QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Leah Elizabeth Floyd**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Maroochydore
FILE NO(s):	2013/3651
DELIVERED ON:	8 December 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 March, 11 July to 15 July, 8 to 10 August 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Death in Care, physicality disability, mental health, human rights, legal decision making capacity, pressure sore management

REPRESENTATION:

Counsel Assisting: Ms Megan Jarvis

BE Lifestyle Pty Ltd: Ms A Coulthard i/b Aitken Legal

Dept of Communities, Child Safety and Disability Services: Mr M Smith i/b Sparke Helmore

Metro South Hospital and Health Service: Ms F Banwell

Blue Care: Mr Schneidewin i/b Barry Nilsson Lawyers

Sunshine Coast Hospital and Health Service: Ms S Gallagher i/b SCHHS

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Introduction

1. Leah Elizabeth Floyd was born on 12 August 1965 and was 48 years of age at the time of her death on 10 October 2013 at the Nambour General Hospital.

2. On 8 August 2012, Ms Floyd suffered a fall from a balcony. She was said to be grossly intoxicated at the time. The fall resulted in tetraplegia associated with spinal fractures, for which she underwent operative procedures. She was then admitted to the Princess Alexandra Hospital Spinal Injuries Unit (PAHSIU) on 28 August 2012 and discharged from there almost a year later on 8 August 2013.

3. As a result of her long term hospitalisation, in July 2013 Ms Floyd developed pressure wounds on her elbows and sacrum. The sacral pressure wounds were noted to be healing before her discharge from the PAHSIU, although there were some pressure areas on her elbows at the time of discharge. She also suffered from ongoing depression and anxiety. It is important to acknowledge, that notwithstanding these conditions and her physical disability, Ms Floyd at all times after discharge had the mental capacity to make her own decisions about her finances and health needs.

4. Ms Floyd moved to Musgrave Drive, Yandina Creek to be supported by BE Lifestyle Ltd. BE Lifestyle is a community-based non-government organisation and provided a supported accommodation service with funding provided by the Department of Communities, Child Safety and Disability Services (Disability Services). BE Lifestyle did not provide nursing or medical care and arrangements were made for Ms Floyd to receive wound care and treatment from Blue Care Nursing Service.

5. Ms Floyd was in the care of BE Lifestyle from 26 August 2013 until she was taken to Nambour Hospital on 5 September 2013. BE Lifestyle raised concerns that Ms Floyd may have suicidal ideations and requested she undergo a psychiatric assessment. Ms Floyd was not consulted by BE Lifestyle or the referring GP about her transfer to hospital.

6. Although it was considered almost immediately that Ms Floyd was not suicidal or mentally unwell and could be discharged, Ms Floyd remained in Nambour Hospital for approximately two weeks. During this time she was reviewed on three occasions by a psychiatrist. The psychiatrist formed the view that whilst Ms Floyd possibly had borderline personality disorder, which can be associated with self-harm, as well as anxiety issues, her overall risk for suicide and self-harm was low and she did not otherwise require inpatient psychiatric care.

7. Ms Floyd was discharged from Nambour Hospital on 19 September 2013 and returned to the care of BE Lifestyle. BE Lifestyle had asked Disability Services for Ms Floyd to be placed elsewhere, as it was concerned it could not meet her physical and mental health care needs. Arrangements were being made by Disability Services to find alternative supportive

accommodation and in the meantime Ms Floyd remained at BE Lifestyle. Her pressure areas continued to be monitored by Blue Care and nurses from the PAH Transitional Rehabilitation Program team also assisted.

8. Ms Floyd was admitted to Nambour Hospital on the 6 October 2013, with a short history of low fever and intermittent coughing. Ms Floyd had delayed agreeing to be admitted until after she had completed a pre-arranged contact meeting with her children. By that time it is apparent she was quite unwell. The sacral pressure area was noted to have progressed to a large ulcer and she had developed a urinary tract infection. On 7 October she had an episode of low blood pressure, the cause of which was unclear. Sepsis was considered to be the most likely cause even though she had been treated for the local and more generalised infections that had been noted.

9. Despite medical management Ms Floyd progressed to develop respiratory failure and died on 10 October 2013. Dr Jenkins of Nambour Hospital issued a cause of death certificate indicating respiratory failure due to the development of sepsis following from an infected sacral wound, with urinary tract infection and tetraplegia contributing factors.

10. Ms Floyd died having been in community care for a total of only 29 days. After her discharge from PAHSIU she received care and support from a number of government (Queensland Health and in particular the PAH Transitional Rehabilitation Program and Nambour Hospital and Disability Services) and non-government (BE Lifestyle, Blue Care and her GP) services.

11. Ms Floyd's death was reported to the Coroners Court as there was some concern about the specific wound care and that sepsis may have caused her death and/or that the management of the pressure ulcers may have contributed to this. As well, given the funding and accommodation arrangements, and Ms Floyd's physical disabilities, Ms Floyd's death met the criteria of a Death in Care.

Concerns

12. Concerns were raised by Ms Floyd's mother, as well as BE Lifestyle, regarding the appropriateness of BE Lifestyle to meet Ms Floyd's complicated medical and mental health needs. There was concern expressed about Ms Floyd being discharged from the PAH and Nambour Hospitals to BE Lifestyle and a concern that there was a reliance on BE Lifestyle to provide medical care.

13. Ms Floyd's husband also expressed concern about the care that was provided at BE Lifestyle including pressure wound care and the decision to have Ms Floyd admitted to Nambour Hospital for a mental health assessment.

14. There was evidence that BE Lifestyle had made several approaches to Disability Services attempting to have Ms Floyd placed elsewhere,

stating they could not meet her care needs and that this was placing Ms Floyd, other residents, and staff at risk.

15. BE Lifestyle also raised concerns regarding Leah's alleged refusal to accept medical treatment, and raised whether that refusal was made in order to end her own life.

16. It became evident that there was a complicated relationship between Ms Floyd and some family members and confusion on the part of BE Lifestyle as to the rights of patients to determine their own health needs when they had capacity.

Issues for inquest

17. A decision was made to hold an inquest. The *Coroners Act 2003* requires an inquest to be held when there is a death in care, in circumstances that raise issues about the deceased person's care. A death in care includes the death of a person with a disability who, at the time of their death, was receiving government funded disability accommodation services.

18. At a pre-inquest hearing held on 17 March 2016 the following issues were determined, as well as witnesses to be called:

    i. The findings required by section 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death.

    ii. The circumstances leading up to the death.

    iii. The adequacy and appropriateness of the health, disability and supported accommodation services provided to the deceased; in particular:

        a) The adequacy of mental health assessment, planning, follow up and support provided by Nambour Hospital in relation to the deceased's discharge on 19 September 2013 and up until the date of her readmission to Nambour Hospital on 6 October 2013.

        b) Whether the Department of Communities, Child Safety and Disability Services responded appropriately to concerns about the deceased's mental and physical wellbeing during her time at BE Lifestyle from 19 September 2013 to 6 October 2013, and the appropriateness of its assessments regarding whether the deceased's needs were able to be met by this service.

        c) The adequacy of care provided to the deceased at BE Lifestyle from 19 September 2013 to 6 October 2013 particularly in relation to pressure sore prevention and treatment.

d) During the course of the inquest it also became apparent that there were two added issues to be considered. The first related to the adequacy of the discharge planning and transitional arrangements put in place by Princess Alexandra Hospital Spinal Injuries Unit. The second related to the adequacy of care provided to the deceased at BE Lifestyle from 26 August 2013 until 5 September 2013 in relation to pressure sore prevention and treatment as well as the circumstances which lead to Ms Floyd's admission to Nambour Hospital for a mental health assessment.

List of Witnesses Called

- CN Sharon Mortensen, Transitional Rehabilitation Program, Queensland Spinal Cord Injuries Service
- Ms Margo Coffey, Occupational Therapist, Transitional Rehabilitation Program, Queensland Spinal Cord Injuries Service
- Ms Sue Booth, Social Worker, Transitional Rehabilitation Program, Queensland Spinal Cord Injuries Service
- Mr Khanh Nguyen, Transitional Rehabilitation Program, Queensland Spinal Cord Injuries Service
- Ms Debra Holton, Carer
- Ms Sarah Frost-Foster, Carer
- Ms Melissa Dyke, Carer
- Ms Angel Prasad, Carer
- Ms Kerry-Anne Cooke, Carer
- Ms Melissa Thomsen, DSQ
- Mr Michael Packman, Support Worker/Service Advisor, DSQ
- RN Charmaine Rawlings, Blue Care Nursing Service
- RN Joanne Martin, Blue Care Nursing Service
- Ms N Gessel, Carer
- RN Wendy Maidwell, Blue Care Nursing Service
- Ms Karleigh Kwapil, Psychologist, PAH
- RN Wendy Tunnicliffe, Blue Care
- Ms Michelle Smith, Service Manager, Blue Care

- Dr Karen Sander, GP
- Ms Stephanie Smith, Carer, BE Lifestyle
- Ms Andrea Messer, Carer, BE Lifestyle
- Ms Belinda Wardlaw, Managing Director, BE Lifestyle
- Dr Anar Taumanova, Psychiatrist, Nambour Hospital
- Ms Allison De Tina, Clinical Nurse, Clinical Forensic Medicine Unit (CFMU)
- Dr Don Buchanan, CFMU

Autopsy examination

19. An autopsy was conducted on 17 October 2013 by Professor Peter Ellis, forensic pathologist. This confirmed the presence of skin ulcers with clean margins. Microscopic examination confirmed some inflammation of the lungs but no full-blown pneumonia. There was some microscopic evidence to suggest an earlier episode of global hypoxia (in which blood pressure and blood oxygenation may have dropped temporarily).

20. Toxicological testing showed benzodiazepine tranquilisers (diazepam and temazepam) as well as the antidepressant sertraline and the pain killer oxycodone. As all were detected at levels considered to be therapeutic, it is unlikely that they specifically contributed to death in the opinion of the forensic pathologist undertaking the post-mortem examination.

21. In his view, it appears likely that death was ultimately due to a septic event, although in the absence of positive culture results this is difficult to prove. It is not uncommon that post-mortem blood and tissue cultures are non-contributory as it is almost inevitable that patients in hospital suffering from infections are also being treated with antimicrobial medication, which has the effect of causing culture results to be frequently negative.

22. On the basis of autopsy examination including toxicology, microbiology, review of medical records (including summarisation by a Clinical Forensic physician as well as police information), it was the pathologist's opinion that death was due to sepsis following pulmonary and cutaneous infections. Other contributing factors were a recent urinary tract infection and tetraplegia, which had been present for some period.

Evidence relating to the Issues

Admission to PAHSIU and Adequacy of Discharge and Transitional Arrangements

23. The care and treatment provided to Ms Floyd at PAH was not considered to be a central issue for the investigation and inquest, but there were some matters raised about the discharge process and whether Ms Floyd was discharged too early. I can deal with these issues in short fashion.

24. Dr Buchanan of the Clinical Forensic Medicine Unit provided a useful summary of her care and treatment up to her discharge in his report. He noted Ms Floyd was a 48 year old woman who was admitted to PAH on 8 August 2012 with spinal fractures following a fall from a first floor balcony. She also sustained a screwdriver laceration to the left wrist, and it was considered the fall may have been a suicide attempt on a background of gross intoxication and alcohol abuse marital discord, panic disorder and prior post-partum depressive disorder. The injuries caused tetraplegia. She underwent operative procedures to stabilise the spinal fractures with a halo.

25. Ms Floyd was admitted to the PAH Spinal Injuries Unit (PAHSIU) on 26 August 2012 for rehabilitation and she was discharged on 23 August 2013.

26. Ms Floyd had episodes of shortness of breath in November 2012 with no evidence of pulmonary embolus. This was considered to be due to mucus plugging in the bronchial tubes. She had poor respiratory drive due to her tetraplegia. A chest x-ray demonstrated right and left lower lobe collapse and antibiotics were commenced. She developed a urine infection in September 2012 and MRSA was grown from the catheter site in November 2012. She was treated for her psychiatric conditions.

27. While at PAH Ms Floyd developed pressure areas on the sacrum (tailbone/base of spine) on 5 July 2013 and a grade 2 pressure area on the left buttock on 25 July. The buttock sores were noted to be healing well on 8 August 2013. Pressure areas on the elbows were noted to be long standing with the right elbow sore oozing with mild cellulitis on 23 August and she was prescribed an oral antibiotic for two weeks.

28. On 22 August 2013 the PAHSIU sent Andrea Messer at BE Lifestyle the Physiotherapy, Nursing, Occupational Therapy and Social Work discharge summaries.

29. The PAH medical discharge summary was sent on 23 August 2013 to BE Lifestyle, and a GP, Dr Sander. This advised that Ms Floyd required nutritional intervention to improve weight gain and wound healing. It was noted that she had relatively inadequate oral intake due to her condition, a long hospital admission, episodes of anxiety, and increased needs due to pressure sores and infections. It was recommended that she have high protein high energy meals and a nutritional supplement and further it was recommended that ongoing dietetic input after discharge from hospital be provided.

30. The discharge summary noted that the hospital was waiting confirmation from Blue Care Nambour regarding her eligibility for dietetic input from their service. Otherwise it was suggested that care planning for subsidised Medicare visits to a local private dietician be initiated. The doctor writing the discharge summary stated that he/she would confirm the follow up plan and notify BE Lifestyle and the GP of the outcome. This latter

suggestion did not appear to have been followed up, but otherwise it is apparent the discharge process was very comprehensive. Skin care was referred to. There was some suggestion expressed by BE Lifestyle and family that it was too early to discharge Ms Floyd in the presence of her pressure wounds. After considering the evidence I am satisfied that Ms Floyd, after such an extensive period in hospital was appropriately discharged and transitional arrangements were adequately put in place. The evidence from a number of witnesses supported a conclusion the pressure wounds could be managed in the community.

31. A comprehensive Clinical Psychology report was sent by Ms Karleigh Kwapil to both Ms Floyd's GP, Dr Sanders, and to the Transitional Rehabilitation Program (TRP) team. The plan was for ongoing review by Ms Floyd's GP and community mental health follow up. Contact was made by the TRP with the Sunshine Coast Community Mental Health Team on 29 August 2013.

32. The inquest heard from the various members of the TRP, which consisted of nursing, social work, occupational therapy, physiotherapy input and clinical psychology input from Ms Kwapil. The full team of the TRP visited on 27 August 2013 and discussed skin care management,

33. Clinical Nurse Sharon Mortensen was actively involved in Ms Floyd's care particularly after the discharge from Nambour Hospital as Ms Floyd was expressing some distrust with the care received at BE Lifestyle. She attended on 2 October to reinsert a catheter and assisted Blue Care in redressing the pressure sores and agreed to attend once a week to attend to dressings whilst Blue Care attended twice weekly.

34. Social Worker Sue Booth also undertook regular social work assessments and interventions and attended at the home with other members of the TRP team on 19 September and on 26 September as well as with Mr Packman from Disability Services.

35. In relation to wound prevention the physiotherapist, Khanh Nguyen and occupational therapist, Margo Coffey attended on 2 October and trialled positioning of Ms Floyd on her side and then provided a step-by-step information sheet for BE Lifestyle staff.

36. It is not intended to refer to the evidence of the TRP members in detail. It is abundantly clear to me the TRP provided an excellent support program for Ms Floyd and I was very impressed with the various team members' caring and professionalism and the proactive manner in which they supported Ms Floyd after discharge.

Adequacy of Services provided by Disability Services and response to concerns

37. This issue can also be disposed of relatively simply. Disability Services funded Ms Floyd so that she could access accommodation support and services within the community. She was allocated the upper limit of

funding of $158,421 per year and with this she was able to decide how to utilise the funding. She chose to receive accommodation support and services through BE Lifestyle, a non-government organisation.

38. BE Lifestyle Connections was approved by Disability Services in 2008 to provide in-home accommodation support, flexible respite, group home accommodation and other programs. It was owned and operated by Belinda Wardlaw. BE Lifestyle supported a number of individuals with departmental funding and also supported a number of privately funded individuals across four approved outlets in the Sunshine Coast region.

39. The process for approval and certification of BE Lifestyle was not an issue considered by the investigation but I was advised and accept that this includes a third-party certification process which assesses the service provider against the Disability Services *Human Service Quality Standards.*

40. Melissa Thomsen was the team leader for the North Coast region Service Access Team. It is evident that her main involvement commenced in early September 2013 when she was advised that BE Lifestyle had concerns regarding their capacity to provide care to Ms Floyd. Her statements to the investigation and her evidence details the considerable proactive efforts made on her part to address the various issues that arose over the period after Ms Floyd went into Nambour Hospital. Ms Thomsen commenced looking for alternative accommodation options for Ms Floyd and was involved in extensive discussions with Ms Wardlaw about options and support that may have been available.

41. It is evident from Ms Thomsen's statement that throughout this period Ms Wardlaw maintained that Ms Floyd had significant mental health issues and believed she did not have capacity to make her own decisions. This was despite the advice from PAH and Nambour that Ms Floyd had no cognitive impairment and had full decision making capacity. Ms Wardlaw maintained she needed to have her staff trained to deal with these issues.

42. Ms Thomsen was also involved in a telelink call on 18 September 2013 where the arrangements for her discharge from Nambour Hospital were discussed. Following this conference she allocated Michael Packman to work with Ms Floyd to ascertain her disability support needs and discuss if she wanted alternative accommodation. He also became a point of contact for all stake holders.

43. Ms Thomsen became aware on 19 September 2013 of the list of 10 rules which will be referred to later in this decision, but she clearly communicated to BE Lifestyle that she considered these incorporated restrictive practices, which disregarded Ms Floyd's human rights and decision making capacity.

44. Mr Packman was diligent in his attendance on Ms Floyd over the next few weeks and was an important support and advocate for her. He visited her almost daily.

45. Despite the difficulties described by both workers in being able to readily find suitable accommodation for people with the level of physical disability of Ms Floyd, it is significant that alternative accommodation had been found and was waiting approval by Ms Floyd. Unfortunately she died before this could be progressed.

46. Ms Floyd was also assisted by Mr Packman in completing a formal complaint to Disability Services concerning her treatment and care at BE Lifestyle. This complaint was investigated by Ms Bernadette Owens and the investigation continued after the death of Ms Floyd. During the course of the complaint process further complaints/information were received from staff members of BE Lifestyle.

47. The complaint was finalised effective on 1 August 2014. Six service improvement recommendations were made and these recommendations were implemented to the satisfaction of Disability Services.

48. The documents provided to the coronial investigation in respect to the complaint process and investigation by Disability Services was comprehensive. It was noted that a finding was made that Ms Floyd had lost confidence in the management of BE Lifestyle. This occurred following Ms Wardlaw's request to Dr Sander for a mental health assessment at Nambour Hospital and Ms Wardlaw's requests for Ms Floyd to be hospitalised. In particular there was a finding that BE Lifestyle did not respect Ms Floyd's decision making capacity and her individual needs were not addressed and responded to appropriately.

49. I am satisfied Disability Services appropriately responded to Ms Floyd's concerns and needs. BE Lifestyle was certified to be able to provide services and care to a person with Ms Floyd's complex needs. When it became apparent Ms Floyd had lost trust in the management of BE Lifestyle, Disability Services acted expeditiously to find alternative accommodation.

The adequacy of care provided to the deceased at BE Lifestyle from 26 August 2013 until 5 September 2013 in relation to pressure sore prevention and treatment as well as the circumstances which lead to Ms Floyd's admission to Nambour Hospital for a mental health assessment.

50. This issue will need to be considered in more detail as there are a number of contentious allegations concerning Ms Floyd's alleged attempt at suicide; alleged refusal to allow medical treatment for her conditions; her mental health as well as pressure sore management.

51. At the time of discharge from PAH in August 2013 there were a number of pressure sores to both elbows and a discolouration to her lower back that required monitoring to ensure they did not develop into pressure sores. The Blue Care documentation has a letter from the PAH spinal nurses to Blue Care dated 19 August 2013 which states inter alia that her

sacral pressure sore had resolved but which is complicated by her inability to lie on her side due to shoulder and neck pain. The letter stated that Ms Floyd had been discharged from PAH with pressure areas on both elbows that needed daily dressings. She had padded arm splints that were to be worn when in bed. She was discharged from PAH with a special mattress. It was advised that her carers check her skin before she got out of bed and when she returned to bed. She was also noted to have bouts of low blood pressure.

52. There was considerable reference through the evidence to the grading of pressure sores. This is important for decisions as to management and prevention. This is generally attended to by nursing staff. In this case I was assisted by a review of the nursing and home care given, by Clinical Nurse Consultant Allison De Tina from the Clinical Forensic Medicine Unit.

53. CN De Tina stated in her evidence that because of Ms Floyd's spinal injury she was at risk of ongoing skin complications. Pressure wounds are caused by pressure, shear or friction and usually form on areas with bony prominence such as heels, elbows and sacrum. It was essential that preventative strategies and ongoing daily skin cares were in place to prevent her wound breaking down even further. Such strategies included regular wound reviews and dressing changes, regular repositioning on bed or in her wheelchair and the use of a pressure relieving mattress. To ensure effectiveness of such strategies it was imperative that documentation was made outlining compliance. Good nutrition assists in prevention. Ms Floyd continued to smoke which increased her vulnerability.

54. Blue Care nurses were all considered competent to grade pressure areas. There are four stages with Stage 1 being the least worrying and Stage 4 involving deep sores reaching into muscle and possibly bone. If pressure sores progress there can be serious complications involving the bone (osteomyelitis) or blood (sepsis).Sometimes the wounds are unstageable because the base of the sore is covered by tissue and pus and cannot be seen. Blue Care Nurse Wendy Maidwell had specialised training in skin/wound management and provided a general description of the grading of pressure sores, which can be usefully adopted as follows:

    a. Grade 1 Intact skin with observable changes including areas of persistent redness.
    b. Grade 2 Partial thickness skin loss involving epidermis and/or dermis.
    c. Grade 3 Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to underlying fascia.
    d. Grade 4 Full thickness skin loss with extensive tissue destruction to muscle, bone. May have undermining or sinus formation.

55. In general, the main concerns where deterioration in her pressure wounds occurred was in the period after Ms Floyd returned to BE Lifestyle from Nambour Hospital. This period will be examined separately in this decision.

56. The wound care provided by BE Lifestyle and Blue Care in the first period from 26 August 2013 to 5 September 2013 could be considered to be adequate because during that period there was no significant deterioration in her wounds. Nonetheless there were a few instances where improvement was warranted and Blue Care acknowledged this.

57. Blue Care helpfully carried out an internal review of services provided to Ms Floyd and provided a report of Ms Michelle Smith, the Manager of Community Services for Brisbane South. She noted a number of areas where there could be improvement. Ms Smith stated that the Blue Care Governance Council have agreed to implement all recommendations.

58. Ms Smith noted the PAH referral to Blue Care was comprehensive and in particular noted a number of vulnerabilities including MRSA infection in pressure wounds and bladder; the need to provide IV antibiotics to treat previous infections; pain affecting the ability to change position; hydration and nutrition patterns; and the facility's ability to meet complex care needs. Ms Smith stated that these were not noted clearly for consideration in Blue Care documentation and subsequent visits and records did not indicate close monitoring of these factors.

59. Blue Care were also reviewing the development of relevant client information regarding best practice wound healing including identifying risk factors and lifestyle measures required to promote healing. A *Pressure Injury Prevention and Management Framework* was implemented in 2015 to assist core staff with best practice and the Blue Care's Community Management System has also been enhanced reducing the likelihood of missing important information. In this case Ms Smith identified a number of issues/risk factors contained in the PAH referral, which were not then referred to in the admission/assessment process conducted by nurses. It was noted that Ms Floyd was admitted to Nambour Hospital after Blue Care had attended on only three visits and that the admission/assessment process was expected to be ongoing and may take a number of visits to complete.

60. On 27 August it was recorded Ms Floyd had a panic attack at night due to overheating and her inability to remove the blankets. Staff were reminded of a fact sheet titled *Advice for Carers, Management of Panic Episodes following Spinal Cord Injury* that had been provided by the Spinal Cord Injury Transition Team at a handover to BE Lifestyle earlier on 27 August.

61. On 28 August she was heard to voice possible suicidal ideation. BE Lifestyle staff were assisting Ms Floyd to have a cigarette on the second storey deck and she allegedly made a comment *I cannot do this anymore if I could drive myself of this deck I would. I want to die.*

62. Belinda Wardlaw contacted Dr Sander by telephone to request regular medication for Ms Floyd's anxiety attacks, regular analgesia and a referral for a mental health assessment.

63. On 31 August it was recorded there was an incident whereby Ms Floyd is reported to have driven her wheelchair onto the road. This incident was considered by Belinda Wardlaw as an attempted suicide. The incident was recorded as one in which Ms Floyd had allegedly driven off on her own in her wheelchair whilst the carer was in a newsagent and on their return *drove her wheelchair straight out in front of a four-wheel drive and was unaware of all the surrounding traffic.*

64. Ms Floyd's explanation, as recorded by Disability Services, was that her wheelchair had rolled back inadvertently into the path of a slow moving car in the car parking area and the vehicle stopped. She stated she had not realised she needed to keep so close to BE Lifestyle staff when she was out in the community as she had accessed the community independently for many months, even with her children without incident while in hospital. Similarly she told Ms Coffey she had been careless and Ms Booth explored the matter briefly and concluded it was not an attempted suicide but a near miss.

65. It is very evident that much was made about this incident and the incident on 28 August 2013 by Ms Wardlaw and the view that Ms Floyd was suicidal permeated and infected much of Ms Wardlaw's actions from then on. There was reported one other incident where it was suggested Ms Floyd had propelled herself onto the road outside the house, although no vehicles were involved. As well Ms Wardlaw spoke to Ms Floyd's mother who was appointed the attorney of Ms Floyd's Enduring Power of Attorney. Ms Wardlaw was given a history from the mother and this included some distressing information.

66. The particulars of that distressing information are the subject of a non-publication order made by me, chiefly because Ms Floyd cannot defend herself and also to protect her reputation in the minds of her children. It is evident that there was a complex family history and dynamic and this is referred to in the PAH records. Ms Floyd was apparently distressed that some of this information was passed on through to other sources, and the information was inaccurate or simply untrue. Ms Wardlaw did not ask Ms Floyd about the substance or veracity of this information and agrees in hindsight she should have verified this information.

67. Ms Wardlaw appears to not have understood that the holder of an EPOA does not have authority to make decisions about a person's health affairs unless the person does not have capacity to make such decisions. To put this in the most favourable light for Ms Wardlaw it is apparent most of her clients did have difficulties with capacity due to such conditions as acquired brain injury and she seems to have put Ms Floyd in the same category. In fact in one file note of 3 October 2013 Ms Wardlaw states BE

Lifestyle was not used to working with people with capacity. As well, Ms Wardlaw is unlikely to have been aware of the difficult family dynamics and appears to have simply accepted the veracity of the history provided by the mother, when she should not have.

68. There were documented further panic attacks on 3, 4 and 5 September. As was noted by the TRP this condition is common for those who have suffered a spinal cord injury and they provided advice and factsheets to assist staff. Blue Care Nurse Joanne Martin attended on 3 September and found Ms Floyd in good spirits and cooperative and not refusing treatment. The sacral wound was a grade 2 and the worst wound was on the elbow.

69. On 4 September Ms Floyd attended Dr Sander for a scheduled appointment. At that time Dr Sander recorded the main problems were of severe anxiety and panic attacks, which were inadequately controlled by her current medication and severe pain in her neck also inadequately controlled by her current regime. Ms Floyd denied any issues with pressure areas at that time. Dr Sander reviewed her medications and instituted a new regime. There was no reference to suicidal ideation in the GP's notes.

70. On 5 September the TRP team visited and noted the wounds were improving and had no other concerns. The team expressed surprise in their statements provided as part of my investigation that Ms Floyd had been taken to Nambour Hospital later that day.

71. On 5 September BE Lifestyle file notes indicate Ms Floyd was having *constant suicidal ideation and expressing threats and the risk was considered to be high.*

72. On 6 September a BE Lifestyle file note stated that Ms Floyd *headed for the grog shop to try begging for alcohol and then went straight into the traffic.*

73. It was put to Ms Wardlaw that these two allegations and other similar references, which were replete throughout the BE Lifestyle records and mainly attributed to Ms Wardlaw, well overstated or exaggerated the reality. The reality was that Ms Floyd made one only statement that could be considered as a self-harming statement, that being the incident of 28 August whilst she was on the balcony. It was put to Ms Wardlaw that the alleged constant threats to kill herself and constant requests for more tablets (Ms Floyd had requested pain relief from her GP) were not based on any objective evidence. Ms Wardlaw was reluctant to admit that this was the only overwhelming conclusion that could be drawn based on the totality of the evidence.

74. On 5 September Dr Sander says she received a call from Ms Wardlaw expressing serious concerns about Ms Floyd's behaviour, particularly the incident in which she allegedly attempted to wheel herself into oncoming traffic. Belinda Wardlaw felt that given the level of mental health issues

she was concerned that they could not adequately deal with them at the facility. Belinda Wardlaw passed on to Dr Sander the distressing information that had been expressed by Ms Floyd's mother.

75. Dr Sander then referred Ms Floyd for assessment to Nambour Hospital mental health that day. In her referral letter she made reference to the distressing information. Dr Sander did not consult with her patient, Ms Floyd although she appears to have discussed Ms Floyd with Ms Wardlaw. BE Lifestyle recorded that Dr Sander asked her if she wanted psychiatric help and Ms Floyd *adamantly refused any treatment.*

76. Dr Sander also appears to have misunderstood her ethical duty as a medical practitioner to ensure patient confidentiality in a patient who had capacity. Dr Sander agreed she relied on information given to her by Ms Wardlaw and it was a mistake to put in some of the information she was told by Ms Wardlaw in the letter of referral.

77. Dr Sander also agreed she provided a report to BE Lifestyle in the context of the Disability Services investigation into the complaint of Ms Floyd but was not clear of her authority to do so. It was suggested at some point in the inquest that Dr Sander had a sloppy view about patient confidentiality, a matter on which I agree. Dr Sander and Ms Wardlaw both misunderstood their role in providing care to a person with significant physical disability but who had full mental capacity to make decisions about her health care.

78. Ms Wardlaw then made arrangements for QAS to attend to take Ms Floyd to Nambour Hospital. QAS must have been told that the person they were collecting would be resistant to leaving and called the Police.

79. Ms Wardlaw then told Ms Floyd she was to be admitted to Nambour Hospital for a psychiatric assessment and ambulance and Police attended. Given those circumstances it is hardly surprising Ms Floyd lost confidence in BE Lifestyle management.

80. Ms Floyd was transferred to Nambour Hospital by ambulance and admitted as an involuntary patient on 5 September 2013. However on 6 September Nambour Hospital advised that they deemed Ms Floyd was safe from a psychiatric review and was safe for discharge. BE Lifestyle refused to accept her return. The decision was made to admit her for a short period on the basis a discharge back to supported accommodation would take place shortly.

The adequacy of mental health assessment, planning, follow up and support provided by Nambour Hospital in relation to the deceased's discharge on 19 September 2013 and up until the date of her readmission to Nambour Hospital on 6 October 2013.

81. This issue can also be dealt with relatively briefly.

82. Clinical Nurse De Tina noted that on 5 September 2013 Ms Floyd was admitted to Nambour Hospital for a psychiatric review and there appeared to be no major issues with respect to her pressure sore areas. Dr Buchanan noted that from the Nambour Hospital admission notes on 6 October 2013 it appears that the sacral pressure area had recurred during the earlier admission, but by the time she was discharged on 19 September it was a healing grade 2 ulcer. Hence it would appear that the sacral pressure area broke down during that admission, but was now healing.

83. Dr Anar Taumanova was the psychiatrist responsible for providing treatment to Ms Floyd whilst at Nambour Hospital. Dr Taumanova stated that Ms Floyd had multiple issues and was receiving care from the wound/stoma nurse, social work, physiotherapy and medical team. Although there was a history of recurrent suicide attempts and deliberate self-harm her impression was she did not have a significant psychiatric disorder requiring an in-patient stay in a mental health unit. The main issues were anxiety and adjustment disorder due to the significant trauma she suffered as a result of her fall resulting in tetraplegia.

84. Ms Floyd denied deliberately trying to hurt herself by wheeling her wheelchair onto the road. Dr Taumanova's statement noted her initial view was that Ms Floyd's denial of a suicide attempt with her wheelchair was likely untrue however subsequent interviews did not reveal this.

85. Ms Floyd reported protective factors of her children and looking forward to restarting her life. Dr Taumanova obtain collateral information from the PAHSIU team who stated that she was bright and happy and the reported anxiety appeared to be her problem, not depression with adjustment issues. Dr Taumanova thought it was likely she had not completed the grief process yet from her accident. Ms Floyd reported a difficult relationship with her mother and the difficulties with her current accommodation and BE Lifestyle's ability to manage her anxiety and airway management.

86. At the time of the psychiatric review the medical records indicated that Ms Floyd was accepting of all cares from the treating clinicians and was therefore making healthcare decisions, which were in her best interests. She was satisfied Ms Floyd had judgement and capacity and accepted treatment. The decision was made to keep Ms Floyd in hospital to look after her medical needs.

87. Dr Taumanova reviewed Ms Floyd on 13 September 2013 and 17 September 2013. The medical issues included an ongoing urinary tract infection and the pressure sores were under control but she was requesting pain relief. Ms Floyd was cooperative with her cares. She became emotional when her discharge was discussed due to issues with her accommodation. The diagnosis was borderline personality disorder, spinal injury, tetraplegia and no major depression. The risk of suicide was considered to be low.

88. Ms Floyd continued to deny any suicide attempts and was anxious to leave hospital and return to her accommodation. On 13 September Nambour Hospital contacted Ms Wardlaw to advise Ms Floyd was ready for discharge and was informed by Ms Wardlaw that her care was beyond the capacity of BE Lifestyle. Ms Wardlaw provided an email to Nambour Hospital stating they were not able to accommodate her due to the lack of trained mental health support workers. This was despite the hospital advice that there was no acute mental health issues.

89. On 19 September 2013 a teleconference was held with participation by Nambour Hospital, Disability Services, BE Lifestyle and members of the TRP. Despite continued expressed misgivings by Ms Wardlaw, the plan was for discharge that day back to BE Lifestyle. Blue Care was not invited to the meeting. This had some consequences as to continuity of treatment, which will be referred to shortly. It was agreed that not involving Blue Care or sending it a discharge summary was a mistake.

90. In the 'follow up' section of the discharge summary from Nambour Hospital there was nothing completed. CNC De Tina noted the discharge summary from Nambour Hospital had not filled in most of the referral or follow-up information. She queried the hospital guidelines on distribution of the discharge summary and said that presumably the care facility would need to be advised as to what is required or what needs to be arranged.

91. The Sunshine Coast Hospital and Health Service (Health Service) responded to a request from me for a statement addressing the policy, procedures and guidelines regarding the distribution of discharge summaries and communication between carers regarding referral or follow-up medical information.

92. The Health Service stated it has two procedures for discharge of patients. The discharge procedure sets out the free planning and preparation to transition consumers back into the community with adequate follow-up and sharing of information. Discharge planning is coordinated by a multidisciplinary team review. The procedure may include the participation of relevant stake holders in the community including carers and other providers.

93. There are two discharge summaries, one specific to mental health and the other for use by other specialties. Before a mental health patient is discharged, the treatment plan is documented in the computer based care program CIMHA.

94. As a general rule, a copy of the discharge summary is sent to the patient's general practitioner who is identified on the Patient Admission Form. The Health Service does not have a procedure that specifies the key stake holders that should receive a copy of a discharge summary as this is determined on a case by case basis and is dependent on the clinical and

social setting and relevant stake holders in the community providing health care to the patient.

95. It should be acknowledged that in this case the discharge planning meeting included the contribution of a number of persons and some arrangements were put in place. For instance the TRP social worker and psychologist agreed they would attend on 19 September and the other team members from occupational therapy and physiotherapy would attend on 20 September to assist Ms Floyd and BE Lifestyle.

96. The TRP social worker and psychologist attended on 19 September and provided staff with information about Ms Floyd's psychological assessment, and family dynamics and advice on how to manage her anxiety. They were advised to contact a local Acute Care Team where there were concerns about safety. BE Lifestyle were also offered ongoing education sessions for carers required in relation to these issues.

97. To that extent, any deficiencies in the discharge summary were mostly in relation to documentation and not the planning itself. I am satisfied that otherwise the mental health assessment and discharge planning was adequate.

The adequacy of care provided to the deceased at BE Lifestyle from 19 September 2013 to 6 October 2013 particularly in relation to pressure sore prevention and treatment.

98. The next issue is obviously a critical period and requires closer examination.

99. It is evident that by the time Ms Floyd came back to BE Lifestyle she had lost trust in BE Lifestyle management although Ms Floyd reportedly appreciated the cares provided by the staff. The evidence clearly establishes that for whatever reason, Ms Wardlaw had grossly exaggerated the facts said to support the allegation that Ms Floyd was suicidal. This loss of trust was contributed to by the actions of her GP Dr Sanders who maintained that some instances of alleged refusal to receive treatment may have been a subtle suicidal behaviour with a fluctuating level of competence.

100. The Disability Services complaint outcome found Ms Floyd had lost confidence in the management of BE Lifestyle. This occurred following Ms Wardlaw's request to Dr Sander for a mental health assessment at Nambour Hospital and Ms Wardlaw's requests for Ms Floyd to be hospitalised. In particular there was a finding that BE Lifestyle did not respect Ms Floyd's decision making capacity. The evidence well supports that conclusion.

101. What followed must have further exacerbated Ms Floyd's mistrust of BE Lifestyle. On 18 September documents contained in the BE Lifestyle records state that Ms Floyd's mother was requested by BE Lifestyle to agree to implement 10 restrictions prior to her return. Ms Wardlaw stated

that the rules were devised by Ms Floyd's mother. The document itself states that Ms Floyd's mother has agreed to the rules and further that they had been approved by Ms Wardlaw's legal team. Ms Wardlaw stated in evidence the document had not been reviewed by her legal advisors and she was unable to explain why that passage is there.

102. I can conclude that on any reading of the file note it is most likely the rules were devised by Ms Wardlaw and her evidence at the inquest by no means dissuaded me otherwise. Apart from initial contact with my office soon after the death, Ms Floyd's mother took no part in the inquest and I make no finding or comment about her involvement one way or the other in the devising of the rules. The rules are below and speak for themselves.

BELR FILE NOTE

Customer x Staff ☐ Other ☐

Allied Health ☐

Topic eg. customer /staff name	**RULES RE LEAH FLOYD**	**Date of issue/event/ discussion**	**18/9/2013**
Person completing form	**Maree Palmer**	**Date form completed**	**19/9/2013**

NOTES:

LEAH'S MOTHER HAS AGREED TO THE FOLLOWING:-

1. NO SMOKING
2. NO COMMUNITY ACCESS
3. NO VISITS FROM CHILDREN
4. NO CONVERSATION TO PCA ABOUT ENDING HER LIFE
5. NO PHONE CALLS IN OR OUT
6. PRN APPROVED BY BELINDA
7. COMPLIANT WITH DIET / FLUID INTAKE
8. COMPLIANT WITH PERSONAL CARE ROUTINE IN RETREAT
9. DO NOT ALLOW FELLOW CUSTOMERS TO GIVE CIGARETTES
10. PAY BILLS WEEKLY

THESE RULES ARE TO BE REVIEWED MONTHLY BY MANAGING DIRECTOR, BELINDA WARDLAW, AND HAVE BEEN APPROVED BY BE LIFESTYLES LEGAL TEAM.

FOLLOW UP:

Who is responsible for follow up?

Date follow up completed?

\\NEWSERVER2\Documents\Public\Customers\Customers\Current Customers\J Musgrave\Leah Floyd\File notes\2013 09 18 File note Leah Floyd Rules as agreed by mother.docx Apr 2013

Exhibit B3 page 217

103. On 20 September 2013 Disability Services through Ms Thomsen advised BE Lifestyle that those restrictions were a breach of her human rights and a breach of the *Disability Services Act 2006* and neither BE Lifestyle or her mother was legally able to impose those restrictions.

104. On the same day Ms Floyd told Ms Foster, one of her carers, she was upset with her family and what Belinda has done and made her feel. This was recorded in a BE Lifestyle file note.

105. On 23 September 2013 Disability Services met with Ms Floyd and she provided details of her complaints including the restrictions that had been implemented without discussion with her. Ms Thomsen from Disability Services expressed dismay and considerable distress about these rules at the inquest. Ms Thomsen by this time had concerns about BE Lifestyle's ability to meet Ms Floyd's emotional needs although she had no concerns about their capacity to meet her physical needs, despite the concerns BE Lifestyle raised. Arrangements were to be put in place to organise some further training for staff on managing mental health issues and community access for Ms Floyd.

106. Ms Wardlaw persisted in her claim in her evidence that the rules were not implemented, although it is most likely Ms Floyd was aware of them and in particular she was distressed at the suggestion of not being able to contact her children let alone see them. Ms Wardlaw conceded in her evidence that once she came to realise that Ms Floyd had the capacity to make her own decisions, and it was not appropriate to impose the 'ten rules', that it was at this time she knew she had lost Ms Floyd's trust about anything.

107. On 23 September, House Leader Andrea Messer who had nursing experience, took it upon herself to redress the wound on the sacrum noting Blue Care was attending the next day. On 24 September Nurse Rawlings attended from Blue Care. There was some confusion based on the Blue Care records as to when they were informed of Ms Floyd's return to BE Lifestyle, given they were not invited to attend the discharge conference on 19 September. This was noted by Dr Buchanan and CNC De Tina in their reports. In the review by CNC De Tina she stated in relation to the referral process, it was evident that there needs to be a clearer definition of roles and a better understanding of clinical pathways. From the notes it was unclear as to whose responsibility it was to notify Blue Care of Leah's return home. It was thought that the hospital had a responsibility to hand over the discharge summary and care plan to those taking over her care. From information provided by Blue Care, this did not happen.

108. CNC De Tina noted the records are unsure as to when Blue Care were notified of her return, although it appears this occurred when the Registered Nurse was requested to attend on 24 September but the reviewer thought that 5 days from 19 September to 24 September was too long to leave the dressing that required changing every 3 days.

109. Although the records at first indicated there had been a gap of 7 days, it is now apparent there was a gap of 5 days from discharge to when Blue Care first attended. It may have been this visit was an add-on and had not been pre-scheduled for that day. It may be BE Lifestyle requested a visit for wound care and Blue Care was contacted and Nurse Rawlings was asked to attend. Blue Care may have been telephoned by BE Lifestyle on 20 September as suggested by Ms Messer, the House Supervisor, although Blue Care have no record of this. In response to this issue Blue Care has reviewed "Re-commencement of Service" processes and considered that it was more likely Blue Care was not informed to recommence services prior to scheduling the visit on 24 September

110. Whatever is the case, Blue Care accepts that a call must have been made at some point.

111. Ms Smith's review also noted that the gap between discharge from hospital and re-commencement of services had a significant impact on the deterioration of the wound, especially the sacral area. She also noted that re-commencement of services would normally include a reassessment of condition, care needs and interventions and there was nothing recorded to indicate this was done. Subsequently no concerns were noted and no action is recorded regarding the condition of the wound. Ms Smith considered the lack of documentation and follow up at this visit is a definite gap in care.

112. In response to the review by Ms Smith, Blue Care staff had ongoing training since 2013 and informed through various communication updates regarding the best practice application and use of information recorded in the case management system. Wound monitoring information is now available by the system including uploading of referrals and photographs.

113. At the wound assessment review on 24 September a note is made by the Blue Care nurse Charmaine Rawlings indicating Ms Floyd had stage 2 pressure areas to her sacral area and both her elbows. All wounds were reviewed and dressings attended to. Nurse Rawlings says she had a clear recollection of the attendance but is unsure as to why she made no record in the progress notes. She thought Ms Floyd was emotionally fragile and had some concerns about BE Lifestyle's capacity to deal with her mental state. She had no concerns about it being able to provide for her physical needs. The pressure relieving mattress was inflated. In relation to the sacral wound she noted no malodour, minimal exudate, no necrosis and considered it was a stage 2 wound but there was some evidence of shearing mark consistent with having been dragged up the bed. The wound was redressed.

114. Nurse Rawlings completed an 'Allied Health & Medical Practitioner Report Form' (Allied Health Form) for BE Lifestyle giving instructions on how to clean, protect and cover the wounds. Nurse Rawlings was moderately concerned about the sacral wound and provided a verbal hand over to the

primary visiting nurse who was to attend on 27 September 2013. In her hand over to the primary nurse Martin she expressed a concern that the sacral ulcer had evidently deteriorated from the description in the progress notes from 29 August to 3 September 2013.

115. Allied Health Forms were requested to be completed whenever Blue Care or other health clinicians attended. The issue of what was done with these Allied Health Forms as well as other documentation was explored at the inquest.

116. On a number of such forms instructions and advice were given concerning Ms Floyd's care. On the face of it, it could be reasonably expected that those instructions and advice would be passed on to staff. This does not appear to have been the case, or at least universally.

117. Rather it appears the forms were sent to Ms Wardlaw where they may or may not have been read. Ms Wardlaw's evidence on this issue varied at times. For instance, Ms Wardlaw only became aware of the issue of the pressure mattress being deflated when it was brought to her attention during the investigation by my office, so it can be assumed she had not read or at least understood the significance of this incident.

118. When questioned at the inquest the evidence from staff was that it was unlikely that any feedback or recommendations were actioned by Ms Wardlaw or other BE Lifestyle staff in respect to most of this advice and the Allied Health forms were not placed within the progress notes for viewing by oncoming staff. Staff told the inquest they would not read the Allied Health forms and their responsibility was to scan and send to Ms Wardlaw and they did not receive any other information about the content.

119. From the perspective of Blue Care, the nurses were unaware of what happened to the Allied Health Forms. RN Martin stated she considered the Allied Health forms would be useful if they were read and passed on but she had no idea if they were. RN Maidwell expressed a similar comment.

120. Otherwise the nurses may have discussed their findings with carer staff present to educate them but as suggested by RN Rawlings were generally unaware of the capabilities of BE Lifestyle staff to provide skin care management.

121. Dr Sander saw Ms Floyd on 25 September where anxiety and pain were her main complaints. She was also suffering from constipation and a laxative regime was altered.

122. On 26 September 2013 a case meeting was facilitated by Disability Services with Ms Floyd and BE Lifestyle. This was to discuss the need for alternative accommodation for Ms Floyd since her return to the premises. At this meeting Ms Floyd requested assistance to find an alternative

general practitioner to Dr Sander and she also requested support to remove her mother as her Enduring Power of Attorney.

123. On 27 September Blue Care Nurse Joanne Martin attended and made more detailed notes regarding the state of the wounds. The sacral wound had deteriorated and it was now large and necrotic. RN Martin stated the wound was now a grade 3/4. It was also stated that the pressure relieving mattress was turned off at the electrical switch on the wall. This meant that although the mattress had a warning alarm when deflated, the alarm would not work without power. RN Martin could not ascertain from the BE Lifestyle staff a satisfactory explanation for this state of affairs.

124. An Allied Health Form dated 27 September 2013 was completed by Blue Care Nurse Martin and stated that Ms Floyd had a necrotic and increasing pressure area at that time. She also noted that the air mattress had not been inflated but was unsure for how long. She made comment about her lying on a towel under the sacral area, the friction from which was contraindicated. It was recommended by her that the dressings be done 3 times a week as well as making a number of recommendations concerning the pressure mattress not being on, changing of position and other pressure sore management. RN Martin had no concerns that Ms Floyd could continue to be managed in the community.

125. The issue of the time frame during which the pressure relieving mattress was off was considered with a number of witnesses at the inquest. Ms Wardlaw stated that staff members do not recall any concerns relating to the mattress at any time. She reiterated that staff were trained in the necessity of repositioning customers who are physically unable to do so themselves. Ms Wardlaw stated that none of the records indicate the mattress was deflated for the period 19 September to 27 September, nor subsequently. Ms Wardlaw stated she recalls specifically on 23 September 2013 that the mattress was inflated.

126. BE Lifestyle carers suggested it was likely only a matter of hours, as if Ms Floyd was being repositioned every hour, it would be “obvious” when repositioning in bed that the mattress was deflated. At the other extreme, it could have been as long as three days if in fact it wasn’t obvious to carers the mattress was deflated. CNC De Tina stated that as there is nothing to state otherwise it can only be assumed it had been off since her return. However at the visit on 24 September RN Rawlings says the mattress was on.

127. It is difficult to be able to resolve the time frame issue with any certainty but I conclude, as submitted by counsel assisting, that it was unlikely to be for a number of days. That leaves the position to be that it was at least a number of hours and could have been substantially more. The significant concern was that this was noticed by a Blue Care nurse and not BE Lifestyle staff and in my view it is not coincidental there was significant deterioration in the sacral wound in this period increasing the possibility it was a more substantial than a number of hours.

128. Ms Smith also commented on this visit. She noted concerns were raised and expected care responses were attended to and documented with the next visit to take place on 1 October 2013. She stated that the exact time frame for the wound deterioration is unclear from the file and as to whether this occurred during the admission to Nambour Hospital or on return to BE Lifestyle. She also stated it was unclear if BE Lifestyle carers were attending to wound care on other days as a regular pattern, noting carers did attend wound dressing on 29 September 2013. Ms Smith considered that not reviewing and scheduling an earlier visit may have impacted on the outcome. She found that actions taken on 1 October 2013 and following visits were responsive. RN Martin acknowledged that in hindsight this may have been a missed opportunity to escalate care to the TRP rather than deferring that decision until 1 October but she considered she did all that was necessary to treat and manage the wound that day.

129. Ms Smith made a number of recommendations concerning Blue Care documentation. She considered that documentation and the responsiveness of nurses to the changes in Ms Floyd's condition and care requirements were insufficient. She noted that holistic care requires a clear understanding of the care provided by BE Lifestyle, particularly for a client with such complex care needs. The Blue Care records did not demonstrate the information that may have been recorded such as advice about wound management to BE Lifestyle. Documentation regarding raising these concerns was particularly important in this case and would support the fact that wound healing is significantly affected by general care and not just wound dressings.

130. CNC De Tina also gave evidence that the documents provided from BE Lifestyle had lapses in documentation regarding the repositioning of Ms Floyd, the body charts and complete omissions about whether the pressure mattress was on and functioning. There were no documents indicating she was moved or repositioned at night. These issues were also addressed at the inquest. This is not to say that BE Lifestyle staff failed to do anything. The records indicate staff had noted wound deterioration and they largely did their best but there appeared to be gaps in the records as to when she was repositioned and there were lengthy periods when she was noted to be sitting or in bed. CNC De Tina thought that some staff seemed to be better with Ms Floyd's complex needs and behaviour but in general they tried the best they could, given her multiple areas of need.

131. It should be acknowledged there were occasions when Ms Floyd refused to be turned because of the pain associated with lying on her side and she continued to smoke against advice.

132. On 29 September BE Lifestyle reported the dressing and pressure area was starting to weep and her IDC catheter had dislodged. They used continence pads as an interim measure. They noted the pressure areas were smelling, she had a vaginal discharge and intended to make a doctor's appointment for the next day on Monday. Ms Wardlaw was

informed and she says she tried unsuccessfully to get an after-hours doctor. An ambulance was called and had arrived to take her to hospital but Ms Floyd refused. Ms Floyd informed Disability Services she was concerned if she left the house she would not be allowed to return.

133. It is apparent that over 30 September there was further deterioration in her condition. Ms Floyd is recorded as saying she did not want to go the hospital and believes the paramedics would replace the catheter, Blue Care would attend to her pressure sores and she would also see Dr Sander about her infection, all in one day.

134. On 1 October 2013 Mr Packman spoke to Ms Floyd at which time she refused to go to the hospital. BE Lifestyle contacted Blue Care to delay their appointment until later that afternoon as Ms Floyd had a medical appointment at 3pm. It is apparent Ms Floyd was not advised of these appointments.

135. On 1 October Ms Floyd attended an appointment with the GP Dr Sander. Ms Floyd described an improvement in her pain levels. Her carer mentioned that Leah had an offensive vaginal discharge, an infected sacral pressure area and her indwelling catheter had come out on the weekend. Ms Floyd was not examined at that time and Dr Sander wrote a referral to Blue Care nurses for catheter insertion, urine samples, wound swab and dressings as a priority. She started her on an antibiotic Augmentin. Dr Sander said she understood that Ms Floyd apparently refused to allow the nurses to take the ulcer swabs as requested when they visited on 2 October, although it is evident that was not the case.

136. Dr Sander claimed she was not permitted by Ms Floyd to examine her or replace the IDC. Ms Floyd subsequently told Disability Services that Dr Sander was unable to view and assess her pressure sores that day as there was no hoist in Dr Sander's rooms, and they both agreed it would be easier for the nurse to attend to this task back at Ms Floyd's accommodation.

137. The prescription for the antibiotic was not taken out until twenty-four hours later. The reason for this was aired at the inquest and seemed to be related to some concern that prescriptions be taken out at the pharmacy used by BE Lifestyle some distance away and not immediately at the pharmacy next to Dr Sander's rooms. The reality is it probably just slipped through the cracks. Dr Buchanan considered this was not optimal but not contributory to death as the antibiotic would not have been effective against the infection ultimately identified.

138. Dr Sander's evidence was she found Ms Floyd to be a difficult and demanding patient, who significantly underplayed her symptoms. She feels she continued to have suicidal ideation during her stay with BE Lifestyle. She refused counselling despite having obvious issues to deal with. She also refused adequate examination, which may have revealed the extent of her illness.

139. Blue Care attended later during the afternoon of 1 October and took swabs, assessed and dressed the wound and contacted TRP to request assistance with the reinsertion of the catheter, wound and overall health. RN Martin was concerned at the state of the wounds. RN Martin wanted assistance with the IDC by a spinal nurse as she had not inserted an IDC in a spinal patient before.

140. On 2 October CN Mortensen of TRP reinserted a new catheter. She found Ms Floyd in bed with a saturated incontinence pad and urine saturating her sacral wound dressing. On reinsertion of the catheter a large quantity of urine was drained with the last 100-150 ml heavily sedimented and purulent.CN Mortensen reinforced the need to have a patent catheter at all times. Ms Floyd expressed concern that if she allowed herself to go to the hospital to have the catheter changed, she would not be allowed to return to the house as she feared they would have her committed to the mental health unit again. CN Mortensen reassured her that having a catheter changed did not generally require an admission and would be attended to in the emergency department. She also discussed the need for Ms Floyd to seek medical treatment in a timely manner, and not delaying due to these fears.

141. RN Martin from Blue Care then attended and the wound was redressed. The sacral wound was now a stage 4. A determination was made that she did not require hospitalisation for treatment and Blue Care would manage the dressing of the wound. CNC De Tina stated it appears this decision was made taking into consideration that Ms Floyd was very reluctant to go back to hospital.

142. An Allied Health Form noted that at the sacral wound was stage 4 and further recommendations were made concerning pressure removal, the role of diet and nutrition was noted and wound dressings would now be changed three times a week by Blue Care and TRP. The TRP physiotherapist and occupational therapist also attended and provided a step-by-step information sheet to assist BE Lifestyle staff. Ms Floyd told the physiotherapist that she felt vulnerable and not supported and that staff members, but not her immediate carers, were lying about her health condition to other services providers. She said she needed to put up with the situation rather than speaking out as it may have implications for access to her children. It is apparent an arrangement had been made for her to see her children on 6 October. She had not seen them for 6 weeks.

143. Ms Smith was also critical of the lack of documentation concerning why the catheter was not replaced until 2 October 2013. RN Martin acknowledged that with hindsight this issue could have been better managed by her but she relied too heavily on reporting from BE Lifestyle staff to the effect that Ms Floyd was filling her pads as showing she was not in urinary retention. She discussed with a member of TRP and they agreed to reinsert a catheter following day. It is evident Ms Floyd went into urinary retention at some point as was evident on 2 October 2013. RN

Martin acknowledged it would have been better practice for her to attempt reinsertion notwithstanding it was difficult and only in the event that could not be achieved should she had deferred to wait for the assistance of TRP.

144. On 3 October 2013 Disability Services staff met with Ms Floyd to discuss a series of events regarding her current wound, her catheter and her support being provided by BE Lifestyle. Ms Floyd stated she had heard two staff members stating that if she was hospitalised she may not be allowed back to the house. Later that day Blue Care nurses attended and advised that the wound was showing signs of improvement.

145. On 3 October Dr Sander received a telephone call from Belinda Wardlaw expressing serious concerns about Leah's refusal to allow treatment. Dr Sander agreed that it may have been a subtle suicidal behaviour with a fluctuating level of competence. She advised Ms Wardlaw to call an ambulance and transport her to hospital even if it was against her will, as she was placing herself in danger by refusing adequate treatment.

146. On 4 October 2013 a discussion was witnessed between BE Lifestyle and Ms Floyd regarding a need for her to be hospitalised but she had refused.

147. On 5 October Blue Care Nurse Wendy Maidwell attended and found a contamination of a dressing due to faecal matter but this had not entered the wound and only the edges of the dressing. Otherwise there was a small necrotic area but she was unable to grade the wound beyond a 3/4 as she was unable to probe it. She stated that where there is any necrosis there was always the potential it might be a grade 4. She considered the sacral wound was progressing in healing and Ms Floyd could be effectively managed in the community dependent upon other management issues including diet, hydration and vigilance about prevention strategies including positioning and repositioning.

148. Over the night shift of 5 October 2013 Carer Nicole Gesell observed Ms Floyd to be very unwell and Ms Floyd begged her not to send her to hospital until after her children visited the next day. She also said she was worried Belinda would keep her in the hospital. Ms Floyd later told Mr Packman she had been feeling unwell and she delayed calling an ambulance when it was offered to her the next day because her children were coming and she had not seen them for over six weeks. Ms Floyd told him she did not understand why her condition had deteriorated the way it did.

149. On 6 October 2013 Ms Floyd was admitted to Nambour Hospital. She had agreed for an ambulance to be called after her visit with her children at around 2:30 pm. At 3 pm it was stated she stopped breathing and staff performed CPR. Ms Floyd later denied she needed CPR but was just having difficulty coughing up phlegm. The ambulance arrived shortly after and she was admitted to Nambour Hospital.

150. On 9 October Disability Services met with Ms Floyd in hospital to discuss her complaints about BE Lifestyle.

151. Despite the efforts of hospital staff, Ms Floyd remained unwell and died on 10 October 2013 due to complications with the infection spreading through her body.

Review by Dr Buchanan of Clinical Forensic Medicine Unit of Nambour Hospital admission leading up to death

152. Dr Don Buchanan reviewed the medical material and provided a helpful summary of the care provided to Ms Floyd at the Nambour Hospital during her last admission.

153. Ms Floyd was taken to Nambour hospital on 6 October 2013 with a 2 -3 day history of intermittent fevers and low temperatures. She had a cough with some greenish phlegm but no shortness of breath. The BE Lifestyle file note dated 6 October stated that the staff were concerned for her health over the previous 2 -3 days; there had been several episodes of coughing that required assistance by staff to clear the phlegm. Ms Wardlaw had stated that Ms Floyd had been refusing treatment over the previous 10 days or so.

154. On the day of Ms Floyd's admission to Nambour Hospital, staff at BE Lifestyle had tried to get an after-hours doctor (it was Sunday) but could not. It is further stated that Ms Floyd was refusing medical treatment and stated she would go to the doctor the next day (Monday), though was informed it was a public holiday. Staff rang 13HEALTH who advised she needed to be taken by ambulance to hospital. There was an apparent episode where Ms Floyd was stated to have stopped breathing at 1501 hours but assisted cough compression enabled her to cough up yellow phlegm and continue breathing. The ambulance arrived at 1522 hours and left with Ms Floyd upset that she was being taken to hospital.

155. Initially Ms Floyd was to only be admitted overnight. This caused disquiet with Belinda Wardlaw. The sacral pressure area was noted to have progressed from a healing stage 2 ulcer (on 6 September 2013) to a 10cm x 8cm stage 3 ulcer with slough and necrotic tissue. She also had bilateral stage 2 heel and elbow ulcers. She was also found to have a urine infection.

156. The wounds were dressed and she was commenced on intravenous antibiotics. She was admitted and the surgical team debrided the ulcers and found an abscess that was drained. An MRI showed no osteomyelitis. She had an episode of shortness of breath on 7 October. Later on 7 October she had an episode of low blood pressure that was symptomatic. A CTPA showed no evidence of a pulmonary embolus. There was a chronic right middle lobe collapse and a moderate pericardial effusion which was slightly bigger than on a previous scan on 26 November 2012. An Advanced Resuscitation Plan (ARP) was completed and Ms Floyd was not for CPR.

157. The cause of the low blood pressure was unclear, perhaps from sepsis or even from autonomic dysreflexia (nerve regulating abnormality due to her tetraplegia). On 9 October it was documented that she probably had sepsis likely from her sacral pressure sore and perhaps a chest infection. It was noted that she had received multiple emergency calls to the ward due to her episodes of low blood pressure.

158. The infectious diseases team reviewed her on 9 October and noted that her wound was MRSA positive and that her temperatures were fluctuating from low to up to 38 degrees. The infectious diseases doctor stated that she did not look septic though noted she felt tired with neck pain. She was acidotic, which was thought to be due to poor respiratory drive from her tetraplegia so she was provided with high flow oxygen to maintain oxygen saturation above 90%.

159. On 10 October Ms Floyd progressed to respiratory failure secondary to sepsis with irregular breathing. It was considered she was terminal and end of life care was to be commenced however she died at 0930 hours that morning.

160. The care provided by Nambour Hospital during Ms Floyd's admission and up until her death was not identified by Dr Buchanan as an issue of concern and I accept his evidence.

Response by BE Lifestyle

161. BE Lifestyle provided a detailed response to the issues raised in the various reports and as requested by the coroner. Ms Wardlaw was examined extensively during the inquest and I have referred to some of that evidence in this decision. It is not intended to refer to this evidence in its entirety and I will make some general observations.

162. Ms Wardlaw's response, consistent with her evidence and numerous BE File Notes indicated that Ms Floyd <u>continually</u> refused medical intervention for her health and BE Lifestyle management and staff have never had a customer before refuse medical intervention or treatment.. BE Lifestyle reiterated throughout the material they were dealing with a customer who was refusing medical intervention and it had been consistently advised that Ms Floyd had capacity to make her own choices. There was almost a pejorative tone to this evidence.

163. Ms Wardlaw expressed concerns to Disability Services and Nambour Hospital on numerous occasions that BE Lifestyle was not the appropriate placement for Ms Floyd.

164. The response noted wound care management nursing is not its responsibility. At BE Lifestyle staff are trained to be alert, recognise factors, change dressings, advised on the need for medical treatment and liaise with the client and providers such as Blue Care.

165. BE Lifestyle said it was not able to provide wound care management as required by Ms Floyd in all of her circumstances despite regularly raising the issue of this needing to be attended to.

166. Ms Wardlaw was also concerned that the community care service by Blue Care for wound care management cannot be activated in a timely manner, is costly for the customer and not always available on weekends, unless the customer is prepared to pay for a private nursing agency.

167. Ms Wardlaw stated Blue Care needs to address the need for a consistent timely service so staff can prepare customers for appointments, and lack of communication in the booking service.

168. BE Lifestyle considered it was consistently attempting to work with Ms Floyd and Disability Services. The process was hampered by the fact that Ms Floyd was refusing medical treatment and there was a lack of attention by others outside of BE Lifestyle to the concerns raised.

169. Ms Wardlaw was examined at length during the inquest on the matters she raised in her response and on other evidence. She accepted that it was unclear if or how recommendations contained in Allied Health forms were communicated to staff and stated she had set up an electronic record system that ensured staff were forced to read such documents.

170. As well she agreed there were some gaps in repositioning and skin integrity records and uncertainty as to overnight repositioning and no record confirming the mattress was inflated or not. She acknowledged how essential this was for wound management. It is evident from the recording of positioning that Ms Floyd could be in a seated position or in bed for long stretches of time. Some agreed this was not optimal but stated this was Ms Floyd's decision.

171. Ms Wardlaw also agreed the 24 hour delay in filling out the prescription was a systemic failing and now all scripts are immediately filled and a policy was being updated to reflect this.

172. The carers involved in attending to Ms Floyd were also questioned. It was evident there was an element of finger pointing and blame directed towards BE Lifestyle with a number of former staff somewhat bitter towards Ms Wardlaw in particular. Other staff were fully supportive of the company and Ms Wardlaw.

173. Some carers had nursing experience, some had completed relevant certificate level courses and some only had training from BE Lifestyle. In general, the carers were probably responsive to Ms Floyd's needs consistent with the views expressed by Ms Floyd that she thought well of the staff but less so of the management. The carers had no capacity to attend to dressing her pressure sores and that was why Blue Care were engaged. The staff generally gave evidence that they had some training

in strategies to minimise pressure sores including the use of the mattress, positioning and not being in one place for any long time, and nutrition.

174. Some staff members such as Ms Frost-Foster, Ms Prasad and Ms Cooke appeared to take the company line about Ms Floyd's behaviour particularly regarding Ms Floyd having little concern for her own health and well-being. Others such as Ms Holton, were aware that Ms Floyd was wary of Ms Wardlaw and did not want to see Dr Sander after she had been taken to Nambour Hospital the first time.

175. I have some concerns as to the reliability of some of this evidence. For instance the evidence of Ms Prasad was of particular concern as to its veracity and extensive cross examination resulted in a highly redacted version of her original statement being produced.

176. I do not suggest Ms Wardlaw or any of the staff behaved with any malice towards Ms Floyd. I accept they were doing as best they could but with limitations in the quality of carer personnel and limitations in the quality of management, leadership and governance at an operational and policy level. BE Lifestyle indeed may not have had the capability to provide for all of the needs of a complex client such as Ms Floyd. Ms Wardlaw had a very limited understanding of client confidentiality and really no understanding of the rights of persons who have capacity to make decisions.

Conclusions

177. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the deaths occurred with a view to reducing the likelihood of similar deaths.

178. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body

179. The impact of hindsight bias and affected bias must also be considered when analysing the evidence. Hindsight bias and affected bias can occur where after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

180. It is also my experience that in most health care related adverse events there are usually multifactorial issues at play and a combination of system and human errors. Poor communication, poor documentation and a lack of safeguards can result in poor decisions being made. Some of those

factors are evident in this case and these resulted in a number of missed opportunities to diagnose the deterioration in condition being suffered by Ms Floyd.

181. In his review Dr Buchanan noted some 70 files were provided and attempting to glean a chronology was difficult. I am appreciative of Dr Buchanan's efforts in so doing. The case was certainly complex from that point of view. As well it was difficult to gather the real picture from considering the BE Lifestyle file notes, as although there may have been an element of truth about them, the content was often tainted by the exaggerated and self-serving tone expressed by Ms Wardlaw and some of the staff. I was however assisted greatly by chronologies prepared by Ms Jarvis and Ms Gallagher.

182. I have made comments that I do not have any major concerns regarding the Discharge Planning from PAHSIU. The subsequent contributions by the TRP appeared to be excellent.

183. I have no concerns regarding the responsiveness of Disability Services to assisting Ms Floyd in her funding, planning, finding accommodation and to protect her human rights. In hindsight, BE Lifestyle may not have been the right placement for Ms Floyd. BE Lifestyle did appear to have the capacity to care for her physical needs although there is a question mark about the level of their skills in this area. It is evident Ms Floyd's emotional needs were not met by management. When that became evident Disability Services set about the task of finding alternative accommodation from a scarce resources and provided Ms Floyd with excellent support and advocacy through Ms Thomsen and Mr Packman.

184. I also have no concerns as to the treatment of Ms Floyd at Nambour Hospital at either admission other than the one issue of discharge planning regarding ensuring Blue Care was advised. That is a matter that the health district should take on board. This may have had some impact on the timeliness of Blue Care's continuity in care and becoming reinvolved, although it was not by any means a significant impact given Ms Messer from BE Lifestyle is likely to have communicated this to Blue Care on 20 September anyway.

185. With respect to Blue Care the evidence suggests that overall the decisions made and treatment given for Ms Floyd's wound care were appropriate. Blue Care acknowledged there could be improvements to their documentation and some decision making that may have provided Ms Floyd a better level of service. That said, it cannot be stated that there was any one decision or treatment option made by Blue Care nurses that was causal to Ms Floyd's death.

186. I agree with Ms Jarvis' submission that Blue Care has demonstrated a genuine concern to improve practices for the future, both at an individual and organisational level.

187. Dr Buchanan stated the issues are many. Ms Floyd developed pressure sores at PAH, however these appeared to have resolved on discharge from PAH in late August 2013, except for the elbow pressure areas. Blue Care first saw her on 29 August 2013 at BE Lifestyle and the entry on that date, backs up the letter from the PAH spinal unit in that the only dressings required were for the elbows. Blue Care saw her again on 3 September where only a few small areas of grazing were noted, which were dressed.

188. When admitted to Nambour Hospital on 6 October it was considered the sacral pressure area had deteriorated since discharge from that hospital on 19 September. Ms Floyd was diagnosed with sepsis and an abscess was found in the sacral pressure area. Her blood pressure was low and her breathing effort poor, resulting in respiratory failure and her ultimate death.

189. Dr Buchanan stated the pressure areas were a challenge to prevent, given Ms Floyd had tetraplegia and neck pain that made it difficult for her to lie on her side to prevent the pressure areas. The PAH provided a mattress and advice on prevention. From the information provided, it appears the sacral pressure area deteriorated markedly after her discharge from hospital on 19 September. By 27 September there was a large necrotic ulcer.

190. Given the sacral wound was at stage 2 on 24 September it is significant it was in that period the sacral wound deteriorated. This period coincided with the air mattress being deflated for a minimum of a number of hours and perhaps more.

191. It was confounding that Ms Floyd's condition appeared to have deteriorated so quickly. Dr Buchanan suggested in his evidence, that the answer to this question is complex and multifactorial. He stated that this rapid deterioration was not normal but it can happen. The factors included her tetraplegia, nutrition and smoking which meant her skin was not in an optimal state.

192. There is no doubt that Ms Floyd's complex pre-existing physical vulnerabilities including respiratory, diet and nutrition, smoking, pain in certain positions and incontinence issues all played a part.

193. Dr Buchanan also considered there were then the factors of the period of time when the mattress was off. The longer the period the more significant the impact. The wound did markedly deteriorate around the period when the mattress was off. As well the IDC could have been dealt with earlier and needed to be replaced and may have played a part.

194. Dr Buchanan queried whether the skills of the carers at the BE Lifestyle were such that they could manage the skin care requirements in a complex patient such as Ms Floyd, where her skin was vulnerable to

pressure areas, with the added difficulties of her being unable to freely lie on her side due to neck and shoulder pain.

195. The review by CNC De Tina also noted that it appeared the staff at BE Lifestyle were uncomfortable dealing with the complex nature of her wound care and it must be asked if they were clinically skilled to identify her escalating wound state.

196. Part of the answer to those questions is that the carers at BE Lifestyle did not have the skills to attend to her wound dressing care, which was the responsibility of a registered nursing service such as Blue Care. BE Lifestyle maintained its staff were trained in induction including the stages of pressure areas to assist staff to identify when medical intervention or wound care is required. BE Lifestyle said it trained its staff in the necessity of repositioning customers who are physically disabled and require the use of wheelchairs or pressure mattresses etc. Evidence obtained from most of the carers at the inquest supported a view that this training was received by them, although it is difficult retrospectively to assess the quality of the training.

197. Dr Buchanan considered that BE Lifestyle were generally speaking able to provide for some of the other general cares including repositioning, handling and nutrition but there may have been some periods when Ms Floyd was not repositioned. The delay of 24 hours in starting the anti-biotics was not desirable but would not have helped in this case as she was subsequently found to have pseudomonas, which the particular antibiotic prescribed was not effective for.

198. What can be said is that even if BE Lifestyle had the capacity to deal with Ms Floyd's physical needs it was not looking after some of her emotional needs.

199. BE Lifestyle said it was the daily practice of all staff to conduct repositioning and recording of this activity for high care customers. Certainly the Customer Daily Handover reports recorded hourly repositioning of Ms Floyd, albeit with lengthy periods of being in bed or in a chair but with no recording of changes when she was in bed sleeping overnight. There were lapses in some of the documentation although not in a significant manner. Given the daily reports were completed as a "tick a box" this does not necessarily confirm the actions recorded in fact took place, but I have insufficient information to suggest they did not. Understandably it was unclear as to what repositioning and the extent of repositioning that took place. I accept the evidence of CNC De Tina that asking for documentation to be more comprehensive on that issue e.g. how she was moved, moved to right, left or upright, etc. could be onerous.

200. There is therefore uncertainty in the evidence as to how often Ms Floyd was repositioned and if this repositioning was effective in relieving pressure on her sacral wound. There was some evidence of possible

damage to her skin indicating 'dragging' on the examination on 24 September.

201. There were also likely times when Ms Floyd refused repositioning due to pain. As well, Dr Taumanova thought that Ms Floyd's Borderline Personality Disorder may have influenced her attitude and behaviours at times, particularly, as Dr Taumanova said, when she did not have a good relationship with someone working with her, as appears to be the case with some of her carers.

202. The period of time when the air mattress was deflated cannot be ascertained. It may have been for a number of days and could have been only a few hours but this occurred at a time when there was marked deterioration in the sacral wound and I consider this omission played a more than minor part.

203. There was also a period of time from the morning of 29 September until 2 October during which Ms Floyd did not have an IDC and was reliant on incontinence pads. This resulted in urine being in contact with her skin and sacral pressure wound with the dressing found to be soaked with urine on 2 October. As well it is evident the urine was significantly infected by this time, and this may have played some part in Ms Floyd's overall well-being making her more susceptible to the impacts of building sepsis.

204. On 1 October Ms Floyd's GP did not examine her sacral wound or take a swab. The GP did not have a hoist but it is possible Ms Floyd refused this examination. The evidence is quite clear that by this time Ms Floyd had lost trust in Dr Sander and wanted a new GP due to her role in the distressing admission to Nambour Hospital for a mental health assessment.

205. As well there was the issue of Ms Floyd's refusal to go to hospital over the period from 29 September to 6 October. In part there was likely a lack of appreciation on Ms Floyd's part of the severity of the wound, and how quickly she might deteriorate without medical attention, given her comment to Mr Packman on this point.

206. More significantly it is well documented that Ms Floyd had a fear of being admitted to hospital and/or mental health unit and not being able to return to her then residence. That was not an irrational fear but a fear that had some substance given the events of the prior admission. As late as 3 October Dr Sander and Ms Wardlaw were still suggesting this may have been subtle suicidal behaviour despite hospital psychiatrists being satisfied this was not the case. I can say on that issue that I am convinced there is no evidence that Ms Floyd was exhibiting suicidal behaviour in refusing treatment.

207. It also appears her decisions were contributed to by a desire to wait until a planned visit from her children, which was to occur on the morning of 6 October. This was a particularly significant moment for Ms Floyd given

she had not seen her children, who were clearly her great love and priority in her life, for 6 weeks.

208. All of this should be seen in the context of the loss of trust Ms Floyd had in relation to Ms Wardlaw and BE Lifestyle management due to the admission of Ms Floyd to Nambour Hospital for a mental health review and then later endeavouring to set up the highly restrictive 10 rules, particularly restricting contact to her children or the outside world.

209. It is apparent that all of these factors and decisions played a significant part in Ms Floyd's death, although it cannot be known whether an earlier medical review and intensive treatment in hospital would have made a difference to the outcome. Clearly the earlier treatment starts the more likely a better outcome occurs.

Findings required by s. 45

Identity of the deceased – Leah Elizabeth Floyd

How she died – Leah Floyd died from sepsis, the source of which was a necrotic sacral pressure wound. Ms Floyd was a tetraplegic and as such she was particularly vulnerable to pressure sores occurring. She was receiving supported accommodation and care at a NGO disability service provider with assistance in wound care by Blue Care nurses. Otherwise the disability service provider was responsible for implementing strategies in wound care prevention. It is evident there was a lapse in wound care prevention as over a period of 3 days from 24 September to 27 September her sacral wound degraded from a stage 2 to stage 4. Although Ms Floyd became unwell she was reluctant to be admitted to hospital. This was largely due to her mistrust of the disability service provider and her GP who had unreasonably against her will required her to be admitted to hospital on an earlier occasion for a mental health assessment. As well, management at the disability service provider wrongfully endeavoured to impose restrictive practices on her and against her human rights. She finally agreed to be admitted to hospital immediately after having seen her children but by this time she was rapidly deteriorating and she died within a number of days. There were multifactorial contributions to her death.

Place of death – Nambour Hospital, Nambour

Date of death– 10 October 2013

Cause of death – 1(a) Sepsis
1(b) Pulmonary and cutaneous infections

2 Urinary Tract Infection (treated) Tetraplegia

Comments and recommendations

210. Given the limited clinical governance framework evident at BE Lifestyle, I may have considered a recommendation that Disability Services consider auditing BE Lifestyle in relation to its compliance with the *Human Services Quality Standards*. I have been informed that BE Lifestyle is now in liquidation and presumably is not providing any more residential care services in Queensland, and to that extent any such consideration is now unnecessary.

211. Ms Jarvis submitted that a recommendation could be considered such that organisations providing nursing services to people with a disability in the community ensure there are appropriate policies and practices for ensuring adequate communication in all care settings, including private homes with paid, professional but medically untrained carers.

212. Mr Schneidewin for Blue Care submitted that Blue Care was providing a defined brokered community nursing service, in this case wound management, to an approved disability service provider and it ought reasonably be able to assume the approved disability service provider is providing a quality of care that otherwise meets *the Human Services Quality Standards*. Blue Care depends on the disability service provider to maintain a good quality of care so that its own care and management of the client is not compromised.

213. Mr Schneidewin submitted such a recommendation imposed upon an organisation, such as Blue Care, would mean that as part of its own care governance framework, there is an obligation to engage in what would effectively be a formal process of risk stratification to identify or predict shortcomings in the care to be provided by the approved disability service provider and to address such shortcomings by education and monitoring of the carers. In doing so this could effectively relieve the primary disability service provider of its own obligation to maintain good care governance. He submitted that this would further create uncertainty in the demarcation of responsibilities in the model of care being provided to the client and would expose an organisation such as Blue Care to potential liabilities for matters over which it has little or no control and probably would increase the cost of providing such services.

214. It was submitted Blue Care does accept there may be occasions in the provision of that service when it will be necessary and appropriate to take

steps to address identified shortcomings, including to effectively communicate any active recommendations to the primary care provider. However, doing so might prove to be futile if the primary service provider's care governance is poor or flawed.

215. Although I appreciate the basis for Counsel Assisting's submission, I accept the submission on behalf of Blue Care is compelling and do not consider it necessary to make any further recommendation. That is particularly so in the context of Blue Care having engaged in its own robust internal review of its services in this case and implementing improvements that were identified and considered to be necessary.

I close the inquest.

I offer my condolences to the family of Leah Floyd.

John Lock
Deputy State Coroner
Brisbane
8 December 2016