QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Kathleen Simons**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/2405
DELIVERED ON:	19 December 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	20 June 2018, 21-23 August 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, aged care nursing home, adequacy of wound care management, death from sepsis due to skin ulcers, communication with family

REPRESENTATION:

Counsel Assisting:	Ms J Cull
Counsel for family:	Ms J Marr i/b Caxton Legal Centre
Counsel for Regis Aged Care:	Ms D Callaghan i/b Lander & Rogers
Counsel for Dr C Harvey:	Mr A Luchich i/b Avant Law
Counsel for Nurse Pratiksha BC:	Mr S Seefeld i/b Roberts & Kane

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Introduction

1. Kathleen Simons was a 96 year old woman who died at the Caboolture Hospital on 23 June 2015, three days after her admission. She was a resident of the Regis Canning Lodge aged care facility.

2. Review of Mrs Simons' nursing and medical records (Regis Canning Lodge, Caboolture Hospital) shows she had a history of insulin dependent diabetes mellitus, hypertension, dementia, hypothyroidism, a skin condition resulting in blistering and breakdown. Mrs Simons was largely bed bound requiring hoists and fall out chairs to transfer her

3. Mrs Simons was admitted to Caboolture Hospital on 19 June 2015 with a reduced level of consciousness associated with hypoglycaemia. On admission she was observed to have a number of bruises, skin tears and wounds to her body. Of particular relevance there was a significant wound to the right outer calf and one to the left outer calf.

4. It was considered by medical staff that Mrs Simons was most likely septic from these wounds. After a discussion with her daughter who resided in Victoria, it was decided to focus on comfort cares rather than aggressively pursue a curative approach due to a poor prognosis. Her daughter arrived from Victoria to be with her mother on 23 June and Mrs Simons passed away later that evening.

5. Mrs Simons' death was reported to the coroner because of concerns expressed by a physician at Caboolture Hospital about the adequacy of the pre-hospital management of her diabetic leg ulcers, which appeared advanced, long term and poorly dressed. These ulcers were considered to be a portal of entry for infection, which ultimately caused her death.

6. An initial review of the wound care pathway and images of the wound by the Clinical Forensic Medicine Unit and describing it as "a horrible wound that looks like it needs skin grafting" was conducted. It was also not clear from the available documentation why a person referred to as a wound care nurse and/or the General Practitioner who attended on Mrs Simons were not reviewing the wound more frequently. Accordingly a further investigation took place looking at the adequacy of the wound care.

Issues for inquest

7. Given the serious and advanced nature of Mrs Simons' leg wounds at the time of her admission to hospital, and the concerns raised by medical experts regarding the management of these wounds, it was determined to hold an inquest into Mrs Simons' death. Concerns raised by Mrs Simons' daughter and her legal representatives regarding the care provided to her mother and a lack of adequate communication with Mrs Simons' daughter also contributed to this decision. In terms of issues for consideration during the inquest the following were determined:

    i. The findings required by section 45(2) of the *Coroners Act 2003* namely the identity of the deceased, how she died, when she died, where she died and what caused her death.
    ii. Any comments/recommendations that may be required pursuant to section 46 of the *Coroners Act 2003*.

iii. In relation to the circumstances of Mrs Simons' death (section 45(2)(b))
    a. The adequacy or otherwise of the care received by Mrs Simons from Regis Aged Care, its employees and consultants (including wound care consultants visiting the care facility),
    b. The adequacy of the care provided to Mrs Simons by the visiting GP to Regis Aged Care prior to her death,
    c. Whether communications by Regis Aged Care with Mrs Simons' next of kin with respect to the state of Mrs Simons' health in the months leading up to her admission were adequate

Proposed Witnesses

8. The following witnesses were heard at the inquest:

Experts:

1. Dr Gary Hall, CFMU
2. Ms Alison De Tina, Registered Nurse, CFMU
3. Ms Pam Bridges, Registered Nurse and Aged Care Consultant.

Regis Canning Lodge Witnesses

4. Ms Jenny Smith, said to be a Wound Care Consultant
5. Pratiksha BC, Clinical Manager, Regis Canning Lodge
6. Ms Trish Fairman, General Manager Quality and Compliance, Regis Canning Lodge
7. Hamoun Zarebani Mohamadi CM

General Practitioners visiting Regis Canning Lodge:

8. Dr Charles Harvey, GP visiting Regis Canning Lodge
9. Visiting After Hours GP (reviewing Mrs Simons on 9 May 2015)

Caboolture Hospital

10. Dr Salih Bazdar, Clinical Director Internal Medicine Caboolture Hospital

11. Rosemary Searle, daughter of Mrs Simons

Admission to hospital on 20 June 2015

12. Mrs Simons presented to the Caboolture Hospital emergency department on 20 June 2015 with hypoglycaemic episodes and reduced level of consciousness. Dr Salih Bazdar was the consultant physician and involved in her care.

13. On examination Mrs Simons was found to have multiple bruises on her upper and lower limbs and multiple raw ulcers on the lower limbs, two of which included exposed tendons. Her glucose level was unstable. Of particular relevance to this inquest, there was a wound to the right outer calf that was by now 11cmx5cm, with the tendon exposed and with green/brown exudate and a wound to the left outer calf that was by now 9x7 cm at the greatest point and was noted to have a tendon exposed and to be sloughy with a green exudate.

14. Mrs Simons was diagnosed with possible sepsis and admitted for further treatment. The leg ulcers were dressed and she was commenced on antibiotics. Her blood sugar level was monitored. Blood test results revealed macrocytic

anaemia, dehydration and malnourishment. Her condition continued to deteriorate despite antibiotic treatment.

15. Dr Bazdar stated in evidence he had an independent recollection of Mrs Simons as the state of the wounds he saw are not easily forgotten. Dr Bazdar stated he would have expected Mrs Simons to have been referred to hospital well before she was.

16. Dr Bazdar said for the wounds to develop to that state of deterioration they needed weeks if not months. He agreed that if a tendon was on view on 21 April 2015 she should have been admitted to hospital then as there is a particular dressing to be applied with a tendon on view. Dr Bazdar also stated that once a tendon was on view some form of surgical opinion was needed and not conservative treatment. As to whether Mrs Simons was a candidate for surgery from 21 April 2015, Dr Bazdar agreed that with her co-morbidities she would have been a difficult candidate, although he was not a surgeon.

17. On 21 June, after discussion with her daughter Rosemary Searle about her poor prognosis, Mrs Simons was commenced on end of life comfort cares. She developed multi organ failure and died at 11:50pm on 23 June 2015 with her daughter present. Dr Bazdar stated Rosemary Searle told him she was aware of only one ulcer on her right leg that had been treated with oral antibiotics.

Autopsy results

18. An external examination and full internal autopsy were performed by an experienced forensic pathologist on 3 July 2015. The pathologist noted the following:

- Right upper limb – there is ecchymosis on the front of the mid upper arm extending to the wrist. On the posterior aspect, ecchymosis is found on the entire forearm. There is a skin tear 4.5cm long on the antecubital fossa (crook of elbow) covered by a dressing with a date 21.06.15 written on it. Serous fluid is noted to extrude from the skin tear. The skin on the entire front and back of forearm appears to be slipping from underlying subcutaneous tissue. There is another dressing on the distal third of the back of the forearm with a date 16.06.15 written on it. It is covering an ulcer 2cm x 1cm which is dry and clean. There is another skin tear 2cm long on the back of the right hand (not covered).

- Left upper arm – there is ecchymosis with atrophic skin similar in distribution with the right limb that is on the front of mid upper arm to the wrist anteriorly and the entire forearm posteriorly. There is a circular dressing covering the needle mark in the crook of the right elbow. There is a dressing partially covering a large ulcer 9cm x 10cm sited on the outer front, outer aspect and back of proximal half of the forearm. The ulcer is superficial but the floor of the ulcer is moist, erythematous in areas and shows clear exudate. There is another ulcer on the back of the hand measuring 6cm x 5cm with an erythematous base.

- Right lower limb – there is a focal area of erythema on the lower front of right thigh with two adhesive plasters holding on to a skin tear 4cm long.

- There is an extensive area of erythema around the leg. There is a dressing date 21.06.15 with the word "2 x skin tear" on the front of the upper leg. It covers an irregular ulcer 8cm x 6cm showing an erythematous base with an area of necrosis. There are two dressings on the back of the leg, the first one is on the upper leg and knee, with the words "skin tears x 2" and a date 26.06.15 and it covers an ulcer 11cm x 4cm. The base of this ulcer is slightly moist with necrotic tissue on its superior aspect. The other dressing is on the upper half of the back of the calf with the date 26.06.15. There is an ulcer measuring 5cm x 3cm, the floor of the ulcer is moist and erythematous and in areas appears to be necrotic.

- There is a bandage covering the lower half of the leg. There are paraffin dressings beneath the bandage. It is covering a deep ulcer, 11cm x 7 cm on the outer aspect of the distal third of leg. The ulcer is deep and in places reaches up to 0.8cm exposing underlying muscles and a distinct strip of necrotic muscle. The tibia is partially exposed. It does not appear to be secondarily infected. There are focal areas of erythema within this wound.

- Microscopic examination of the floor right leg ulcer showed necrotic tissue in association with acute inflammatory infiltrate and bacterial colonies.

- Left lower limb – there is a focal area of ecchymosis on the front of the leg. Slightly more extensive ecchymosis surrounding an ulcer is present on the back of the leg. There is a dressing dated 26.06.15 on the outer aspect of the upper leg covering a skin tear 4cm long. The floor of this skin tear is erythematous and exudes clear fluid. The lower half of the leg is bandaged with paraffin dressing covering an ulcer. The ulcer is located on the lower half of the back of the calf and measures 9cm x 5cm. It is about 0.8cm deep and there is exposure of underlying muscle. The central area shows apparent necrotic muscle tissue with surrounding erythema. The floor of the ulcer is moist.

- Microscopic examination of the floor left leg ulcer showed extensive acute inflammatory infiltrate involving subcutaneous necrotic tissue.

- Cultures of the leg ulcers (two different sites) grew pseudomomonas aeruginosa. Blood culture was negative, a not unexpected result given that Mrs Simons had been treated with antibiotics in hospital.

- There was bilateral pneumonia, more severe in the lower lobes.

- The heart showed evidence of recent infarction associated with moderate atherosclerosis. The kidneys showed extensive nephrosclerosis, which would cause renal insufficiency. There was recent infarction involving the basal ganglia.

19. Taking these findings into account, the forensic pathologist determined the cause of death to be sepsis complicated by multiple organ failure, with the infected leg ulcers being the source of the sepsis. Bronchopneumonia was considered a likely secondary infection rather than the primary source of sepsis as it was moderate in severity.

Evidence on the issues

Adequacy of the care Mrs Simons received from Regis Aged Care, its employees and visiting consultants

Overview of care

20. Mrs Simons was admitted to Regis Canning Lodge from another nursing home on 29 April 2013. On admission she had diagnoses of dementia, insulin dependent diabetes mellitus, a history of falls, deafness, hypertension, hypothyroidism and a skin condition causing extensive blistering, treated with prednisone.

21. During her admission to Regis she had a number of skin wounds, including multiple skin tears. Two wounds in particular, which were identified early in 2015 on her right and left lower legs, became problematic and the management of these wounds in particular was the focus of this investigation and inquest.

22. On 22 February 2015, the wounds on both the right and left lower legs were identified. As at 22 February 2015, according to the Regis Canning Lodge wound care management plans for Mrs Simons, the wound to the right lower leg was 9cm x 3cm and the wound to the left lower leg was 8cm x 4cm.

23. On 21 April 2015 Dr Harvey, the visiting GP, was contacted to review Mrs Simons' right ankle, after Enrolled Nurse (EN) Webb saw a tendon on view. On 22 April 2015 the progress notes indicate Dr Harvey reviewed the wound and documented that Mrs Simons had an ulceration to her right lower leg and to "continue present treatment." On 30 April 2015 the progress notes show Dr Harvey reviewed the wound again and documented that the right lower leg was improving and to continue treatment. Dr Harvey has no specific recollection of these reviews and his response is referred to later in this decision. He accepts his notes of the presentation are inadequate.

24. On 9 May 2015 it was noted by nursing staff that the wounds on the right and left lower legs were 'sloughy, oozing' and possibly infected'. Mrs Simons was referred by nursing staff to an out of hours GP, Dr Anchita Karmakar who was working for the National Home Doctor Service.

25. Dr Karmakar reviewed the wound on the evening of 9 May 2015. She commenced the antibiotic cephalexin. She reported her assessment and plan to Dr Harvey as the treating practitioner via a brief electronic report which stated in essence that she had seen Mrs Simons in relation to "a wound with ++ pus for oral antibiotics and wound review and had prescribed cephalexin and bactoban cream". The report did not raise specific concerns about treatment moving forward, note there was a tendon on view or request that the treating GP review the wound.

26. The evidence provided by Dr Hall was that bactoban cream was not appropriate for a wound of this nature and that cephalexin would also not have been effective in this case. He stated in his report that a wound swab and request for a review by the regular GP would have been routine if not very basic management of the ulcer. He stated during his oral evidence this would have been another point at which Mrs Simons might have been referred to hospital for assessment.

27. Dr Kamakar has no recollection of the visit but based on the limited records she produced, she said she presumes she diagnosed Mrs Simons with a wound and deemed it needed oral antibiotics. She recorded her temperature 37°. It was her usual practice at the time to not note any further observations on the record unless it was adverse or an important finding to determine the course of therapy. Dr Kamakar also requested a review from her regular GP Dr Harvey. From the notes and limited recollection she does not believe the patient was septic or in acute distress at the point of contact. She did not believe Mrs Simons needed hospital referral, particularly in the middle of the night. She also said she does not recall a wound with the tendon exposed and if she had she may have referred her to the hospital or the GP.

28. Dr Kamakar did not consider taking a swab to determine the nature of the infection. Her focus was to provide urgent interim care and she considered it was better for her GP or hospital to take swabs. She sent a report of her attendance to Dr Harvey for him to consider.

29. On 15 May at 12:07pm there is an entry in the progress notes which appears to be created by Hamoun Zarebani Mohamadi regarding the right lower leg 'ulcer' and setting out a management regime for the wound, with the name Jenny Smith, following the entry.

30. Also on 15 May, at 3:29pm, there is an entry that appears to be from Pratiksha BC Clinical Manager(CM) to the effect that the wound was reviewed by Jenny Smith and setting out the advised management regime.

31. On 26 May 2015 there is further entry at 11:40am in the progress notes to the effect the wound was showing *significant improvement* with the name Jenny Smith following the entry. The progress note is again created by Hamoun Zarebani Mohamadi CM.

32. Hamoun Zarebani Mohamadi was also a Clinical Manager (CM) at Regis Canning Lodge but his involvement with Mrs Simons was minimal as he was not allocated to the wing in which Mrs Simons resided.

33. CM Mohamadi said he did have discussions with CM Pratiksha BC about Mrs Simons, which he thinks involved around how to handle her care and the involvement of Dr Harvey and Jenny Smith. He said knew Jenny Smith as a wound consultant used in a number of Regis facilities. To his knowledge Ms Smith had written a number of books on wound care and had also assisted Regis with its wound management policy. His recollection is Ms Smith would be contacted to come in and look at specific cases. He does not recall Jenny Smith being on site for any other reason.

34. CM Mohamadi is not sure if Ms Smith saw Mrs Simons but he has a vague recollection of her reviewing wounds for another resident, which involved actually visiting the resident. He does recall Ms Smith used his account to log in details in the computer program used at Regis Canning to make progress notes, because Ms Smith did not have her own account in their software. He believes this occurred on 15 May 2015 and 26 May 2015. CM Mohamadi stated he did not make any entries in Mrs Simons' records on those days.

35. Dr Harvey is documented as seeing Mrs Simons on 19 May 2015 and charting to continue Flaminal Forte every three days and to have changed the antibiotic to dicloxacillin.

36. On 4 June there is an entry by Dr Harvey to the effect that Mrs Simons had a chest infection and was prescribed Augmentin Duo forte.

37. On 8 June nursing staff documented contacting Mrs Simons' daughter with a health status update, explaining her chest infection, ongoing wound management, poor oral intake and increased sleepiness.

38. On 19 June Mrs Simons was found to be sleepy and was 'unconscious' at 8.30pm with a blood glucose level of 2.8. QAS were notified and she was transported to Caboolture Hospital.

Response by Regis Canning Lodge

39. A report has been provided by Ms Trish Fairman, General Manager Quality and Compliance, dated 17 August 2015 outlining the findings of a clinical review of Mrs Simons' treatment.

40. The clinical review noted Mrs Simons had been admitted to the nursing home in April 2013 with a history of a skin condition causing extensive blistering.

41. From the time of the admission she had skin tears and rashes that were managed by nursing staff under the direction of the treating doctor. Wound pathways were used to monitor the progress of wounds.

42. The facility wound management policy indicates that an external wound consultant should be consulted when indicated. Ms Fairman stated in relation to the wounds on Mrs Simon's legs referrals were made to an external wound specialist (Jenny Smith) on 15 May 2015 and 26 May 2015. The entries in the progress notes from the wound specialist indicated that on 26 May 2015 there was a significant improvement in the wound.

43. Ms Fairman stated in evidence that wound specialists could be a range of persons including Registered Nurses attached to a nursing home, or in some cases it would be a hospital based service. At Regis Canning the records indicated the wound specialist was an outside consultant Jenny Smith.

44. Ms Fairman stated in evidence at the time in 2015 Regis did not have a policy or process in place to ensure such persons were suitably accredited or clinically trained. There was no register of wound specialists although Ms Fairman stated this is being set up now. She said she did not know Jenny Smith was providing wound care specialist advice to Regis Canning in 2015 and was surprised to hear Ms Smith had not been a registered nurse for 10 years.

45. Ms Fairman stated Ms Smith had been engaged to assist in contributing to the Regis Group wound care policy and manual in 2009 and 2013 and Ms Smith wanted her logo on the policy document to gain some recognition for her part in it. Regis agreed hence the Betta Health Outcomes logo on the wound care policy and manual.

46. Overall Ms Fairman stated that given Mrs Simons' medical status and poor skin integrity, in her view the care of complex wounds of Mrs Simons was "consistently carried out".

47. Ms Fairman acknowledged the clinical review did find the referral to the wound management consultant could have occurred earlier and there were delays in the review of the wound on the right lower leg and left lower leg on two occasions. She has advised that additional wound training was implemented. This included reinforcement of the Regis Policy in relation to the requirement for weekly photographic recording of wound progress and the importance of compliance with dressing change and review directives.

48. Ms Pratiksha BC Clinical Manager and Registered Nurse at Regis Canning Lodge also provided information concerning the management of Mrs Simons' wounds.

49. A Wound Care Pathway was commenced on 22 February 2015 when the wounds were first noted and photographs were taken.

50. Ms Pratiksha BC stated that different health personnel including the GP, dietician and a wound specialist were consulted and reviewed to promote the healing of her wounds. Mrs Simons was reviewed by her GP and treatment was started with oral antibiotics. It was stated Mrs Simon's daughter was made well aware of the present health condition of her mother.

51. Ms Pratiksha BC said Mrs Simons was referred promptly to a dietician when she was identified with 3 kg loss in weight in one month and started with fortified milk twice daily to optimise her nutrition and hydration.

52. Ms Pratiksha BC said there was no review of the wound by the GP and wound specialist from 26 May 2015 until she was sent to hospital. From her review of the records she stated this was not necessary as there was no further wound deterioration. She further stated the healing process of the wound was slow due to Mrs Simon's age and disease process and in particular her insulin dependent diabetes.

53. In summary, Ms Pratiksha BC stated that there were only a couple of occasions when wounds were not redressed as per wound assessment and management plan. Otherwise she said the wounds were attended to and reviewed by clinical staff in a timely manner.

54. In evidence at the inquest Ms Pratiksha BC said it would surprise her if Ms Smith only attended Regis to provide dressing advice as a wound "product" consultant. She had been told at induction that Ms Smith was a wound care specialist and Ms Smith was the only one Regis Canning Lodge referred to.

55. When it was suggested to Ms Pratiksha BC that much earlier referral to hospital should have occurred she responded by saying the GP had reviewed the wound and the wound care specialist had said the wound was improving, so on that basis there was no reason to refer her. Ms Pratiksha BC was shown the progress notes and photographs and was asked if they show significant improvement. She appeared reluctant to answer that question and said she was unable to say.

56. When it was suggested to Ms Pratiksha BC that nurses would not have been prevented from sending Mrs Simons to hospital on their own initiative, she

believed it would be difficult for the nurses who would want to go along with the doctor's opinion and plan.

Referral to Jenny Smith, Betta Health Outcomes

57. Both Ms Pratiksha BC and Ms Fairman asserted that Mrs Simons' wounds were reviewed by Jenny Smith, of the Betta Health Outcomes on 15 and 26 May 2015. Ms Fairman has stated this was in accordance with the facility wound management policy. Ms Fairman refers to Ms Smith as a "wound care specialist" who is "an external health professional who is contacted by staff to advise on management of complex or chronic wounds".

58. Jenny Smith was requested early in the investigation to provide a statement regarding her involvement. Her response was to provide an email response sent to the Court, the contents of which was confirmed by her in evidence as true and correct, In that email she stated she is the Director of Betta Health Outcomes and her role is as a researcher and educator, specialising in wound care products and equipment. As an educator she educates staff with respect to a holistic approach ensuring a collaborative and inter-professional approach in wound management, wound prevention and skin integrity.

59. She stated it was not common practice that she physically reviewed wounds but she would have suggested to the nursing home a dressing regime appropriate for the wound based on the facts presented to her by a registered nurse and after all other assessments have been attended to.

60. Ms Smith stated in her email she never reviewed the wound of Mrs Simons. This information appears to be in conflict with the information provided by Regis Canning Lodge and what the understanding of Regis Canning Lodge staff was as to her capacity to provide clinical advice.

61. It was unclear on the evidence available during the investigation if Ms Smith had any professional medical qualifications or registrations as she was not registered as such with AHPRA. Ms Smith gave evidence she had been a Registered Nurse for 20 years but had let her registration lapse 15 years ago. She had qualifications at diploma level for auditing, training and assessment. The services her company provided was in respect to medical supplies, training on use of products and auditing of the Aged Care Standards.

62. Ms Smith stated she attended Regis Canning Lodge on 26 May 2015 for a totally different purpose, and during the visit one of the registered nurses asked her *("pleaded with her")* if she should continue with the dressing regime she was applying. Ms Smith says she did not see the wound but was told it was improving. Her role was to recommend appropriate dressing after the facts were given by the registered nurse: As she was told the wound was improving she suggested they continue with the current regime.

63. Ms Smith says she was asked to document in the progress notes her advice to continue with the dressing regime being used. Ms Smith gave what I considered to be unconvincing evidence about the notes of 15 May 2015 and 26 May 2015 and as to whether she wrote the notes herself or was present when someone wrote it for her. She also gave unconvincing evidence as to whether she actually looked at the wounds, stating on one occasion she had a quick look at the wound with a nurse but said this was not a wound review. She says she cannot recall if it was a clean wound and the tendon was exposed. When pressed she stated

she was there on 15 May and may have seen wound but did not see the wound on 26 May.

64. Ms Smith stated it was not part of her role to review or document a clinical assessment although on the face of the records she appears to have so reviewed and recorded. She said any review is to be undertaken by the nursing staff with a further review every seven days, and if there is a delay in the healing process the holistic process needs to be re-evaluated including assessing the wound bed, nutrition, aetiology, diagnostic investigation and assessment of wound care products.

65. Ms Smith stated she has no direct management of care for wounds and instead provides guidance of an appropriate dressing with the facts presented.

66. Ms Smith stated she had provided the Regis Group in Melbourne with information to assist in the development of their wound care policy. She was taken to the Wound Care Manual and stated she had provided information for the development of the manual directly from the Wound Care Association. In relation to the Betta Health Outcomes logo on the manual she stated this had been used without her permission. Ms Smith denied she had assisted with the compilation of the Wound Care Manual for Regis and that she requested her logo be utilised for her own marketing reasons.

Adequacy of the care Mrs Simons received from the visiting GPs to Regis Aged Care

Response of Dr Harvey

67. Dr Charles Harvey had a GP practice at Beachmere. He attended Regis Canning Lodge and other local nursing homes following a request from nursing home staff to see a particular resident. The request would be either by telephone or facsimile. He did not have a fixed day for visits and relied heavily on the nursing staff to request reviews and bring new issues to his attention. Following a request he would endeavour to attend within forty-eight hours.

68. Dr Harvey stated that wound care and management in frail and elderly patients was a difficult condition to manage, and is often made more difficult by the patient's other comorbidities. In Mrs Simons' case the healing process was complicated and prolonged by her diabetes. If a debridement was considered appropriate this could not be performed in a nursing home setting.

69. Review of the medical records confirms nursing home staff had initiated a number of wound management plans for wounds and staff were attending to these wounds daily or second daily. There were in total six separate wound care plans. Two of these related to wounds on her right lower leg.

70. Dr Harvey states the records show he reviewed the wound on her right lower leg on 22 April 2015, the same day his attendance was requested by nursing staff. Dr Harvey stated he decided to manage the wound conservatively and he noted in the records the nursing home staff were to continue with present treatment. He reviewed the same wound on 30 April 2015 and noted the ulceration was improving and the plan was to continue with the current therapy.

71. Dr Harvey stated he has no recollection of his attendances on 22 and 30 April and accepts the notes of his attendances are quite inadequate. He is unable to

say why he formed the view on 22 April that a wound swab and commencement of antibiotics was not warranted and likewise referral to hospital. Similarly, he is now unable to say why he formed the view on 30 April, as recorded in the notes, that the wound on the right lower leg was improving and again that a wound swab, commencement of antibiotics or referral to hospital was not warranted. He now accepts those steps should have occurred and he regrets they did not.

72. Dr Harvey has also reviewed the records and accepts he was also asked to review Mrs Simons on 19 May 2015 and it appears he has done so. He again has no recollection of this attendance and accepts his notes are again quite inadequate.

73. Dr Harvey says he received a request from nursing staff to review Mrs Simons' insulin dose on 9 June 2015. At this review he reduced the insulin Glargine dose to 14 units. He was not asked to review her leg or other wounds on this occasion and does not recall any concerns being raised by nursing staff at the time.

74. Dr Harvey stated he did not receive any further requests by staff to review the wound on the right lower leg and believed that if it was not improving he would have been asked to carry out a further review.

75. In hindsight, Dr Harvey agrees he relied on nursing home staff and this may not be a sufficient follow-up system. He had since asked for external advice to assist in implementing an appropriate follow-up system for any attendances on nursing home patients.

76. Dr Harvey stated he would have reviewed the wound if he had received a request to do so. Had that review considered the wound was not responding appropriately to conservative treatment he would have considered the option of recommending Mrs Simons be transferred to hospital for further assessment and management.

77. Dr Harvey had noted Mrs Simons was prescribed prednisone and he said he continued with it, presumably on basis this was correct at the time, although he cannot recall if he turned his mind to the skin condition it was prescribed for at the time. He was aware prednisone makes diabetic control more difficult.

78. Dr Harvey stated that with the benefit of hindsight and having now had further education, particularly in wound management, he should have referred Mrs Simons to hospital for assessment and management if not on 22 April 2015 then on 30 April 2015. He also accepts it would have been appropriate to perform a wound swab on 22 April and then commence antibiotics.

79. Dr Harvey also advised he has undertaken further training including attending a workshop course entitled *"Fundamentals of Wound Management Workshop",* as well as the Holy Spirit Northside Private Hospital Multidisciplinary Care Education weekend for GPs, which included sessions dealing with geriatric and management options for varicose veins and ulcers. He has also attended a number of other courses dealing with the value of good clinical documentation and medical records.

80. Dr Harvey advised he has stopped attending on nursing homes as a visiting GP.

Whether communications by Regis Aged Care with Mrs Simons' next of kin with respect to the state of Mrs Simons' health in the months leading up to her admission were adequate

81. Mrs Simons' daughter Ms Jane Searle has provided a detailed statement concerning the state of her knowledge of the seriousness of her mother's wounds. Ms Searle was residing in Victoria from early January 2015 and her contact over this period with her mother and the nursing home was generally by telephone. Ms Searle stated she was not aware her mother was on prednisone and that this was for a history of multiple skin blistering, although this appears to have been longstanding.

82. In general Ms Searle's statement noted the medical records indicate a number of telephone calls were made to her by nursing home staff over the following months, most of which she has no recollection of.

83. Telephone records have since been provided by Regis Canning Lodge. The records confirm Ms Searle was called on her mobile on 21 occasions between December 2014 and 30 June 2015. She has noted that 12 of the calls were for less than a minute and she believes these may have gone to her message service.

84. Ms Searle now accepts these calls were made although she does not recall many of them. The call records generally correspond with what is recorded in the nursing records as calls being made to her for all except two occasions. Ms Searle states that she was not advised of the severity of the wounds on her mother's legs and certainly if she had been told a tendon was on view she would have asked for her mother to be admitted to hospital.

85. Ms Searle also initially stated she was not informed by Regis that her mother had been taken to hospital. She said she first knew about the admission after Caboolture Hospital rang her on 20 June 2015. The telephone records note a call was made to Ms Searle on 19 June for 51 seconds and Ms Searle now accepts a call was made to her about the hospital admission by Regis staff.

86. According to the nursing records Ms Searle replied with words to the effect *'my mother is 96 years old and it is to be expected'.* Ms Searle denies this statement and says she was very shocked at her mother's condition on seeing her at Caboolture Hospital.

Expert reports

87. Reports have been provided by Dr Gary Hall and Ms Allison De Tina (Registered Nurse) of the Queensland Health Clinical Forensic Medicine Unit. Both Dr Hall and Ms De Tina are critical of the care received by Mrs Simons. A report has also been provided by Ms Pam Bridges, of Pam Bridges Consulting. Ms Bridges is a Registered Nurse with a BA (Social Welfare) and Graduate Diploma of Health Services Management.

Report of Alison De Tina –CFMU

88. Ms De Tina is a clinical nurse consultant and forensic nurse examiner with the Forensic and Scientific Services Clinical Forensic Medicine Unit. In her report Ms De Tina raised concerns about the quality of the wound assessment and management plans. She also expressed concern at Mrs Simons not being referred to hospital earlier noting that nursing staff could have referred Mrs

Simons to hospital had they felt her wounds needed more aggressive treatment than that recommended by the visiting GP. She suggested nursing staff might benefit from further training regarding wound management and from having clearer referral pathways available.

89. Ms De Tina reviewed the nursing home notes from January to June 2015. Multiple skin tears were identified by nursing staff. A left lower leg and right lower leg ulcer continued to be the most problematic for staff to manage. There were multiple colour photographs of poor quality but these showed a marked decline in the ulcer on her right leg over the course of three or four months. Ms De Tina also noted there was an initial measurement of the wounds but none were documented after that.

90. Ms De Tina stated in her opinion the progress notes and wound assessment and management plans were inadequate in volume and detail. There was an absence of any detail relating to pressure area care information, something essential for the optimal care of a patient with poor skin integrity complicated by diabetes. Ms De Tina observed during her evidence that photographs in the wound care plans were limited and of varying quality and measurements of the wounds were minimal. Her evidence was that more regular and consistently taken photographs, measurements of the wounds and greater details in the notes in terms of the care provided would have assisted in tracking the development of wound and would have assisted in terms of continuity of care between registered nursing staff working various shifts.

91. Ms De Tina stated there was no information as to how often pressure area relief was provided and what pressure relieving devices were used. She stated it would be helpful to see if this information is recorded as a matter of routine/policy. If this is not the case, it may have contributed to the skin tears and bruises that were identified by staff due to the incorrect placement of skin protectors or the possible lack of required pressure area cares. It was mentioned on more than one occasion that the skin protectors had either been on too tight (causing bruising) or had inadvertently sheared her skin causing skin tears.

92. Ms De Tina said on 21 April 2015 nursing staff noted that Mrs Simons had a tendon on view in the ulcer on the right lower leg. Dr Harvey was notified and he stated he decided to treat the wound conservatively and had advised the nursing staff no changes to the treatment plan were being made. The progress notes provided do not have any information regarding Dr Harvey's impression of the tendon on view, something she would have thought to have been of some concern to him, as these things typically do not heal without intervention.

93. Ms De Tina also stated that looking at the wound care treatment provided between March and June 2015, and given there was a marked decline in the right lower leg ulcer, she is unsure why the nursing staff and Dr Harvey have not escalated any treatment options earlier. There is no documentation that wound swabs were taken and of any referral to specialty services, except to the wound care specialist who stated it was not her common practice to physically review wounds. Ms De Tina stated in evidence there should have been a low threshold to take swabs as early as February/March 2015 given the description of yellow slough exudate on 23 March 2015.

94. Ms De Tina stated that early intervention during this period of time may have changed the outcome.

95. In summary, from a nursing perspective, Ms De Tina stated staff of Regis Canning Lodge would benefit from more education in wound care management, including risk assessment and documentation. They would also benefit from having a clearer pathway of referral for patients they feel have not been given optimal treatment. There was no reason nursing staff could not refer Mrs Simons to the hospital if they felt her wounds needed more aggressive treatment. If they were not aware she needed more aggressive treatment and a referral to hospital, this would highlight the need for more education around wound care and management.

96. With regards to the wound care specialist, Ms De Tina felt that there needs to be a clearer understanding of what role she played in the management of Mrs Simons' wounds and what advice she was qualified to give.

97. Ms De Tina stated Mrs Simons did not receive adequate advice/care regarding her wounds. The visualisation of a tendon should have alerted the wound care specialist/medical staff/nursing staff that this wound had already been left too long without appropriate treatment. In respect to communication with the family Ms De Tina stated family do not need to be contacted about everything that is happening in a nursing home but certainly if there was a marked decline.

Report of Dr Gary Hall - CFMU

98. Dr Hall is an experienced forensic medical practitioner with the Clinical Forensic Medicine Unit. Dr Hall noted Mrs Simons died from Pseudomonas sepsis secondary to infected chronic leg ulcers on a background of diabetes mellitus and possible bullous pemphigoid. There was evidence over the last six months of her life that she was deteriorating in overall condition with weight loss, poor oral intake and refusal at times to take oral nourishment. She also developed a number of chest infections, which required oral antibiotics. Dr Hall had no concerns regarding the nursing home management of her nutrition or attention to chest infections.

99. Nursing staff reported Mrs Simon had a skin condition that required steroids to manage, which raises the suspicion of bullous pemphigoid. Dr Hall noted treatment with steroids would have rendered her diabetes to be more labile with a fluctuating level of control. A combination of diabetes, oral steroids and perhaps an autoimmune disease increased her susceptibility to infectious disease. These required any skin breach sustained to be monitored closely for early signs of infection and that appropriate attention to wound hygiene and dressings was paid. This did occur in the early stages and was evidenced by the commencement of Wound Management Plans.

100. Dr Hall could identify a number of opportunities for nursing staff to request review of the ulcers and argues this could have occurred as early as mid-March 2015.

101. Dr Hall noted Dr Harvey was requested to review the wounds on 21 April and 30 April. Dr Hall opines that Dr Harvey's response was poor in that he offered no reasonable suggestion with regard to management despite the likelihood there was an exposed tendon on view at the time of review. He did not recommend a wound swab as a most basic response.

102. Dr Hall stated Dr Harvey's statement to the court implies he assumed the leg ulcers had improved as he was not asked to review them again. Dr Hall stated he finds the lack of further review based on nurses not asking him to do so, was

not acceptable given the state of the ulcer at the time he reviewed her and his knowledge of Mrs Simons' past medical history.

103. Dr Hall stated nursing staff then continued to dress the wounds as before and photograph the unsuccessful results. Nursing staff did not appear to question Dr Harvey's response and did not attempt to arrange referral to a hospital or elsewhere as they were entitled to do. There was no reasonable communication with family to seek this direction either.

104. On 9 May 2015 an out of hours GP was called in who also had an opportunity to refer Mrs Simons to hospital but did not do so.

105. Dr Hall noted on 15 and 26 May 2015 nursing staff referred Mrs Simons to a wound care consultant whose qualifications appear to be unknown but it does not appear she was formally qualified as a health care professional.

106. Dr Hall stated he has no reason to believe nursing staff or medical staff ought to have considered that Mrs Simons had secondary pseudomonas infection. Appropriate management of skin infections with this organism required debridement of necrotic tissue, cleansing of the wound and antibiotics targeted to the organism. This is not able to be achieved in a nursing home setting.

107. Dr Hall stated that before 21 April 2015 the gold standard treatment would have been a washout, debridement, swab and antibiotics in hospital and this might have been attempted. Dr Hall stated there needed to be some reasonable direction for the future. This was not likely to be curative and more likely to be palliative and looking at how to keep her comfortable and the wound dressed properly. Communication and bringing the family into the discussion would have been important and a clear pathway was important.

108. After 21 April 2015 Dr Hall stated wound debridement, surgical washout and intravenous antibiotics were likely to be of limited value. Once the tendon exposure occurred it is more likely than not surgical management would have been considered more toward amputation. This is extremely invasive surgery with high mortality risk in a very elderly lady with comorbidities and it is likely surgery might have been unacceptable to and refused by Mrs Simons and her family with the decision to pursue a non-invasive pathway and more likely to be palliative.

109. Dr Hall stated that earlier referral therefore to a surgeon may not have been outcome changing. That stated, it would still have been reasonable to have referred her to a hospital or surgeon to at least discuss the range of treatment options going forward.

110. Dr Hall stated that medical and nursing staff might benefit from further education in relation to wound management.

111. Dr Hall had concerns with respect to the qualification of the wound care consultant and stated there needs to be a robust process to ensure that patients are managed appropriately under fully qualified health workers.

Report of Pamela Bridges

112. Ms Pamela Bridges is a Registered Nurse holding a BA (Social Welfare) and Graduate Diploma of Health Services Management. She has worked in the aged

care sector for 30 years including as a residential care manager. She runs an aged care consultancy in conducting audits, investigating complaints, reviewing funding strategies and developing quality systems.

113. Ms Bridges formed the opinion Regis were managing Mrs Simon's ongoing diabetic management, nutrition and hydration adequately.

114. Ms Bridges does have some concerns about the wound management processes. She noted the statement from Dr Harvey that he depended on nursing staff to advise him of problems. There is some evidence he may have reviewed the wounds but this is unclear. In her opinion his response to staff requests was inadequate and should have included referral to a specialist such as a hospital or surgeon for review.

115. In addition there were conflicting reports as to what involvement Ms Jenny Smith had with respect to Mrs Simon's and her ongoing wound care.

116. Ms Bridges stated the wound care management plans indicated staff were doing lots of things but there was room for more commentary when there were changes, for example the increase in size and dimensions of the wounds, and better photographs.

117. Ms Bridges also noted clinical nursing staff always have the option of referring a resident to hospital if they are concerned about the care they or the general practitioner is providing. This does not appear to have occurred in this instance and Ms Bridges said she would have taken it to the next level by way of a hospital referral.

118. Ms Bridges also noted that attracting General Practitioners to visit residents in residential aged care services has been problematic for some time and is becoming more difficult throughout the aged care sector. Many aged care services are constrained by less than optimal GP coverage and are frequently placed in the predicament of using out of hours GP services or sending residents through to the local hospital. Most aged care services try to minimise the need to transfer residents to hospital because of the impact this has on the frail and elderly.

119. Ms Bridges stated Regis had comprehensive wound care policies and procedures in place during Mrs Simons' residency. These have been reviewed and re-issued along with widespread staff up-skilling and training in wound management. The breakdown in this case would seem to be between the visiting GP and the engagement of the services of Ms Jenny Smith as a wound care specialist.

120. Ms Bridges was asked about the practice of seeking advice from a wound care consultant. She stated the practice of involving a wound care specialist is common within the aged care industry, however there are not many such specialists out there and the alternative would usually take the form of referral to a hospital service either by way of an admission or through Hospital in the Home (HIH). Ms Bridges stated HIH has had some funding curtailments so she was not sure how available this service was.

121. Ms Bridges was aware of Ms Smith's company. She understood Ms Smith trained as a registered nurse but that registration has lapsed some time ago. She was aware Ms Smith had written at least three books on wound care, which

outlines types of wounds and appropriate dressing options. She noted there are concerns over the involvement of the "wound care specialist" Jenny Smith around whether or not a review of the wounds was undertaken or whether a verbal discussion only took place.

122. Ms Bridges stated the *Aged Care Quality Standards* include outcomes such that skin integrity becomes critically important to the general health and well-being of the frail elderly. Ms Bridges noted that Regis undertook a subsequent review of care services requiring all staff to undertake "clinical decline and training" and training records confirm this has occurred.

123. Ms Bridges noted staff have also been reminded there should be no delay in seeking a medical officer's opinion or alternatively transfer to hospital if required. Regis has since purchased a digital camera as a way to improve high quality photographs for wound management plans. Processes have also been implemented to ensure that photographs of chronic wounds will be consistently taken during weekly wound reviews.

124. Ms Bridges was of the opinion that Regis implemented appropriate reviews and ongoing staff training.

125. In summary, Ms Bridges' opinion is that given Mrs Simons' diagnosed conditions, advanced age and frailty, Regis Canning Lodge appear to have cared 'quite well' for her needs. She considered there to be areas where provision of care and documentation of care could be improved and considers there are 'obvious gaps' in the ongoing monitoring of Mrs Simons' complex wound care. She considered the GP should have been more proactive and clinical staff should perhaps have instigated referral to hospital for advice regarding treatment options. She expressed the view that Regis Canning Lodge have essentially addressed the gaps by implementing mandatory training in clinical decline and noted Dr Harvey no longer visits Regis Canning Lodge or nursing homes generally.

126. Ms Bridges noted that in view of Mrs Simons' comorbidities, age and general health and well-being, her demise as a result of sepsis would have been difficult to arrest, particularly in regard to her unstable diabetes, and reluctance to eat and drink among other things.

Conclusions on the issues

127. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe 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 death occurred with a view to reducing the likelihood of similar deaths.

128. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[1] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the

[1] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

129. With respect to the *Briginshaw* sliding scale it has been held that it does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.

130. In matters involving health care, when determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered. That is, after an event has occurred there is an inclination to see the event as predictable, particularly where the outcome is serious, despite there being few objective facts to support its prediction.

131. In my experience, where there are negative medical outcomes, there is often evidence of poor communication that contributes, and usually not just one event but a number of such events. As a result, critical information is lost, not communicated, or falls between the cracks and is therefore not considered.

132. In this case it is evident there were a number of such events where there was an opportunity to escalate care due to obvious deterioration in Mrs Simons' wounds. These included:

    a. Failure of nursing staff to effectively document on her wound management plan the evidence of the deterioration of her wounds in accordance with Regis policy;

    b. The inadequate documentation of examination of the wounds by two GPs on three occasions and failing to identify the significance of the deterioration, which compounded the diagnosis, in so far as nursing staff were concerned, by indicating the current plan for treatment should continue;

    c. Nursing staff relying on the examination of the wound by a person identified to them by Regis as a wound care specialist, whose advice was largely to continue with the current plan and indicating some improvement in the wounds;

    d. Probable nursing staff and GP effective communication issues contributed to a misunderstanding of the true clinical state of the wounds;

    e. Due to the cumulative act effect of these personnel and system deficiencies the deterioration in Mrs Simon's wound was not adequately identified until the options available to address the concerns were largely palliative in approach.

How she died

133. Mrs Simons suffered from a number of skin tears and skin wounds. In particular, two wounds to the right and left lower legs, both of which were identified on 22 February 2015, became problematic and deteriorated in a serious manner. The progress notes of Regis Canning Lodge indicate in relation to the left lower leg wound that the tendon was on view from 21 April 2015.

134. Mrs Simons was admitted to Caboolture Hospital on the evening of 19 June 2015, with a reduced level of consciousness associated with hypoglycaemia. On admission she was observed to have a number of bruises, skin tears and wounds to her body. Of particular relevance to this inquest, there was a wound to the right outer calf with the tendon exposed and a green/brown exudate and a wound to the left outer calf that was noted to have a tendon exposed and to be sloughy with a green exudate.

135. It was considered by medical staff that Mrs Simons was most likely septic. On discussion with her daughter in Victoria it was decided to focus on comfort cares rather than aggressively pursuing a curative approach due to a poor prognosis. Dr Bazdar confirmed in his evidence at the inquest that he would have expected a patient in Mrs Simons' condition to have been referred hospital earlier and that he thought she should have been referred earlier, at least at the stage that there was an exposed tendon involved.

Adequacy of the care Mrs Simons received from Regis Aged Care, its employees and visiting consultants

136. The evidence of all experts who reviewed the material strongly supports a finding that the care provided to Mrs Simons by Regis Canning Lodge nursing and assistant nursing staff employees in relation to wound care, was not adequate with respect to documentation, treatment provided and referral for medical intervention and escalation of care.

137. I accept the opinion of CN De Tina that documentation of wound development and care for the wound in the wound care plans for the left and right lower legs was not adequate.

138. The wound care management plans set up for Mrs Simons and management of the wounds were also not strictly in accordance with the Regis Wound Care Policy in place at the time. This policy required dated photographs on commencement and then weekly thereafter and required that any changes to the wound should be entered in the progress notes and care plans updated. The wound care management plans themselves recommended weekly measurement, which did not occur. Regis has in its submissions conceded there were inadequacies in relation to wound care assessment and management such as regular photographs and measurement of wounds.

139. The wound care management policy also stated that wound care must be managed by a Registered Nurse for high care residents, of which Mrs Simons was one. The plan required a weekly review by a Registered Nurse (RN), which the records generally indicates occurred to a large extent, although the use of words "Attend" and "Reviewed" confuses the issue somewhat. The records also indicate that on many occasions the wound and dressings were be attended to by Enrolled Nurses such as EEN Joanne Webb. Ms Webb gave evidence that "reviews" of chronic wounds were performed by RNs but that she as an EEN would also attended to wound dressing changes or assessing if dressings were intact in the company of a RN. Ms Webb's evidence was that two nurses were required for dressing changes and she would often input her attendance in the records but her evidence was that she was assisted by a RN. The evidence of Ms Webb was uncontroverted, although it has to be said, and accepting what Ms Webb said is true, the documentation certainly has not assisted in transparently recording what actions took place and by who.

140. What is also uncontroverted is that no photographs or measurements were taken of the left wound leg after Saturday 9 May and of the right leg after 2 June. No-one (doctor or wound care specialist of any kind) was called in to review the wounds after the alleged review by Jenny Smith on 26 May 2015. After 26 May 2015 there was no meaningful documentation of the progression of the wounds to the left and right lower legs, which on Mrs Simon's admission to hospital on 19 June 2015 had clearly worsened significantly.

141. The fact that both wounds were deteriorating during the period of 22 April to 20 June 2015 is clear from the description of the wounds in the statement of Dr Bazdar, including comparing these to what Regis recorded as the description of their size and the nature of the wounds combined with the digital images of the wound attached to his statement.

142. Based on the opinions of Dr Hall and Ms De Tina, the totality of the evidence is that a referral to a doctor ought to have occurred earlier than it did. Ms De Tina agreed with the evidence of Dr Hall that referral to a doctor, at least in relation to the right leg should have occurred by mid-March 2015.

143. Dr Hall, Ms De Tina, Ms Bridges, Dr Bazdar and Dr Harvey himself all agreed that Dr Harvey should have referred Mrs Simons to hospital for a second opinion regarding management options for the wound by 22 April and at the latest 30 April 2015. It is accepted by me the treatment path was likely to have been a conservative one but at the least at that review the family could have become involved in making an informed decision as to the appropriate pathway to be taken forward. This was a lost opportunity for that to occur.

144. One of the issues relating to the care provided to Mrs Simons is the extent to which nursing staff could and should have questioned the response of Dr Harvey on 22 April, 30 April and 19 May and/or referred Mrs Simons to hospital for a second opinion regarding management options for the wound. I accept there were probably a number of hindrances to such action taking place.

145. Firstly, I accept that CN Pratiksha BC may have thought Ms Smith was a registered nurse and an expert and specialist in wound care management and therefor it was not unreasonable for CN Pratiksha BC to accept Ms Smith's opinion.

146. Secondly, Dr Harvey reviewed Mrs Simons on a number of occasions and gave instructions to nursing staff to continue with treatment as "per the plan". A fair reading of the progress notes would have indicated to nursing staff that Dr Harvey considered the wounds had improved.

147. Thirdly, as touched upon by Ms Fairman and CN Pratiksha BC in their evidence, there is the perennial tension in the Doctor/Nurse relationship such that nurses are likely to defer to a doctor's opinion and plan and not override it.

148. Ms Fairman conceded in evidence that although she does not believe the outcome would be resolved by necessarily sending Mrs Simons to hospital, there was scope for significant improvement in the clinical staff having a more robust conversation with the attending doctors and seeking earlier consultation for management of Mrs Simon's wounds.

149. In terms of ensuring appropriate wound care specialists were in use in the various Regis Aged Care facilities around the nation in the first half of 2015, it is

also apparent that due diligence needed to be improved. Ms Fairman stated in her evidence that she was responsible for release of all policies, and said she was not aware in 2015 of what wound specialist services Regis Canning was relying on or that Jenny Smith was providing this service. Certainly the clinical staff at Regis Canning were of that view.

150. A resolution of the contradictory evidence around the involvement of Ms Smith with the Regis Group in terms of policy development and with Regis Canning Lodge in terms of reviewing patients and providing advice and in particular Mrs Simons' care is not at all easy.

151. Ms Smith said in her evidence she made it very clear to Regis Canning Lodge staff in 2015 that she was there to provide general advice as to dressings based on clinical information provided to her by registered nursing staff. She also suggested she reiterated to Regis Canning Lodge on many occasions, if not specifically in relation to Mrs Simons, that they should refer complex wounds that were not responding to treatment to hospital.

152. On the other hand CN Pratiksha BC and CN Mohamadi stated it was their understanding Ms Smith was the wound care specialist to whom wounds should be referred if they were complex, not healing or specialist support was required. Ms Smith's name featured on a couple of occasions in the wound care policy and manual for the Regis Group but there was no reference to her as a consultant in any of the Regis Canning Lodge documents other that her two attendances on Mrs Simons.

153. Other evidence or lack thereof regarding Ms Smith's formal involvement with Regis Canning was in many respects unsatisfactory. No evidence was produced that she was ever paid for her attendances and Ms Smith said she was not paid. It is apparent there was no direct formal contractual arrangement with her. One presumes Ms Smith was not attending Regis Canning on some gratuitous venture however Ms Smith denied she supplied products or dressings at any time in 2015 or earlier and her evidence in that respect was not particularly challenged. The evidence of her attendances on other nursing home residents was largely absent and at the most we know of two and perhaps a third occasion.

154. The evidence that most controverts Ms Smith on this issue are the entries of 15 and 26 May 2015 that included "Jenny Smith Consultant "at their conclusion. I find these were inputted by Ms Smith and not CM Mohamadi. Those entries along with the understanding of staff as to her position as a wound care specialist, does give some credence to the suggestion staff on the ground at least believed she was qualified to provide clinical advice on wound management. The difficulty is Regis Canning staff may not have been put in that position if more robust processes had been in place at an organisational level ensuring the registering of external consultants.

155. Submissions were made that I should refer Ms Smith to the Australian Health Practitioners Regulation Authority for it to investigate if any offence has been committed under s 116 of the *Health Practitioner Regulation National Law* on the basis she held herself out to be a clinical expert in wound management. Based on the unsatisfactory state of the evidence I am unable to find the threshold has been reached to suggest a breach of the *Health Practitioner Regulation National Law* such that I should refer that matter to another body for consideration. Ms Smith's legal representatives advise she has not been a registered nurse for many years and has no intention of registering again.

Care by Dr Harvey

156. The evidence very strongly supports a finding that the care of Dr Harvey was not adequate in terms of documentation, follow up, appropriate treatment and referral.

157. Dr Harvey was aware of Mrs Simons various comorbidities (diabetes, dementia, skin condition that may have been bullous phemphigoid and was treated with steroids) and the vulnerabilities this predisposed her to in terms of skin wounds and infection of such wounds.

158. Despite this he did not have any process in place to ensure he followed up on Mrs Simons' wounds, once he was alerted to a tendon being on view on 22 April. At that point Dr Harvey directed staff to continue treatment ie.to continue the dressing the wound. Dr Harvey was again asked to review the wound on 30 April and recorded that the right lower leg was improving. He still did not consider if any antibiotics should be given, let alone a swab, nor referral to hospital. Dr Harvey was called out again on 19 May and changed the antibiotic regime commenced by the Out of Hours GP and the cream being used but did not do so on the basis of any swab result or testing for infection. He did not recommend referral to hospital.

159. The evidence of Dr Hall is that the wounds to the right and left lower legs were deteriorating from mid-March.

160. Dr Hall's evidence was that Dr Harvey should have referred to hospital for review and second opinion from 22 April and should have also recommended a wound swab so that the most appropriate antibiotic could be commenced. His evidence was also that Dr Harvey should have followed up on the wound independently to determine whether it was healing, given the state of the wounds by late April and that it was not good enough to rely on the nursing home to alert him to any deterioration.

161. Dr Harvey has accepted this opinion. He has acknowledged his care was deficient and his record keeping inadequate. He has undergone significant training as detailed in his second statement to address these deficiencies and no longer attends on nursing homes.

Care by Dr Karmakar, the Out of Hours GP who saw Mrs Simons on 9 May 2015.

162. Dr Karmakar in her oral evidence observed that she was the after-hours GP only, visiting on a one off basis and was not in a position to follow up Mrs Simons. She had no recollection independently of seeing Mrs Simons and did not recall a tendon being on view. She suggested in oral evidence that if she had seen a tendon she would have referred Mrs Simons to hospital for IV therapy or recommended this to Dr Harvey.

163. The essence of her evidence was that whilst she would take on board the suggestion that she should have considered a swab, she considered her treatment was appropriate in the circumstances.

164. On the evidence before me there is no doubt that on 9 May there was a tendon on view in the right leg, and it had been on view from 21 April. Dr Karmakar was called out in relation to concerns about both leg wounds (as per the progress notes) and it is a concern that she did not record there being a tendon on view and appears not to have seen a tendon on view. This suggests there was a limited examination of the wounds. Given the circumstances of her visit and the limited nature of her involvement with Mrs Simons, and noting a letter was sent to Dr Harvey, which should have alerted him to review Mrs Simons earlier than 19 May, it is not considered further comment should be made on the adequacy of the attendance of Dr Karmakar as ultimately that attendance and the plan made was not outcome changing, as is discussed below.

Impact of different medical and nursing intervention and care on Mrs Simons clinical outcome

165. The evidence supports a finding that even had Mrs Simons received the medical and nursing care the experts say she should have, this may not have been outcome changing. The evidence of Dr Hall was that prior to the tendon exposure in the right wound being noticed on 21 April 2015, the best treatment for Mrs Simons would have been referral to hospital for review and then the gold standard would have been surgical wound debridement and washout and IV antibiotics commenced, once a swab had been taken and the specific infection and associated appropriate antibiotics identified. Dr Hall noted that this treatment involves an anaesthetic, which would have been dangerous in a patient as old as Mrs Simons with her co-morbidities. Dr Hall also noted the types of antibiotics that would have been effective are quite toxic and could have caused kidney damage to Mrs Simons. Given all this Dr Hall said it is possible a decision would have been made not to proceed with that aggressive treatment.

166. Dr Hall considered however that the referral to hospital should have occurred well prior to the tendon exposure, and treatment advice would have been sought and the family would have been involved in decision making around how to proceed, even if the decision was to proceed with palliative care to ensure Mrs Simons' last days were as comfortable as possible.

167. Dr Hall's evidence was that once a tendon was exposed, so by 21 April 2015, the most likely surgical intervention would have been amputation, which is highly invasive with a high mortality risk so it is therefore possible surgery would have been unacceptable to Mrs Simons' family and a decision would have been made to pursue a less invasive pathway. Irrespective of when a referral was made, Dr Hall considered referral to hospital should have occurred so that various options for treatment, even if treatment had been palliative, could have been considered by Mrs Simons and her daughter. In so saying Dr Hall emphasised that palliative care does not necessarily mean giving medication and allowing someone to quietly pass away. It would have more been about directions with regard to how to keep her comfortable, perhaps in the nursing home and to bring family and nursing staff in to be part of that decision making process and to actually put ceilings on what the care may be.

168. Dr Bazdar agreed that with her co-morbidities Mrs Simons' would have been a difficult candidate for surgery.

169. However in not having made that referral, discussions as to available treatment and the pros and cons of that treatment, even if it had been palliative treatment, was not had with Mrs Simons or her daughter and this opportunity was lost. Regis accepts it was optimal to have discussions with treating medical practitioners, family and others to ensure all potential options were considered.

170. As to what options were likely to be taken up and how this would have changed the approach taken and how that impacted on Mrs Simons' last days is not clear, but certainly earlier communication may have meant Ms Searle was able to spend more time with her mother in comfort before she passed away.

Communication with family

171. It is acknowledged that much of the evidence initially provided by Ms Seale about her recollection as to lack of communication with her was later established to be inaccurate, in that telephone records established a majority of calls referred to in the progress notes did occur, including calls Ms Searle initially disputed.

172. That said, a significant number of the calls were of very short duration and not of a length that would have allowed any detailed discussion.

173. Importantly there were some recorded in the progress notes or records during some critical periods in terms of Mrs Simons' wound development, but not all critical moments. There was a call on 21 April, which was the point at which Mrs Simons' tendon was first noted to be exposed in the right leg wound bed and again on 29 April the day before Dr Harvey was called back in (late April and May when the doctor was first consulted). There was a call on 9 May, the day the after hours' GP was called back in.

174. Following this however there were no calls on 15 May 2015, the day Ms Smith was said to have reviewed the wound, and no calls on 18 and 19 May when Dr Harvey was called out and then came and reviewed the wound. There was also no call on 26 May when Ms Smith was again documented as having reviewed the wound.

175. The nature of the content of many of the calls, particularly the call on 16 June where Ms Searle is said to have spoken to EEN Webb and praised Regis for their care is disputed. As well Ms Searle disputes there was a call on 22 April where EEN Webb says she informed Ms Searle that a tendon was on view.

176. It is difficult to resolve these inconsistencies. Ms Searle conceded under examination from Counsel for Regis Aged Care that she cannot now recall the nature of the conversation on 22 April. It is also apparent that as the calls were often short and many may have been messages it is unclear as to the length of time conversations were had when Ms Searle returned those calls as Ms Searle stated she would have.

177. Regis has conceded that regardless of the number and timing of telephone calls, Ms Searle felt she was not being adequately apprised of the progressive deterioration in her mother's condition and Regis acknowledged the resultant distress and that a level of communication that resulted in this outcome was not adequate.

178. Regis also conceded there was not adequate communication between its staff, the general practitioners and Ms Searle about the referral to the wound care specialist. As submitted by Counsel Assisting, given the Regis Canning staff themselves do not seem to have appreciated the seriousness of Mrs Simons' situation it is likely the seriousness of her situation was also not then communicated to Ms Searle and therefore Ms Searle did not have an opportunity to consider the available options for treatment for Mrs Simons.

Comments/recommendations pursuant to section 46 of the Coroners Act 2003

Changes made by Regis Canning Lodge

179. It is noted that since Mrs Simons' death, a number of the changes have been made by the Regis Group. Ms Fairman noted in her original letter to the court setting out the findings of the clinical review and that since the incident involving Mrs Simons, additional wound management training has been provided to Regis Canning Lodge staff and the wound care policy and manual has been updated. I am certainly not convinced the clinical review was a robust one but I have noted there have been a number of improvements and changes made by the Regis Group.

180. Ms Pam Bridges of Pam Bridges Consulting has noted in her report to that all staff have undertaken *"Clinical Decline training"* and have been reminded that there should be no delay in seeking a medical officer's opinion or alternatively transferring residents to hospital if required. Processes have also been implemented to ensure photographs of chronic wounds will be taken consistently during weekly ward rounds.

181. The details of the training and changes to policy are set out in a letter from Roslyn Cooper the National Quality Assurance Manager to the court. The letter provided the *Wound Management Policy and Manual* in operation in 2015 and the amended version as of 19 August 2016. The letter also detailed the various training initiatives conducted by Regis since 2015.

182. There is some criticism of the new policy by the legal representatives for Ms Searle, which allows Enrolled Nurses to attend (presumably to change or look at dressings) if they are competent to do so and the task has been delegated to them by a Registered Nurse. Weekly reviews must be performed by the RN. I am not critical of such a change in policy. The policy refers to ENs who are trained in wound care, and provided that is the case then wound care would therefore be within their Scope of Practice.

183. Ms Fairman also noted that in addition Regis was setting up a register of wound care specialists to ensure that individuals relied on by Regis Aged Care have appropriate qualifications. It is a little surprising that such a register had not already been in place by the time of the inquest and it was submitted there should be a recommendation that Regis as soon as possible institute the register and other necessary processes for ensuring credentialing of wound care specialists relied upon by their aged care facilities. Dr Hall emphasised the importance of this in oral evidence.

184. In her written submissions, counsel for the Regis Group stated that her instructions were that such register has now been set up, which includes the wound specialist or service that is available to the facility and the qualifications of the persons providing the wound specialist care. Regis has registered nurses with additional training in wound care. In those more remote areas where services are limited, consultations are conducted by telephone discussions and a review of wound photos. Members of the Regis Clinical Support and Quality and Compliance teams, including two with post graduate qualifications in wound management, are also available to provide wound management advice as required.

185. Ms Fairman also outlined in oral evidence other changes made such as a National Program for Trending and Analysis and Project Lift, which involves sampling of complex wounds to monitor the extent to which complex wounds are resolving in Regis facilities. It was stated the National Program for Trending and Analysis would pick up a delay in the recognition and referral of a complex wound like the one Mrs Simons suffered.

186. Project Lift commenced in late 2017. This involves a registered nurse available on call with electronic access to all files, primarily to give real-time clinical advice and support across facilities. Part of the role is to perform audits on such clinical matters as complex wounds, to identify measures which have assisted or interfered with wound healing, so there can be shared experience and learning across the Regis facilities.

187. Evidence was also provided that in July 2018 Regis Canning Lodge was subject to an accreditation ordered by the Australian Aged Care Quality Agency and was assessed as compliant.

188. Taking into consideration the changes made by Regis, I am not minded to make any other recommendations for changes to policies or procedures. Policies and Procedures are important and provide guidelines and uniformity of practice to help staff make safe decisions. Policies and Procedures do not in themselves guarantee safety and cannot deal with every circumstance that may apply. Of more importance are that clinical decisions are made by appropriately skilled clinicians and that gets very much back to clinicians' experience and training. In that respect I note the evidence and opinion of Ms Bridges who was supportive about the changes made by Regis, and in particular training around clinical decline and the importance of not delaying in seeking a medical officer's review of a wound or transferring a patient to hospital.

189. There was some reference by Ms Bridges and Ms Fairman about the paucity of wound care specialists available to visit nursing homes and the difficulties associated with transferring frail elderly relatives to hospital. It was also commented that Hospital in the Home, a program said to provide short home based acute care instead of a hospital admission had experienced resourcing difficulties and was not able to provide sufficient cover for all cases. Ultimately, the evidence heard in this respect was not extensive and I have not heard from the authorities who manage these resources so it would be unfair to comment.

190. The difficulty attracting GPs to aged care facilities was noted by Dr Hall and also Ms Bridges. This is an issue that has been raised in recent times within the media and commentators in the area. Clearly, this is a significant structural issue but of a magnitude outside the scope of an inquest to comment.

Findings required by s. 45

Identity of the deceased – Kathleen Simons

How she died – Mrs Simons was a 96 year old woman and a resident of Regis Canning Lodge. Her medical history included diagnoses of dementia, insulin dependent diabetes mellitus, a history of falls, deafness, hypertension, hypothyroidism and a skin condition causing extensive blistering, treated with prednisone.

During her admission to Regis she had a number of skin wounds, including multiple skin tears. Two wounds in particular were identified early in 2015 on her right and left lower legs, and the management of these wounds in particular, became problematic.

Although medical opinion is that Mrs Simon's deteriorating wounds should have been escalated to consideration of an admission to hospital by at the latest 30 April 2015, this did not occur despite the review of the wounds by nursing staff, General Practitioners and a purported wound care specialist.

Even with a referral to hospital at that point it is likely the outcome would not have changed but treatment advice would have been sought and the family would have been involved in decision making around how to proceed, even if the decision was to proceed with palliative care to ensure Mrs Simons' last days were as comfortable as possible.

Mrs Simons was ultimately admitted to Caboolture Hospital on 19 June 2015 with sepsis complicated by multiple organ failure, with the infected leg ulcers being the source of the sepsis. She died as a result three days later with her daughter present.

Place of death – Caboolture Public Hospital Caboolture QLD

Date of death– 23 June 2015

Cause of death –

1(a)	Pseudomonas aeroginosa sepsis
1(b)	Infected leg ulcers
2	Diabetes melitus

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
19 December 2018