence's TLC records, I note that many reviews of cases that involve aged care identify similar deficiencies.

64. The improvements made by TLC in response to the ACQSC investigation are commendable and should improve their systems, especially with regards to the identification of the deteriorating patient. However, there remains more significant and widespread deficiencies to the provision of quality residential aged care in Victoria, such as staffing, numeration, operational resources, and governance of facilities providing aged care services.

65. On 1 March 2021, the final report from the Royal Commission in Aged Care Quality and Safety was tabled.[21] Following this, its 148 recommendations have been accepted by the Federal Government and have helped form the five-pillar plan for aged care reform that is being rolled out over a five-year period until 2025. I am hopeful that the aged care reform plan will permanently improve all facets of aged care in Australia.

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

[21] https://www.health.gov.au/initiatives-and-programs/aged-care-reforms/changing-aged-care-for-the-better

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:

Jamie Brooks, Senior Next of Kin

Westgate Aged Care, Newport

Dr William Crouch, TLC Primary Care

TLC Aged Care – Marina, Altona North

Dr Sam Honigman, Altona Medical Centre

Aged Care Quality and Safety Commission

Constable Cf Fiore, Victoria Police, Reporting Member

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 20 February 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.