

FINDING AFTER AN INQUEST INTO THE DEATH OF KATE THERESE BUGMY

In March and June 2010, sitting as State Coroner at Broken Hill, New South Wales, I heard 7 days of evidence relating to the death of this young woman, who died at Broken Hill Hospital on June 28, 2007, aged 26 years.

THE FACTS

Kate Therese Bugmy was born on 31 December 1980 with cerebral palsy, epilepsy and an intellectual handicap, which caused her to never develop speech. Her only mobility was in a wheelchair.

She was clearly deeply loved and cared for by her family throughout most of her difficult life. She attended some schooling, and after turning 18, was given funding to attend the Post School Options day programme run by Broken Hill City Council Disability Services and funded by the Department of Aging, Disability and Home Care (DADHC). From time to time she was looked after in respite care in order to give the family some relief. Her dependence and immobility increased, as she grew older, so that she needed to be dressed, fed, moved and changed.

Tragedy for Kate and all the family struck when her father, Edward 'Old Man' Bugmy, died in early 2004. It seems it was he who had, until the short illness which led to his death, been her primary carer, lifting her, feeding her, driving her generally to her day programme, and ensuring her well being.

Daphne Hall, Kate's mother, herself has a history of serious cardiac problems and was unable to do anything that involved heavy lifting. Apparently that job fell to Jenna Bugmy, Kate's sister, after the death of 'Old Man'. Kate stopped attending her programme, was sad and depressed according to her relatives, her health deteriorated and she lost weight.

On 31 March 2005, Daphne Hall sought advice from Nurse Dickinson at Maari Ma Clinic about dietary supplements and pressure care. Nurse Dickinson treated an ulcer, or bedsore, on Kate's hip in mid April. On 20 April 2005, DADHC re-opened their file after Maari Ma made a referral on Kate's behalf, the file having been closed for some inexplicable reason of

protocol when Kate turned 21 in 2002. After the referral, DADHC assessed Kate as being in urgent need of assistance, with comments recorded that the extended family were concerned about her care, food and support at home, in view of her mother's depression following her widowhood. Some respite care was provided, with ominous notes over the next few months regarding Kate's pressure points, blood sugars, and loss of weight, as well as the fact that Daphne was not coping. The possibility of alternative accommodation for Kate was raised.

On 25 September 2006, Carol Marsden and Karen Plane visited the Bugmy/Hall home at 321 Eyre Street to offer support and extra funding. They noted that Daphne requested a "lifter" to assist with Kate's care at home, because Kate's sister Jenna was pregnant and also unable to lift. Carol Marsden apparently forwarded this request to the manager. Further notes about the lifter appear in DADHC documents up until Kate's death, with no result.

Jenna was due to give birth in May of 2007. Daphne requested respite care for Kate, and she spent two weeks at Algate House until 4 May. Most of the carers during that time recorded her as relatively well, but several expressed shock at her loss of weight and appearance of unhappiness. She did not have any bedsores, but her mouth and teeth were noted to be in a very poor state. On 2 May, Marie Pettitt from the Algate House staff took Kate to Maari Ma because she was barely eating, and constantly whimpering. She was prescribed antibiotics for a presumed dental abscess.

On 4 May, Kate was to be collected by her family at 4 pm and when no one came, Leesa McInnes drove her home. It was claimed that the antibiotics were handed over in a bag with Kate's belongings when she was returned home. It is not known whether Daphne was aware that they were in the bag or administered to Kate.

Over the next few days, Kate was noted to be less than happy. Daphne advised Karen Plane that Kate was unwell and would not come to the day programme, and later, that because of the new baby, would not be brought in for a while.

On 13 June, Daphne again sought advice about Kate's nutritional needs and some 'sores' from Maari Ma. Nurse Dickinson says that she made an offer to make a house call on at least two occasions but Daphne declined saying she was capable of doing it herself.

At some point between 15 and 19 June, Daphne's brother Darren Hall (known as 'Uncle Ponch') went to the house, saw Kate and phoned his daughter Marissa, who worked at Maari Ma, expressing great concern about Kate's health. According to Judith Nancarrow, Marissa told her on the morning of 19 June that 'Uncle Ponch' had described Kate as very ill, thin, with arms a funny colour, and stated that he thought she was dying. As a result, Marissa and Ms Nancarrow approached Dr Elizabeth Wakatama at Maari Ma, who told them that if Daphne did not bring Kate in to the clinic, she would contact the Guardianship Board.

After a phone call during which Daphne stated that Kate was "ok and eating and drinking", Jenna Bugmy brought Kate in to the clinic. Dr Wakatama examined her and found her to be cachectic, malnourished, dehydrated, breathing poorly, and bearing a number of pressure sores on both hips and her lower back. She diagnosed hypostatic pneumonia and probable sepsis, and organised for Kate to be taken by ambulance to the Emergency Department of Broken Hill Hospital. During the drive, Jenna who was emotional and crying, told ambulance officers that Kate's seizures had increased from a normal 2 to 8 a day in the last couple of weeks. Jenna also told Dr Irekpolo in the ED that the ulcers had been little bedsores that had worsened over the past week, and that Kate had barely eaten and had lost weight over the last 2 weeks and was constipated.

At 4 pm Kate was examined by specialist Dr David Pugsley who found her to be extremely sick, grossly underweight and dehydrated, unconscious and with extensive infected ulceration of the skin on the hips and back. He doubted the family's information that she had been taking her anti-seizure medication because she could not be fed orally due to the extent of thrush in her mouth and throat, and her depressed consciousness. She was intubated and heavily medicated and transferred to the Medical ward. Nurses who cared for her at this stage were appalled at her overall state and size in comparison to knowing her as a well-dressed and cared-for child, and by the extent of the sores.

Karen Plane and Carol Marsden met Daphne Hall at Eyre St as arranged on 20 June. Daphne told them that Kate would be coming home in a couple of days and asked for an air mattress to assist with the sores, and again a lifting device. Because she, Daphne was to have bypass surgery in early August in Adelaide, and Jenna did not want to care for Kate because of her new baby, Daphne's sister would come to help, and home care service would be provided. Further notes about the lifter were made.

Over the next few days, Kate's condition fluctuated. She had surgery to insert a triple lumen catheter and a naso gastric feeding tube was introduced. She was barely conscious, and whimpering in pain when visited by Carol Marsden, who had not seen her since the previous September and was horrified at her state.

On June 26, Kate became feverish. Her temperature climbed to 40° over the next 48 hours, and she lost blood pressure. The sores had improved, but then deteriorated again.

A case meeting was held at the hospital with DADHC and Broken Hill City Council disability carers on 27 June, and a decision was made to apply to the Guardianship Tribunal for management of Kate's accommodation and care needs with or without her mother's consent. Dr Pugsley expressed a strong view that on admission "she showed neglect of caring".

During the night of the 27 June, concerns grew about Kate's condition. She was observed to have a possible seizure with her temperature remaining at 40.5°, and her blood pressure and urine output were low. Dr Pugsley recorded that because of "extreme limitations engendered by her illness, and (it was)...agreed with her family intensive life preserving interventions were not undertaken." Despite all efforts, she died at 9.45 am on 28 June.

THE ISSUES

1. Could Kate Bugmy's death have been prevented?
2. Was she neglected to the point that her death could be considered manslaughter by criminal negligence?
3. Did each of the authorities involved, the Greater Western Area Health Service (GWAHS), the Department of Aging, Disability and Home Care (DADHC), Broken Hill City Council Disability Services (BHCDS) as well as the primary carers and medical and nursing staff at both the clinic and the hospital, meet their duty of care to Kate?

THE EVIDENCE

Mr Hamill, Senior Counsel Assisting me, with Ms Edwards and Ms Berry, tendered lengthy submissions, which were distributed to all parties, and form part of the evidence in this matter. Those submissions address in great detail the witnesses called, their oral evidence and documents tendered, as do those of the other parties. I therefore do not intend to duplicate their admirable work, but to comment upon the most vital aspects of the evidence only.

Family and Friends

I agree with my Counsel Assisting's Submissions that evidence taken from most members of Kate's family was moving, and emotionally fraught. However, although understandable, it was concerning that some of them had difficulties in giving truthful evidence about Kate and other family members.

Darren Hall ('Uncle Ponch') on 18 June visited his sister Daphne and Kate at home. He then contacted Marissa Bugmy, Kate's cousin, who worked at the Maari Ma Clinic, and in voicing his concerns about Kate, began the process by which Kate was shortly after admitted to hospital.

Marissa spoke to Nurse Nancarrow and Dr Wakatama at the clinic, and from her description, Dr Wakatama threatened to go to the Guardianship Board if Kate was not brought in to Maari Ma. When she was presented, Dr Wakatama was so appalled at her condition that she had her taken directly to the Broken Hill Hospital.

Darren Hall had trouble admitting to the court what he had seen.

Jenna and Maree Griffiths (who as Kate's brother's partner was also living at the house) each gave descriptions of Kate, which simply could not have been correct. Nevertheless, Jenna shared the care of Kate with her mother, and at least until the later stage of her pregnancy, had done her best for Kate, without any real knowledge of medical matters.

Another Uncle, Doug Hall, known as ‘Peanut’ perhaps made the most truthful and telling statement of all. He had moved from Broken Hill soon after ‘Old Man’ died, and was not directly involved in the last months of Kate’s life. Despite that, he showed his grief and his shame when he wept from the witness box: *“Everybody... we all. Failed Kate”*.

There can be no doubt, whatever else, that many people loved Kate throughout her life.

Carers

During the inquest I acknowledged the compassionate and difficult job carried out by those who care for the handicapped and the aged. I reiterate my admiration for them and their efforts.

Those who looked after Kate in respite care were required to keep a “communications book” recording details of Kate’s physical condition, eating, drinking and showering. Once this book was found and produced to the court, the increasing difficulties Kate experienced during her final stay at Algate House became obvious, including the fact that on 2 May 2007 Dr Wakatama at Maari Ma Clinic diagnosed her as having a dental infection and prescribed an antibiotic.

Overall, Kate patently declined during this period, but there is no evidence that DADHC or its staff were made aware of this.

It is also unclear whether Daphne Hall was made aware of the medication on Kate’s return home, where her health worsened.

DADHC staff Ms Carol Marsden (Community Services Worker) and Ms Karen Nash (Manager Community Access) were in daily contact with each other. Ms Nash as Manager had no direct contact with the Bugmy/Halls, but Ms Marsden theoretically was to make three-monthly reviews. However, her enormous and geographically widespread caseload made this impossible. In the critical six weeks leading up to Kate’s death, she had not apparently contacted the family, and was unaware of the problems arising for Kate during the respite period at Algate House.

Ms Nash explained that as Kate was a community access client, and not a residential care client, responsibility for her day-to-day care including medical and dental needs remained with the family. Once aware of a client being at risk, the Department can approach the Guardianship Board for appropriate orders, but it was not known that Kate was at risk despite Ms Nash being well aware of the family circumstances (Daphne's heart condition and depression, and sister Jenna's pregnancy).

While Daphne Hall disliked home calls and was reluctant to seek assistance, there is no evidence that she resisted assistance or home visits from the Department or any other carers during this time. She had been asking the Department for months to consider providing a lifter to help at home, without success. I take the point made by Counsel for the Department that lifters are rare in private homes, need two people to operate, and are likely to have been considered unsuitable in this case. The fact remains that no assessment was ever carried out so that suitability might be ascertained or not, and lifting Kate remained a major problem for the family.

Karen Plane was one of the staff of the Broken Hill City Council Disability Services. She had greatly cared for Kate, and gained Daphne's trust. With hindsight, she appeared concerned that she had missed the significance of Kate's ceasing to attend the Post-School Options programme from 8 May 2007. Combined with other factors such as Daphne's depression and health, Jenna's baby and Kate's medical problems during respite care, that was a missed warning signal.

Medical and Nursing Staff

Nurses Veenstra, Everuss, Clemens and Mathers from Broken Hill Hospital were witnesses before the court. They were all dedicated, caring professionals who were shocked by Kate's condition and its severity. Nurse Everuss had known Kate for over ten years, and was appalled by her weight loss. They were all horrified at the state of the pressure sores and her overall emaciated appearance.

Nurse Judith Nancarrow was a community midwife at the Maari Ma Health Service. She had no direct connection whatsoever with Kate, but was skilled enough to recognise and prompt in acting upon, the concerns first raised with her by Marissa.

Nurse Dickinson, also from Maari Ma, was asked for advice about pressure sores and nutrition by Daphne, which she gave. Contrary to Maari Ma practice, she provided Daphne with dressings without having seen the patient herself. As has been submitted, even though against protocol, it was preferable to not providing suitable dressings at all.

Dr Wakatama was working as a medical officer at Maari Ma at that time. She diagnosed Kate with a dental abscess when she was brought to the clinic from respite care on 2 May (2007). She also noted extensive tooth decay.

But it was her role on 19 June 2007 which became highly important. When approached by Nurse Nancarrow and Marissa Bugmy with concerns for Kate's health (after Marissa had spoken to Darren Hall), Dr Wakatama immediately demanded to see Kate, identified the severity of her condition and arranged for her hospitalisation. She noted that Kate had pneumonia and potential sepsis. She ensured follow-up with the hospital, and raised concerns about the standard of her home care.

Dr Pugsley, a senior and experienced physician, examined Kate on her hospital admission and described her as "an extremely sick woman, grossly underweight, grossly dehydrated. She was unconscious and there was extensive ulceration of the skin, over both Trochanteric regions and the Sacrum. These areas were obviously infected." Her condition on admission was "the most parlous he had ever seen".

He expressed the view to the court that this was due to neglect by her mother, and contacted the police after Kate's death to advise them of that view. His opinion was that she was always unlikely to have recovered sufficiently ever to receive treatment outside hospital.

While Kate improved under the initial treatment, she was debilitated to such a point that she became feverish (temperature over 40°) on 26 June, and died of an infection probably contracted in the hospital.

The Department of Aging, Disability and Home Care

Why DADHC closed Kate's file in 2002 (when she was 21) was never clarified to my satisfaction. It had been involved with Kate throughout her life to that time and if anything,

she was more handicapped at age 21, than when she was very young, and more needy as a result.

Ms Marsden gave evidence that files would be closed generally when clients began to attend the Post-School Options programme and their case management assumed by the Broken Hill City Council Disability Services. She also stated that closure of files was a solution to the impossible caseload.

Kate's file was re-opened in 2005 only after the Department received a referral from Maari Ma expressing concern about her home care.

Appropriate steps at this point may have avoided the terrible deterioration which later occurred in Kate's health.

The process of obtaining a lifter for the home, including assessment of the family's ability to use it, should have been begun.

At the very least, an overall management plan for Kate's medical, dental, dietary and general care needs with a competent overseer to co-ordinate services was essential at this point, but was not developed.

Two issues hampered DADHC: firstly, that its services are voluntary and that there is no power to force them upon a reluctant carer; and secondly, that the isolation of Broken Hill created even more difficulties for an already pressured, under-resourced and understaffed Department.

There were no body scales suitable for weighing Kate in the area, except for one at the hospital. There was no private or DADHC employed occupational therapist in Broken Hill from Sept 2006 on. Funding was scarce and slow to be considered. Pressure mattresses, which were essential for someone in Kate's state of immobility were unknown to DADHC staff, even had funding been available. Dental services were few, and waiting lists extremely long. The staff of DADHC, were not then cognizant of the enormous risk to life of extreme pressure sores.

In an environment of extreme under-resourcing and lack of co-ordination between services, Ms Marsden and other staff were simply unable to perform their roles effectively.

The Experts

The court heard over two days, by AVL, expert evidence from Dr Sheehy (a geriatrician and endocrinologist), and Dr Durvasula (a specialist in medical services for the intellectually and developmentally disabled), both acknowledged as senior experts in their respective fields.

I acknowledge the self-evident truth in the submissions on behalf of DADHC that each Doctor practices “with the benefit of the facilities...available at major teaching...hospitals in Sydney” as opposed to dealing with indigenous health in remote areas. But Dr Sheehy was sufficiently aware of the tyrannies of distance to note that the intense needs of Kate could not possibly be provided by her family or by the service providers as they were resourced, in Broken Hill. She agreed that Ms Marsden’s caseload made impossible the level of co-ordination needed. This was also acknowledged by Dr Durvasula, who has provided detailed recommendations for additional resources to be deployed by DADHC.

Dr Sheehy commended the medical/nursing care given to Kate at the Hospital, other than whether she was provided with a pressure mattress. The use of pressure mattresses was emphasised by her as vital for patients at risk of bedsores both in hospital and at home.

Both specialists agreed that Kate needed an overall management plan well before her admission to hospital, with a dedicated case worker to conduct an annual review of needs, regular assessments, and co-ordination of access to all services. Those services should have included an occupational therapist, a nutritionist, a general practitioner who would make home visits, dental care, a physiotherapist and equipment such as a pressure mattress, a lifter and an adapted wheelchair.

As ‘default plans’, Dr Sheehy suggested two options, the involvement of an Aged Care Assessment Team, or an application to the Guardianship Tribunal, which should have been made when it became known to DADHC that Maari Ma had treated Kate for pressure sores in May 2005.

Similarly, Dr Durvasula focussed upon the importance of annual comprehensive health plans for the disabled in home care. Her ideal would be a properly managed plan conducted by a health professional, in order that all health needs are identified, and co-ordinated by a case worker who would work with family to ensure all appointments and strategies are met.

CONCLUSIONS

The extreme disabilities with which Kate Bugmy was born required full time care, with which her family struggled to cope, staunchly resisting alternative, outside care.

Although that resistance clearly arose from love, it came at a price and may not have been best for Kate, at least in her later years.

The death of her father had a devastating and complicated impact on the whole family. Daphne became depressed, as did Kate, who may never have recovered from it. She lost weight. She lost some of her sparkle. Her health began to decline, and her immobility to increase. This, along with her weight loss, increased the risk of developing pressure ulcers. The first indication of pressure ulcers and weight loss arose shortly after Old Man's death. Without him, Kate's mother and siblings were less able to cope with her complex needs. In fact, Daphne herself had serious heart problems, and Jenna bore her first child.

Kate's condition on admission to hospital in June 2007 suggests that they were unable to cope at all in the previous weeks. It is quite clear that Kate was badly neglected at this time and that the family should have sought medical and other help much earlier. Although they may have been ignorant of the life-threatening risk posed by pressure sores, it must have been apparent how distressed and debilitated Kate was for days before. Perhaps at some point panic set in. It appears to have been only the threat by Dr Wakatama of calling in the Guardianship Board, which forced Daphne and Jenna in to taking Kate to the clinic.

Daphne was a private proud woman with her own health problems. She was resistant to even the best intentioned outside intervention and some of the service providers (with the outstanding exception of Karen Plane) found her difficult. Knowing that she had direct knowledge of the history of the stolen generation, that is understandable. However, it does not explain her failure to seek the necessary help for Kate to prevent her reaching the

condition she had reached in June when her Uncle Darren, seeing Kate for the first time in months, was so appalled at her state that he contacted Marissa to beg that something be done.

Jenna too must have had her attention and ability hugely diverted by her new baby, but again, must have realised that Kate was extremely ill and needed medical help. She, Jenna, was not incapacitated.

The services available in far western New South Wales are dangerously strained. Ms Marsden's impossible caseload is one example of this, as is the fact that no DADHC occupational therapist was available for a home visit for two years. Those services, which were available, were not co-ordinated, so that none of the service providers was aware until too late, of Kate's deterioration and the overall problems developing for the family.

Had there been some co-ordination, ideally in the form of a case manager, between the various service providers (Maari Ma, BHCDS, respite care and case workers) the risk may have been identified in time to prevent Kate's death.

As a direct result of that lack:

- no occupational therapy assessment was ever carried out for a lifter, even though in 2006 Kate was seeing the Broken Hill Hospital Occupational Therapist in relation to customising her wheelchair;
- the suitability of a lifter or hoist to relieve pressure areas was never assessed;
- the need for a pressure relieving mattress was never identified;
- the family was never made fully aware of the perilous risks involved in leaving bed sores untreated or in trying to treat them incorrectly at home;
- Kate's weight was never monitored;
- Ms Holland did not review the "communications book" from Algate House and was thus unaware of the observations made by the respite carers of ill health;
- there was no follow up after Kate left Algate House and the case worker was not told of the difficulties she had experienced in that last period of respite.

Every individual involved in Kate's care, her primary carers and the employees of the service providers, meant well and most did their best in extremely difficult circumstances. However, the absence of a dedicated advocate or case worker to co-ordinate the services and to liaise

with and advise the family, exacerbated the rapid deterioration of her condition and the inability of her family to cope.

All these factors suggest that Kate's death could have been prevented had they been put in place within the last year of her life. Dr Sheehy's opinion was that Kate's chances of survival at the time she was hospitalised were low, less than 20%. Dr Pugsley too held low hopes for her. Apparently because of her condition, her immune system was unable to fight off any further infection. The care she received in hospital is beyond any criticism. The same cannot be said for how she was treated at home.

No individual can, in law, in my view, be said to have been guilty of criminal neglect. However, the failure of Kate's mother and sister to seek medical help will remain inexplicable, while the carers' omissions seem to have been due primarily to their scarce resources and the lack of co-ordination which dominates all the evidence in this inquest.

Almost no one met their full duty of care to Kate while she was at home. If not, as her uncle said, failed by everybody, Kate Bugmy was failed by a fragmented, badly under-resourced, under-staffed, and unco-ordinated system.

I concur with Counsel Assisting that it is regrettable that the three parties who also made submissions after the conclusion of the evidence all adopted a defensive approach to the issues arising from Kate's death. Sections 3(e) and 82 of the *Coroners Act* of 2009 are not designed to attribute blame, but to seek prevention of similar deaths in the future by making any recommendations which appear to the Coroner to be necessary arising from the evidence.

There is no questioning the good intentions of DADHC, Broken Hill City Council Disability Services, or Maari Ma Health Service. Surely each institution should be seeking any possible assistance with, and recognition of, the difficulties in providing services in a remote town to people with huge problems, and with far too little funding and staffing. Witnesses from each recognised that their systems could be improved or done differently.

The recommendations I intend to make are formed with that in mind, not in order to criticise.

RECOMMENDATIONS:

It is hereby recommended to the NSW Minister for Aging, Disability and Homecare (DADHC):

(1) That DADHC should give strong consideration to:

- (a) Developing and implementing a policy to ensure that the disabled with complex needs living with family, particularly in remote areas, are allocated a caseworker who together with a General Practitioner and other service providers ensures that an annual health care plan is developed and met and all services co-ordinated.
- (b) Reviewing and implementing the allocation of human resources to and within the Broken Hill office to ensure that caseworkers are able to complete the currently required annual plans and three-monthly reviews and whether further training is required. This might include the appointment of Clinical Nurse Consultants to assist with health care plans and ensure on going case management.
- (c) Implementing a respite care discharge protocol which requires that issues arising during respite care, including any health problems and their treatment or future treatment are communicated to the primary carer and the DADHC case worker, and a decision made as to who bears the responsibility for following up where necessary.
- (d) Developing a protocol which could be incorporated in to the existing three-monthly review for recognising 'flags of concern' (to include weight loss, pressure sores, absence from contact or refusal to accept services) in order that early consideration be given if necessary to an application to the Guardianship Tribunal.
- (e) Providing urgently a protocol for managing prolonged staff absences including physiotherapist, occupational therapists, social workers, speech pathologists and dieticians, at least by the case manager advising all service users of the

likely duration of the absence, seeking advice for alternative assistance from local hospital staff, and considering whether funding private access to allied health services might be provided.

- (f) Promoting awareness among staff, patients and primary carers of the “Clinical Practices, Pressure Ulcer Prevention-Policy Directive-NSW Department of Health-PD2005_257” and of “Taking the Pressure Off-Wound Care Association of NSW Inc.-2008” guide.

(2) I recommend to the Manager of Maari Ma Clinic, Broken Hill

I recommend to the General Secretary of the Nurses Association

- (a) In the same terms as paragraph (1)(f), that strong consideration should be given to promoting awareness among staff, patients and primary carers of the “Clinical Practices, Pressure Ulcer Prevention-Policy Directive-NSW Department of Health-PD2005_257” and of “Taking the Pressure Off-Wound Care Association of NSW Inc.-2008” guide.

(3) I recommend to the Manager, Broken Hill City Council:

- (a) In the same terms as paragraph (1) (f), that strong consideration should be given to promoting awareness among staff, patients and primary carers of the “Clinical Practices, Pressure Ulcer Prevention-Policy Directive-NSW Department of Health-PD2005_257” and of “Taking the Pressure Off-Wound Care Association of NSW Inc.-2008” guide.
- (b) Strong consideration should be given to developing a protocol and training for carers to recognise, and report to the case manager, ‘flags of concern’ (to include weight loss, pressure sores, absence from contact or refusal to accept services) and to recognise and have knowledge of the treatment of pressure sores including communication of that knowledge to primary carers.

(4) I recommend to the Minister for Health

- (a) That NSW Health be commended for its consideration of establishing specialised multidisciplinary teams, and recommended to give priority to the provision of the teams to regional areas with limited or no access to specialist services

- (b) The Greater Western Area Health Service to consider consulting a wound care specialist in relation to the Area Health Service's policies and protocols in respect of:
 - (i) The assessment of pressure ulcer risk on admission to hospital;

 - (ii) The provision of care and treatment in order to prevent the development of pressure ulcers in hospital, including through the provision of pressure reducing equipment;

 - (iii) The treatment of pressure ulcers in hospital, including through the provision of pressure reducing equipment;

 - (iv) The documentation of steps taken to assess, prevent and treat pressure ulcers in hospital.

Reform of the *Coroners Act*

An issue arose during the course of the Inquest concerning the ability of a Coroner to make a non-publication order covering submissions relating to the question of referral of the papers to the Director of Public Prosecutions under s. 78 of the *Coroners Act*. The clear policy behind various provisions of the *Coroners Act* is to ensure that the coronial process does not interfere with the future course of criminal justice: see, for example, sections 76 and 81(3). However, there is no express power to order non-publication of submissions made in relation to whether a known person may have committed an indictable offence. In some cases, the publication of such submissions would have real potential to cause prejudice to the future conduct of criminal proceedings. Such prejudice could impact on the case of either the Prosecution or the accused person.

Accordingly, I make the following recommendation to the Attorney General:

The Attorney General and New South Wales Parliament consider amending the *Coroners Act* by:

- (i) Inserting the words 'or any submission or any part of the proceedings' after the word 'evidence' in s. 74(1)(b) of the Act.
- (ii) Adding the following paragraph to s. 76:

'(d) any submissions by legal representatives or comments made by the coroner in relation to whether an Inquest should be suspended under s. 78'.

FINDING

That Kate Therese Bugmy died on 28 June 2007 at Broken Hill Hospital, as a result of Streptococcal Sepsis resulting from Skin Ulceration and complications of Cerebral Palsy.

Magistrate Mary Jerram

August 26 2010

NSW State Coroner

Chambers, Glebe